COMPASS MEMORIAL
HEALTHCARE
Discover the difference

Marengo Memorial Hospital d/b/a

Compass Memorial Healthcare

Annual Program Evaluation for the Fiscal Year 2025
July 1st, 2024-June 30th, 2025

COMPASS MEMORIAL HEALTHCARE
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Annual Program Evaluation
Report Period: July 1st, 2024- June 30th, 2025

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Annual Evaluation: Purpose

In accordance with the Regulation and Interpretive Guidelines 485.641, Compass Memorial Healthcare has prepared the following report to comply with the standard for the periodic evaluation and quality assurance review.

The purpose of the review is to determine if the utilization of services was appropriate; determine if patient care policies were implemented; and to determine if any changes are needed. The annual program evaluation can be used for planning and reporting. All the information within this document was reviewed on a monthly and/or quarterly basis. Any identified areas of improvement were addressed throughout the year as a part of the Organizational Performance Improvement Plan.

Annual Evaluation: Mission, Vision, Values

The hospital's mission is to provide remarkable healthcare that makes a difference in the well-being of the patients and communities we serve. Our values are our True North. They keep us true to our north and unwavering in all that we do (NSEW).

- Neighbors Caring for Neighbors
- Service Excellence
- Embracing Change
- unWavering Commitment

Every day our work is guided by our true North. We seek to provide a positive unique patient experience.
As an organization, goals were established within the strategic plan to support the mission of the hospital. This plan will assist in achieving the goals that were set within the strategic plan, these goals are:

- Create a foundation of efficient and effective operational practices to improve performance, service, and outcomes;
- Seek out and cultivate strong partnerships with providers who share our vision;
- Aggressively pursue our role as the provider of choice in our service area;
- Create a culture in which great talent will be led by great leaders to deliver amazing results;
- Become known for our remarkable patient care experiences.

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Annual Evaluation: Service Volumes

In compliance with CAH regulation CFR 485.641(a)(1)(i), table 1.1 provides the number of patients served and the volumes of services in FY2025.

Table 1.1: Service Volumes Comparison

Service Volumes	FY22	FY23	FY24	FY25	Difference FY24-FY25	% Growth FY24-FY25
Hospital Admissions	**386**	**389**	**439**	**444**	**5**	**1.1%**
• Acute	295	288	359	376	17	4.7%
• Skilled	53	57	45	37	(8)	-17.8%
• Transitional Care	25	30	28	21	(7)	-25%
• Hospice	13	14	7	10	3	42.9%
Observation Stays	**284**	**394**	**430**	**400**	**(30)**	**-7.0%**
Emergency Department Visits	**4266**	**4834**	**5232**	**5202**	**(30)**	**-0.6%**
Service to Patient (Nurse Visit)	**622**	**538**	**603**	**801**	**198**	**32.8%**
OR Surgical Procedures	**1081**	**1328**	**1649**	**1935**	**286**	**17.3%**
• General Surgery	138	147	173	172	(1)	-0.6%
• Orthopedic Surgery	78	63	79	101	22	27.8%
• Endoscopy	366	469	561	534	(27)	-4.8%
• Ophthalmology	139	230	241	289	48	19.9%
• Urology	-	34	52	102	50	96.1%
• Podiatry	23	17	28	22	(6)	-21.4%
• ENT	35	33	44	27	(17)	-38.6%
• Pain Clinic	291	319	471	688	217	46.1%
Laboratory Tests	**66734**	**75439**	**87655**	**88179**	**524**	**0.6%**
Imaging	**9634**	**10925**	**12340**	**13159**	**819**	**6.6%**
• X-Ray	5019	5566	5973	6348	375	6.2%
• MRI	603	632	748	820	72	9.6%
• CT Scans	2023	2471	3053	3078	25	0.8%
• Ultrasound	1164	1303	1399	1580	181	12.9%
• Bone Density	155	180	240	252	12	5.0%
• Mammography	630	733	869	1008	139	15.9%
• Needle Guided Biopsy	40	40	58	73	15	25.8%
Infusion Center Visits	**1605**	**1613**	**1359**	**1737**	**378**	**27.8%**
Oncology Clinic Visits	**1422**	**1295**	**1181**	**1165**	**(16)**	**-1.4%**
Respiratory Therapy Procedures	**4047**	**3990**	**4299**	**4360**	**61**	**1.4%**
Pulmonary Rehabilitation	**87**	**177**	**246**	**214**	**(32)**	**-13.0%**
EKG	**1395**	**1628**	**2010**	**2019**	**9**	0.4%
Cardiac Rehabilitation	**437**	**646**	**906**	**619**	**(287)**	**-31.7%**
Therapy Units of Service	**16765**	**16639**	**17596**	**21342**	**3746**	**21.3%**
• Physical Therapy	11073	10578	11958	14517	2559	21.4%
• Occupational Therapy	4619	5134	4691	5726	1035	22.1%
• Speech Therapy	1073	927	947	1099	152	16.1%
Sleep Studies	**121**	**141**	**138**	**176**	**38**	**27.5%**
• Home Sleep Study	73	90	90	113	23	25.6%
• Sleep Study	48	51	48	63	15	31.3%
Senior Life Solutions Sessions	-	-	**195**	**1059**	**864**	**443%**
Telemedicine Outreach Visits	-	-	-	**85**	**85**	-
Total Tests/Visits (Hospital & Clinic)	**140,059**	**151,566**	**172,736**	**180,771**	**8,035**	**4.7%**

Annual Evaluation: Service Statistics Summary

As part of the Organizational Performance Improvement Plan (PIP), the organization sets a growth goal based on the previous years' service statistics. Our fiscal year 2025 ended the year with a total number of tests/visits/procedures of 180,771 which came in over budget by 415 total tests/visits/procedures and had 8,035 more visits than FY24, putting us at an overall growth of 4.7% from FY24, with a total overall growth rate of 29.1% since FY22. Please note, the Rural Health Clinic service statistics are not shown in Table 1.1 but are included in the total tests/visits/ procedure numbers. Service statistics for the rural health clinics can be found in the Rural Health Clinic Program Evaluations.

Service statistics are reviewed and reported monthly to the Quality Steering Committee, Medical Staff, and the Board of Trustees. Service volumes are analyzed for trends and action plans associated with growth and marketing are discussed and developed, which typically include additional equipment or staff needed to support growth; additional marketing efforts; additional services offered, and staff recruitment.

Annual Evaluation: Chart Review

In compliance with CAH regulation CFR 485.641(a)(1)(ii) a representative sample (at least 10%) of both active and closed clinical records were reviewed in the past year. Records addressed included inpatient and outpatient records. Both active and closed reviews were conducted for completeness, accuracy, and adherence to policy standards, protocols and standards of clinical care.

As a part of the Organizational Performance Improvement Program, chart reviews are completed monthly, and results are analyzed for trends and implement corrective action if needed. Outcomes are reported either monthly or quarterly to the appropriate committees and performance improvement initiatives are discussed if corrective action is needed. Table 2.1 includes all chart review measures, type of review and if the measures reviewed met the standard of care or threshold set by the organization.

Table 2.1 FY 2025 Open and Closed Chart Review Measures/Outcomes

Measures	Type	Cases Reviewed	# of Cases Reviewed	% Cases Reviewed	Standard Met
Inpatient (Acute/Skilled) Chart Review: Documentation Standards Consents and Required Documents Physician Assessment and Documentation Requirements Nursing Assessment and Documentation Requirements Therapy Assessment and Documentation Requirements Social Services Assessment Requirements Activities Documentation Requirements Death Documentation Requirements Discharge Documentation Requirements	Open	Admissions	65	16%	☒
Inpatient/Observation Chart Review: Provider Documentation Standards Timeliness of H&P completion Timeliness of Discharge Summary completion	Closed	Discharges	846	100%	☒
Inpatient/Observation Chart Review: Patient Safety Medication/Patient Identification Safety Standards	Closed	Med Administrations	31,960	100%	☒
Inpatient Chart Review: Patient Safety Computerized Provider Order Entry Compliance CPOE	Closed	Admissions	844	100%	☒
Inpatient Chart Review: Patient Safety Medication Reconciliation	Closed	Admissions	844	100%	☒
Inpatient/Observation Chart Review: Standard of Care Review-VTE Appropriate Prophylaxis	Closed	Admissions	844	100%	☒
Inpatient Chart Review: Standard of Care Review-Prevention of ADR Blood Glucose <50	Closed	Glucose Readings	1,766	100%	☒
Inpatient Chart Review: Standard of Care Review-Prevention of ADR INRs >5	Closed	INR Results	139	100%	☒
Inpatient Chart Review: Standard of Care Review-Prevention of CAUTI Appropriate Indications Proper Insertion Daily Assessment	Closed	Catheter Insertions	152	100%	☒
Inpatient Chart Review: Standard of Care Review-Prevention of Falls Fall Assessment/Reassessment	Closed	Admissions	844	100%	☒
Inpatient/Observation Chart Review: Standard of Care Review- Pressure Ulcer Prevention Skin Assessment/Reassessment High-Risk Plan Documentation/Compliance	Closed	Admissions	844	100%	☒

Inpatient Chart Review: Standard of Care Review-Hospital Readmissions Follow-Up Appointments Made Prior to Discharge (Home)	Closed	Discharges	382	100%	☒
Inpatient Chart Review: Standard of Care Review-Antibiotic Stewardship Standards	Open	Doses	5,088	100%	☒
Inpatient Chart Review: Regulatory Standards Acute Length of Stay <96 Hours	Closed	Discharges	382	100%	☒
Emergency Chart Review: Patient Safety Medication and Patient Identification Standards	Closed	Administrations	4,053	100%	☒
Emergency Department Chart Review: Documentation Vitals (30 mins prior to discharge) Nurse/Nurse Handoff on Transfers	Closed	Transfers	245	100%	☒
Emergency Chart Review: Documentation Standards (EMTALA) Transfer Documentation Standards	Closed	Transfers	245	100%	☒
Emergency Department Chart Review: Provider Documentation Standards Timeliness of Emergency Room Note Completion	Closed	Discharges	5,202	100%	☒
Emergency Department Chart Review: Trauma Documentation and Care Standards Provider Response Time Injury Date/Time Transfer Time GCS Vascular access Trauma Alert Trauma Readmissions Safety Equipment Blood Alcohol Patient Weight Ambulance Diversion Vitals	Closed	Trauma Visits	84	100%	☒
Emergency Room Standard of Care Review: Chief Complaint of Chest Pain Arrival to EKG Time	Closed	Patients with CC of CP	258	100%	☒
Emergency Room Standard of Care Review: AMI Aspirin at Arrival Arrival to EKG Time Arrival to Transfer Time	Closed	Patients with primary DX of AMI who Transfer to HLC	4	100%	☒
Emergency Room Standard of Care Review: Stroke Arrival to Head CT Time	Closed	Patients with primary DX of Stroke	7	100%	☒
Emergency Room Standard of Care Review: Sepsis Timing of Antibiotics Blood Cultures Fluids	Closed	Patients with primary DX of Sepsis	41	100%	☒
Emergency Room Standard of Care Review: Efficiency Standards Arrival to Doc Time Arrival to Discharge Time Arrival to Transfer Time Arrival to Admit Time	Closed	ED Visits	5,202	100%	☒
Surgery Chart Review: Documentation Standards H&P Requirements Pre-Op Teaching Requirements Pre-Op Screening Requirements Pre-Procedure Consents Pre-Op Assessment Requirements	Closed	Surgical Procedures	86	7%	☒

Anesthesia Documentation Discharge Procedures Surgeon Post-Op Requirements					
Surgery Chart Review: Patient Safety Safe Surgery Checklist (exclude endoscopy)	Closed	Surgical Procedures	713	100%	☒
Surgery Chart Review: Patient Safety Medication/Patient Identification Safety Standards	Closed	Med. Admins	3,680	100%	☒
Surgery Standard of Care: **SCIP** Antibiotic Timing Appropriate Antibiotic Selection VTE Prophylaxis	Closed	Knee/Hip Surgeries	23	100%	☒
Surgery Chart Review: Surgical Surveillance Post-Surgical Site Infection	Open	Surgical Procedures	713	100%	☒
Surgery Chart Review: Provider Documentation Standards Timeliness of OR Note	Closed	Procedures	1,935	100%	☒
Lab: Patient Safety Inpatient/Outpatient Critical Result Reporting	Closed	Critical Labs	3,098	100%	☒
Pharmacy: Patient Safety Inpatient/Outpatient Order Verification	Open	Orders	35,814	100%	☒
Oncology: Patient Safety Medication/Patient Identification Standards	Closed	Med Admins	1,977	100%	☒
Infusion: Patient Safety Medication/Patient Identification Standards	Closed	Med Admins	1,205	100%	☒
Imaging Services (CT) CT: Undue Exposure to Radiation	Closed	CT Exams	3,078	100%	☒
Imaging Services (Mammography) Follow-Up Documentation	Closed	Mammogram Exams	1,008	100%	☒
Imaging Services: Radiology Interpretation Time	Closed	Imaging Exams	13,086	100%	☒
Imaging Services: Pregnancy Documentation	Closed	Imaging Exams	6,348	100%	☒
Respiratory Therapy: Patient Safety Medication and Patient Identification Standards	Closed	Med Admins	1,410	100%	☒
Respiratory Therapy **Completion of Interpretation and Follow-Up**	Closed	Interpretations	6,379	100%	☒
Pulmonary Rehab Chart Audit Documentation Standards Clinical Requirements Physician Signature Requirements Patient Goals	Open	Therapy Charts	10	100%	☒
Cardiac Rehab Chart Audit Documentation Standards Clinical Requirements Physician Signature Requirements Patient Goals	Open	Therapy Charts	22	100%	☒
Pain Clinic Medication/Patient Identification Safety Standards	Closed	Med Administrations	1,021	100%	☒
Physical, Occupational, and Speech Therapy Outpatient Documentation Standards	Closed	Therapy Charts	81	10%	☒

Annual Evaluation: Chart Review Summary

Compass Memorial Healthcare exceeds the 10% record review requirements for each service area. This result directly correlates with our commitment to the state and national patient safety standards, as well as our ability to automatically abstract a substantial amount of documentation, standard of care, assessment, and outcomes information from our EMR. Record review results are analyzed, and corrective action is implemented if needed. Chart review measures listed above can be found within the Quality Dashboard Report starting on page 25 of this document.

CMH will continue to review a large percent of medical records to ensure high quality of care, compliance with regulatory requirements and compliance with hospital policies and procedures.

Annual Evaluation: Policy and Procedures

In compliance with CAH regulation CFR 485.641(a)(1)(iii), Compass Memorial Healthcare evaluates all hospital patient care policies, at least biennially. Policies are developed, reviewed, revised and/or deleted by action of leadership, medical staff and board.

CMH follows policy AM 3000 for the policy development and review process. The purpose of the policy is to provide the procedure for consistent implementation of new policies at CMH. To meet regulatory requirements, this policy also assures appropriate review and approval tracking prior to implementation. All hospital policies are reviewed on a annual basis and changes are made based on the review. Table 3.1 includes all new, revised, and deleted policies from FY2025. Table 3.2 includes all hospital policies reviewed during FY2025.

Table 3.1 New/Revised/Deleted Policy Listing from FY2025

Department: Administration			
Policy #	**Policy Name**	**Action**	**Description**
AM 1205	CAH Services & Service Agreements	Revised	Updated to reflect current services & service agreements.
AM 2001	Dependent Adult Abuse	Revised	Updated and changed to an HR policy
AM 2009	Child Abuse	Revised	Updated and changed to an HR policy
AM 9000	Notarization	Revised	Updated for team members, and also noting screening done by someone other than a notary
AM 9001	Schedule of Meeting Rooms	Revised	Add in trash remove or notify housekeeping
Department: Business Office			
BO 2002	Adjustment for RHC Nurse Visit without a qualifying RHC visit	NEW	RHC Billing Guidelines
BO 4008	Bad Debt	NEW	Procedures that have previously been implemented never had a policy attached to them.
Department: Compliance/Risk Management			
CP 2000	Billing Compliance	Deleted	Outdated process - covered in coding audits policy
Department: Central Scheduling			
CS 1052	After-Hours Access	NEW	Guidelines regarding access to Central Supply outside of normal business hours
Department: Dietary			
DS 3009	Diet Order Texture/Liquid Modification Conversion	Revised	Update conversion; new conversion chart

Department: Emergency Department			
Policy #	**Policy Name**	**Action**	**Description**
ED 1203	Assessment of the ED Patient	Revised	Updated
ED 1212	Legal Blood Alcohol/Toxicology Level (serum)	Revised	Recent increase to collection fee - updating to reflect this
ED 1323	Administration of IV Fluids and IV Medications	DELETE	No longer have EMT staff
ED 1382	Fluid/Blanket Warmer	Revised	Added some charting expectations
ED 1506	Diversion	Revised	Updated
ED 2200	ED Department Readiness Crash Cart	Revised	Updated
ED 2506	Use and cleaning of surgical instruments and trays	Revised	Updated process due to utensils with rust
Department: Emergency Operations			
HICS	Cardiopulmonary 2	Deleted	Added information to the Cardiopulmonary unit leader
HICS	Cardiopulmonary Unit Leader	Revised	Added Cardio 2 to the Cardio unit leader
Annex	Annex Surge Capacity	Revised	Updating names and the amount of food available
Form	Annex Form	Revised	Conference Center change to Oncology addition
Department: Employee Health			
EH 1003	Post Offer/Pre-Employment Health	Revised	Specified signed documentation & religious affiliate leader
EH 1006	Periodic Health Assessment	Revised	Deleted information is in the TB policy or mask fit policy
EH 1007	Medical Surveillance of Healthcare Worker Handling of Drugs	Revised	Change in assessment.
EH 4000	Flu Immunization Policy	Revised	Defined team member to encompass all working with CMH patients
Department: Employee Benefit Pharmacy			
EB 4001	CMH Pharmacy - North English Telepharmacy	Revised	Add Emilee & Policy, grammatical/content update
EBRX 4002	Licensure and Professional Standards	Revised	Reviewed and updated add NE Pharmacy
EBRX 4035	Employee Benefit Program	Revised	Update to hours/contact information
EBRX 8001	Pharmacy Security	Revised	Updated to content

Department: Finance			
Policy #	**Policy Name**	**Action**	**Description**
FS 3000	Limits of Authority	Revised	Updated the need for Chiefs to be replaced by directors/chiefs, removed additional CEO column in table on page 2, updated page 3 to reflect a reference to an organizational chart to keep any changes current for the policy.
FS 3001	Scope of Investment	Revised	Removed the statement that investments should be 397 days or longer
Department: Human Resources			
HR 1032	Continuing Education	Revised	Updated
HR 1035	Payroll Procedures	Revised	Updated
HR 1037	Holidays	Revised	Change of coverage hours
HR 1092b	Non-employed Personnel	NEW	Define
HR 992	Student Opportunities	Revised	Addition of immunization exemption requirements
HR 992	Student Opportunities	Revised	Removed COO
Form	Child Abuse and Dependent Adult Abuse Reporting Form	Revised	No longer need to send to DHS will use form internally
Department: Housekeeping			
HS 1003	Cleaning Patient Room Discharge/Transfer	Revised	Updating procedure
HS 1026	Cleaning Restrooms	Revised	Change in the cleaner used
HS 1036	Cleaning Offices	Revised	Updated procedure
HS 1039	Cleaning Exam/Treatment Rooms	Revised	Added procedure
HS 1059	Department Hours	Revised	Updated hours in policy
HS 1072	Attendance & Scheduling	NEW	
Department: Infection Control			
IC 1002	Infectious Disease Program	Revised	Updated data reporting
IC 1011	Bloodborne Pathogen Management	Revised	Updated procedure
IC 1023	Infectious Disease Outbreaks	Revised	Clarification/rewording of when IDPH are involved
IC 4002	Contracted Services Absences	DELETE	No longer contracted employees.

Department: Information Technology			
Policy #	**Policy Name**	**Action**	**Description**
IT 4000a	Artificial Intelligence	Revised	UPH added a new AI policy
IT 7004	Workstation Use	Revised	Added Vocera texting
IT 7009	Video Surveillance	Revised	Changed to 60-day retention
IT 8001	Helpdesk	Revised	Removed Spiceworks
Department: Laboratory			
LB 1003	Priority Timing for Specimen Collection	Revised	Developed timing guidelines for specimen collection
Department: Maintenance			
MD 1001	Plant Ops and Maintenance Program	Revised	Added Clinics
MD 1005	Work Order Forms	Revised	Added detail on process of work order
MD 1008	Use of Outside Contractors	Revised	Added Clinics
MD 1015	Snow Removal	Revised	Added clinics and snow removal company
MD 1016	Indoor Air Quality	Revised	Added Clinics
MD 2008A	Testing of Life safety Equipment	Revised	Updated monitoring company adding VFMC
MD 2011	Med Gas Shutoff Locations	Revised	Updated locations
MD 3009	Fire Plan	Revised	WFMC has its own plan and updating fire extinguisher placement
MD 4001	Hazardous Material Handling	Revised	Added clinics
MD 4005	Emergency Procedure for Hazardous Waste	Revised	Name change and MSDS location
MD 5010	Equipment Safety	Revised	Biomed service - how to report service needs
MD 6022	Blood Bank Alarm System	DELETE	The system does not exist
Department: Medical Staff			
	Standing Orders	Revised	Addition of Chloroacetic
Department: Nursing Services			
NS 10099	Drawing blood from Central Venous Catheters	Revised	Updating lab process alcohol caps, documentation, and removing betadine

Department: Nursing Services			
Policy #	**Policy Name**	**Action**	**Description**
NS 10132	Skin tear prevention and management	Revised	Updated referral to wound clinic
NS 10222	Intravenous Therapy	Revised	Addition of a skin barrier
NS 10251	Patient Weights	Revised	Updated
NS 10284	Laboratory Ordering Guidelines	Revised	Add lab present when RN draws off venous access lines and call if labs are cancelled at short notice
NS 10306	Nasogastric and Orogastric Tube	Revised	Documentation - addition of tube intact after removal
NS 10306	Nasogastric and Orogastric Tube	Revised	Addition of an anti-reflux valve
NS 10371	Oxygen Therapy	Revised	Changed the care of suction canisters
NS 10492	Transfer of Patient to another facility for Admission or Procedure	Revised	Ambulance information & other updates
NS 10510	Midstream Urine Specimen for Culture	Revised	Change in product
NS 10511	Urinary Catheter Insertion: Prevention of CAUTI	Revised	Updated procedure
NS 7003	Admission Policy	Revised	Update PTA Documentation
NS 8016	IV Admixture Preparation-Immediate Use Compounding	Revised	Updated to reflect USP 797 guidelines
NS 10124	Dental Services	Revised	Updated with regulation requirements
Department: Patient Access			
PA 5509	Point of Service Collection	Revised	Update policy to include commercial insurance guidelines
Department: Pharmacy			
PS 10007	Pharmacy Cleanroom Surface Sampling	NEW	New requirements for USP 787/800 Guidelines
PS 1008	Pharmacy Cleanroom Facility & Engineering Control Requirements	NEW	Created to meet BOP regulations & USP 797 requirements
PS 2004	Presenting/Ordering Controlled Drugs	Revised	Updated to reflect the current process

Department: Pharmacy			
Policy #	**Policy Name**	**Action**	**Description**
PS 2005	Prescribing/Ordering General Practitioner	Revised	Updates to reflect the current EPIC process
PS 2011	Antimicrobial Stewardship	Revised	Update process to reflect use of "Bugsy" in EPIC
PS 4004	Prescribing & use of Aminoglycosides	NEW	Aminoglycosides use limited - unable to have onsite serum monitoring
PS 4005	Pharmacy to Dose Aminoglycosides	DELETE	Limited utility of Aminoglycosides - no onsite serum monitoring
PS 4010	Emergency Medication	Revised	Updated med list for adult kit to note premix Norepi infusion
PS 4010	Emergency Medications	Revised	Update change to Narcan Vial size
PS 4013	Sterile Admixture/Compounding Sterile Preparation	Revised	Updated to meet USP 797 requirements
PS 4026	Vaccine Storage & Handling	Revised	Updated to include inpatient pharmacy process and cross referencing NE Pharm.
PS 4029	Pharmacy to Dose - Adult Vancomycin Dosing	Revised	Updates
PS 4031	Adult Renal Dosing Protocol	Revised	Update - add new regiment
PS 6001	Medication Errors	Revised	Minor update to fix grammatical, formatting
PS 7010	ADM's Quality Assurance & Monitoring Plan	Revised	Updated policy
PS 8004	eDrug Storage Conditions	Revised	Minor updates, add NE Pharmacy
Department: Respiratory Therapy			
RT 1017	Flex Staffing Program	Revised	Updated time-keeping system
RT 2003	RT Standing Order	NEW	
RT 2005	Respiratory Care Access and Treat RCAT Protocol	NEW	Adding policy for frequently ordered RCAT
RT 2006	Oxygen Therapy	Revised	Referenced Policy Number Change
RT 2068	Triology EV 300	Revised	Include in-line neb placement due to recent field safety notice
RT 2073	Holter Monitors	Revised	Updated charge capture procedure

Department: Surgery			
Policy #	**Policy Name**	**Action**	**Description**
SG 2051	Management of Pt. with MH	Revised	Review with minor changes
SG 2051B	MH Cart	Revised	Worked with pharmacy to update - new drug and med box
SG 2051C	Dantrolene Mixing and Administration	DELETE	
Department: Social Services			
SS 2002	Continuing Education for Social Services Personnel	Revised	Clarification of who is responsible for maintaining documentation
SS 3002	Social Services Role in Recognizing and Reporting Abuse/Neglect	Revised	Updated to reflect changes in need for a written report and changes in hospital policy numbers
SS 4005	Discharge Planning When NO Family Available	Revised	Updated name of policy and added guidance related to each of the decision-making authorities by family/possible need for the hospital to initiate guardianship
SS 4012	Preadmission Screening and Resident Review	Revised	Updated to reflect changes in the online process, guidance from Maximus, and a form added for ease of location
Department: Utilization Review			
UR 1002	Levels of care - OBS	Revised	Medicare Advantage Plans change to acute for obs (only covered for up to 48 hours with new Medicare regulations)

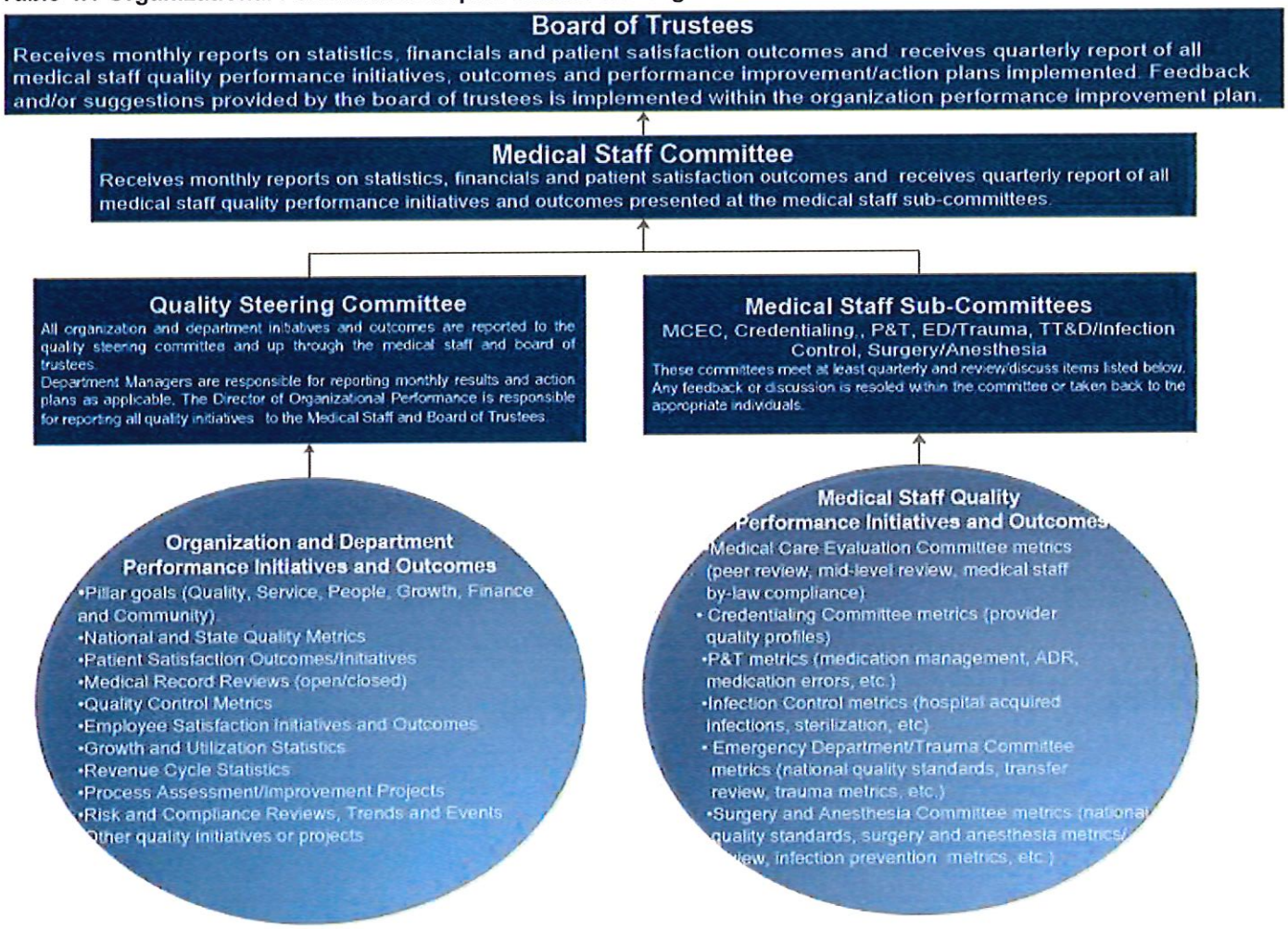
Annual Evaluation: Organizational Performance Improvement Program

485.641 (b) Standard: **Quality Assurance. The CAH has an effective quality assurance program to evaluate the quality and appropriateness of the diagnosis and treatment furnished in the CAH and the treatment outcomes.**

Compass Memorial Healthcare has an ongoing Organizational Performance Improvement Program that is organizational-wide and includes all departments and services provided under contract. The purpose of the program is to evaluate the quality and appropriateness of the diagnosis and treatment furnished, patient experience and satisfaction, utilization of services, efficiency and effectiveness of our operational practices and staff competency and satisfaction by completing ongoing monitoring and data collection; problem prevention, identification and data analysis; identification of corrective actions; implementation of corrective actions; evaluation of corrective actions; and measures to improve quality on a continuous basis.

The Board of Trustees is responsible for carrying out its responsibilities for overseeing and ensuring quality throughout the organization. The Board of Trustees has given the authority to the Chief Executive Officer, along with the Medical Staff and Leadership team to assist in carrying out these responsibilities. To carry out these responsibilities, hospital leadership and medical staff developed a committee structure to ensure quality of clinical care, patient safety, customer service, appropriate service utilization, financial strength and stability is consistently evaluated, and action plans are developed and monitored when identified. The committee structure detail can be found on table 4.1.

Table 4.1 Organizational Performance Improvement Plan Org Chart



Annual Evaluation: Organizational PIP Org Chart Committee Description

Board of Trustees
The CMH Board of Trustees is ultimately responsible for assuring the quality of care and services provided by CMH through the development of a comprehensive performance improvement plan. The Board delegates the responsibility for the implementation and evaluation of this plan to the Chief Executive Officer and the Quality Steering Committee.

Quality Steering Committee
The Quality Steering Committee (QSC) is comprised of the Chief Executive Officer, Chief Financial Officer, Chief Nursing Officer, Director of Ancillary Services and Organizational Performance, and the Director of Ambulatory Clinics and EPIC Administrator.

The Quality Steering Committee is responsible for assisting the board in carrying out its responsibilities for overseeing and ensuring organizational performance. In order to meet these responsibilities, the Quality Steering Committee implements the PI plan; sets standards, expectations, and desirable outcomes for performance metrics; evaluates hospital-wide performance data; reviews the effectiveness of the PI program and authorizes necessary resources or changes in organizational structure, systems, and staff to improve program performance; assures that all employees are educated in performance improvement principles and methods; holds staff accountable for complying with the plan; and performs disciplinary action to individuals that do not meet the expectations set within the PI plan. To ensure these responsibilities are met, the Quality Steering Committee will meet monthly, or as needed.

Medical Staff Committee
The Medical Staff is responsible to the Board of Trustees for the quality of care provided to patients. The Medical Staff meets at least quarterly, and is responsible for: receiving and acting upon the reports and recommendations from the Medical Executive Committee and/or other Medical Staff Committees; approving patient care policies or policies affecting the Medical Staff and/or patient care; approving Medical Staff Bylaws (new or revised); reviewing and approving the drug list or formulary of drugs, additions to and deletions from drug list and update the list annually, evaluate and advise selection of drugs which meet therapeutic quality standards, and reviewing regulations associated with medication use; reviewing and approving appointments and reappointments to the Medical Staff Membership, staff categorization, department or service assignments and delineated clinical privileges, in order to make recommendations to the Board of Trustees; delegating authority to the Medical Executive Committee; and fulfill the Medical Staff's accountability to the Board of Trustees for the quality of overall medical care rendered to the patients/residents in the Hospital.

Medical Care Evaluation Committee
The Medical Care Evaluation Committee (MCEC) is a sub-committee of the medical staff and functions as the peer review and quality improvement committee to monitor, review and evaluate the hospital's medical performance measures in regard to patient care and treatment, acute readmissions within 30 days; trauma, chest tube, and codes; return to the emergency room within 48 hours; unplanned return to surgery, surgical complications, deaths peer review monitoring for appropriateness of care, patient safety, patient complaints, patient compliments, discharge planning, medical record completion deficiencies, health information management processing and sentinel events.

MCEC reports provider-specific data for utilization statistics, medical outcomes data, compliance with medical staff by-laws, rules and regulations, policies and procedures to the credentialing committee in the form of the practitioner quality file/reappraisal profile. MCEC is also responsible for reporting any known concerns, breach of ethics or breach of compliance with the Medical Staff By-Laws, the Rules and Regulations, or the law, to the Credentialing Committee.

Tissue, Transfusion/Infection Control Committee
The Tissue, Transfusion and Infection Control committee serves as a medical staff sub-committee and meets at least quarterly.

The purpose of the Tissue and Transfusion function of the committee is to review tissue specimens for all surgical cases where tissue examination was determined to be necessary. Review of such specimens includes but is not limited to evaluation of the appropriateness of all cases in which tissue specimens are evaluated, the development or approval of

Annual Evaluation: Organizational PIP Committee Purpose Description Continued…

policies and procedures relating to tissue specimens, the processing of tissue specimens, and the review of the adequacy of pathology services to meet the needs of patients.

The committee is also responsible for review of blood usage for all cases in which patients were administered blood transfusions and/or blood derivatives. This review includes, but is not limited to evaluation of the appropriateness of all cases in which patients were administered blood transfusions and/or blood derivatives; the evaluation of all confirmed transfusion reactions; the development or approval of policies and procedures relating to the distribution, handling, use and administration of blood and blood components; the review of the adequacy of transfusion services to meet the needs of patients; and the review of ordering practices for blood and blood products. Screening mechanisms are used to identify problems in blood usage for more intensive evaluation.

The purpose of the Infection Control function of the committee is to ensure that all infections in the hospital are reported on the prescribed forms, including whether the infection was contracted while a patient was in the hospital, or if the patient had the infection upon entering the hospital, the review and analysis of infections, the promotion of preventative and corrective program to minimize infections, and the supervision of infection control in all phases of the Hospital's activities.

Pharmacy and Therapeutics Committee

The Pharmacy and Therapeutics Committee is a medical staff sub-committee that meets at least quarterly and performs the following functions: development and surveillance of Pharmacy and Therapeutics policies and practices; policies and procedures developed relating to the selection, intra-hospital distribution and handling, and the safe administration of drugs; develop and maintain a drug list or Formulary of drugs accepted for use in the hospital; review additions to and deletions from the drug list and to update the list at least annually; evaluate and advise in the selection of drugs which meet the most therapeutic quality standards; prevent unnecessary duplication in the stock of the same basic drug or its combination; evaluate and review recommendations from pertinent regulatory agencies when regulations involve the use and oversight of medication and determine the proper course of action/implementation if required; review financial data related to medication budget and develop strategies to address, if needed; study problems which may arise within the scope of the Pharmacy and Therapeutics Committee and to make recommendations regarding these matters.

Credentialing Committee

The Credentialing Committee functions as a sub-committee of the medical staff which meets at least quarterly, or as needed, and reports to the Medical Staff.

In accordance to the Medical Staff By-Laws and Rules and Regulations, the duties of the Credentialing Committee are to: Investigate the credentials and qualifications of all applicants for initial and continued Medical Staff Membership, for initial and continued delineation of Hospital privileges, and to make recommendations to the Medical Staff; review provider quality files/reappraisal profile data and arrive at a decision regarding the competence and performance of the Medical Staff Member to make recommendations for granting privileges, and for appointments and reappointments.

Emergency Department/Trauma Committee

The Emergency Department (ED) Committee is comprised of all Emergency Department providers that hold an active medical staff membership, along with other designated clinical and support staff of the organization. The Committee meets monthly, or as needed, and reports to the Medical Staff.

The ED Committee oversees the patient care provided in the hospital's Emergency Department, including appropriate transfers of patients; reviewing policies that relate to ED and Trauma patient care, reviewing any complaints related to the ED or to ED patient care, and making reports and recommendations related to the ED or emergency patient care to the Medical Staff.

Annual Evaluation: Organizational Performance Improvement Program

In accordance with CAH regulations 485.641(b)(1) and 485.641(b)(2), Compass Memorial Healthcare assures that all patient care and other services affecting patient health and safety are evaluated through the Organizational Performance Improvement Plan (PIP), along with nosocomial infections and medication therapy is evaluated. As a part of the Organizational Performance Improvement Program, performance metrics are reported monthly, and results are analyzed for trends and implement corrective action if needed. Outcomes are reported monthly or quarterly to the appropriate committees and performance improvement initiatives are discussed if corrective action is needed. Table 4.1 includes the organizational goals that were set by the Board of Trustees as the focus of the Organizational Improvement Plan. Each pillar goal cascades down to department goals set for ongoing data collection and monitoring. Table 4.2 includes the organizational outcomes for each pillar goal.

Table 4.1 CMH FY2025 Organizational Goals by Pillar

FY25 Organization Goals	FY25 Goal
Service Pillar	
To maintain "always" responses on the inpatient HCAHPS survey to 80% as measured by Press Ganey.	80%
To maintain outpatient satisfaction rate of 95% as measured by the outpatient satisfaction survey.	95%
Quality Pillar	
To meet or exceed 95% of the quality metric set within the organization.	95%
Growth Pillar	
To have an average total of tests/visits of 180,356 annually or 15,030 per month.	15,030
Finance Pillar	
Maintain positive bottom line	> 0%
People Pillar	
To maintain or exceed employee satisfaction at or above 98% as measured through the internal employee satisfaction survey.	98%
Community Pillar	
To provide 120 community service and/or health-related events in FY2025.	120

COMPASS MEMORIAL HEALTHCARE
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Annual Evaluation: Organizational Performance Improvement Program

Table 4.2 CMH FY2025 Organizational Pillar Goal Outcomes

Compass Memorial Healthcare
FY 2025 Organization Goals Dashboard

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	FY25 Goal	July	August	September	October	November	December	January	February	March	April	May	June	FY25 YTD
Organization Goals: Service														
Maintain % of patients answering ALWAYS on the Inpatient HCAHPS questions	80%	64%	77%	89%	82%	80%	88%	87%	81%	79%	76%	84%	72%	80.0%
Maintain outpatient satisfaction mean score at 95%	95%	98.4%	99.2%	98.2%	97.2%	98.2%	97.7%	97.7%	98.6%	97.6%	97.9%	98.0%	98.2%	98.1%
Organization Goals: Quality														
To meet or exceed 95% of the quality metrics set within the organization	95%	96%	98%	96%	96%	96%	94%	96%	96%	96%	95%	95%	99%	96.0%
Organization Goals: Finance														
Maintain positive bottom line	> 0%	8.46%	7.39%	6.88%	11.09%	72.91%	4.40%	10.47%	11.23%	7.10%	13.52%	-8.42%	18.79%	13.63%
Organization Goals: Growth														
To have an average total of tests/visits of 180,356 annually or 15,030 per month	15,030	14,846	15,508	13,863	16,415	14,603	15,362	15,891	14,633	15,373	15,893	14,085	14,261	15,061
Organization Goals: People														
To maintain employee satisfaction at or above 98%	98%												99.8%	99.8%
Organization Goals: Community														
To provide 120 community service and/or health related events in FY25	120	18	18	18	26	12	24	12	8	8	14	12	12	182

*HCAHPS YTD is 12 month rolling average
*Community YTD is an annualized average

Annual Evaluation: PIP-Service Pillar Outcomes

CMH continues to fulfill our mission to provide remarkable healthcare that makes a difference in the well-being of the patients and communities we serve. During the past year, our patients continued to voice their satisfaction with the services they received at Compass Memorial Healthcare. In our outpatient areas, 98% of patients stated they were very satisfied with their services at CMH through our internal survey provided to all patients for the service they received, and 100% of patients would recommend the hospital. For inpatients, we continue to survey using the HCAHPS requirements through CMS. We ended FY 2025 with 80% of our patients answering "always" on the HCAHPS questions and 80% of our patients stating that "Yes" would definitely recommend our hospital to others.

Table 5.1 includes a breakdown of each department's service goals and outcomes for FY 2025. All HCAHPS section goals listed below are set off the state benchmark for that section of the survey.

Table 5.1 CMH Service Pillar Dashboard for FY25

Service Pillar Dashboard

COMPASS MEMORIAL HEALTHCARE	FY25 Goal	July	August	September	October	November	December	January	February	March	April	May	June	FY25 YTD
INPATIENT HCAHPS														
ORG GOAL: To meet or exceed average of HCAHPS questions to 80% or higher as measured by Press Ganey.	80%	64%	77%	89%	82%	80%	88%	87%	81%	79%	76%	84%	72%	80%
Percent of patients who reported definitely YES, they would recommend our hospital to others.	75%	75%	71%	93%	83%	88%	75%	85%	64%	71%	76%	100%	70%	80%
Percent of patients who rated our hospital at a 9-10 rating from scale of 0-10.	77%	63%	87%	93%	83%	89%	100%	86%	75%	76%	86%	100%	60%	85%
Percent of patients who reported that their nurses ALWAYS communicated with them well.	83%	63%	80%	95%	83%	100%	96%	92%	94%	78%	79%	90%	85%	85%
Percent of patients who reported their providers ALWAYS communicated with them well.	83%	75%	88%	100%	89%	100%	83%	97%	89%	82%	76%	87%	89%	88%
Percent of patients who reported they ALWAYS received help from staff as soon as they wanted.	71%	36%	77%	71%	82%	61%	83%	90%	71%	66%	80%	76%	67%	71%
Percent of patients who reported that their room and bathroom were ALWAYS clean.	77%	63%	93%	93%	100%	78%	100%	95%	92%	90%	81%	80%	70%	85%
Percent of patients who stated they ALWAYS had a quiet environment at night.	69%	63%	60%	71%	80%	67%	88%	77%	50%	86%	74%	80%	60%	71%
Percent of patients who reported that their medications were ALWAYS explained to them.	65%	60%	58%	92%	67%	56%	63%	73%	100%	69%	59%	57%	44%	67%
Percent of patients that reported YES they were given information about what to do for their recovery at home.	88%	100%	78%	95%	75%	83%	100%	91%	90%	94%	74%	83%	100%	90%
OUTPATIENT SATISFACTION														
ORG GOAL: To meet/exceed outpatient satisfaction	95%	98.4%	99.2%	98.2%	97.2%	98.2%	97.7%	97.7%	98.6%	97.6%	97.9%	98.0%	98.2%	98.1%
% of patients who would recommend the hospital	95%	99.8%	100%	100.0%	100%	100%	100.0%	100%	100%	100%	100.0%	100.0%	100.0%	100.0%
Cardiac Rehab	95%	x	x	x	x	x	x	x	x	x	100.0%	100.0%	x	100.0%
Colonies Family Medical Clinic	95%	99.8%	100%	98.7%	99.4%	100.0%	99.0%	97.3%	97.7%	99.7%	98.9%	99.4%	98.4%	99.0%
Emergency Department	95%	96.5%	99.3%	98.6%	97.4%	98.1%	97.7%	97.1%	96.3%	94.8%	97.0%	98.8%	95.0%	97.2%
Home Sleep Study	95%	93.9%	98.2%	100.0%	88.1%	95.2%	96.4%	93.4%	99.4%	94.0%	89.3%	93.3%	100.0%	95.1%
Imaging Services	95%	98.1%	98.4%	98.8%	98.5%	98.9%	99.0%	98.6%	98.1%	98.6%	97.9%	99.4%	99.4%	98.6%
Laboratory	95%	98.6%	100%	97.9%	99.4%	99.7%	99.3%	98.6%	98.5%	99.1%	98.9%	98.8%	99.4%	99.0%
Marengo Family Medical Clinic	95%	99.7%	97.0%	98.7%	98.5%	100.0%	98.2%	97.7%	97.4%	98.2%	97.8%	97.1%	98.5%	98.2%
Marengo Family Medical Clinic-*General Surgery*	95%	x	x	x	x	x	92.0%	100.0%	99.0%	92.9%	94.8%	94.6%	100.0%	96.2%
Marengo Family Medical Clinic-*Ortho*	95%	x	98.8%	85.7%	86%	100.0%	91.1%	93.6%	96.1%	91.7%	96.7%	98.1%	97.6%	94.1%
Marengo Family Medical Clinic-*Urology*	95%	x	100%	x	x	x	100.0%	93.8%	99.1%	100.0%	98.5%	99.1%	98.2%	98.6%
Marengo Family Medical Clinic- Wound	95%	x	x	x	x	x	99.4%	98.5%	99.0%	96.7%	97.5%	97.1%	96.7%	97.8%
North English Family Medical Clinic	95%	98.5%	98.4%	97.6%	98.9%	100.0%	97.9%	98.1%	98.3%	98.8%	98.3%	97.4%	98.2%	98.4%
Oncology	95%	100%	x	100%	x	x	x	x	100.0%	95.6%	98.2%	x	100.0%	99.0%
Pain Clinic	95%	100%	100%	99.3%	x	96.7%	96.2%	93.1%	100.0%	100%	99.2%	97.5%	95.8%	98.0%
Patient Access	95%	98.7%	99.5%	99.1%	98.7%	98.8%	99.0%	97.8%	98.5%	98.9%	98.9%	97.9%	98.6%	98.7%
Physical, Occupational and Speech Therapy	95%	99.6%	100%	100%	100%	98.8%	99.4%	100.0%	100%	100.0%	99.4%	100.0%	97.5%	99.6%
Pulmonary Rehab	95%	100%	100%	x	x	x	x	100.0%	100.0%	100.0%	x	x	x	100.0%
Respiratory Therapy	95%	98.8%	100%	100.0%	99.4%	99.2%	100%	100.0%	100%	100%	100.0%	97.9%	97.9%	99.4%
Senior Life Solutions	95%	x	x	x	x	100.0%	x	x	x	100%	x	x	x	100.0%
Service to Patient	95%	x	x	100.0%	100.0%	100.0%	93.3%	100.0%	98.6%	x	x	98.6%	98.6%	98.6%
Surgery	95%	98.7%	100%	97.9%	99.4%	99.2%	98.1%	98.6%	98.6%	99.0%	99.4%	99.4%	100.0%	99.0%
Victor Family Medical Clinic	95%	95.5%	99.9%	98.1%	98.3%	98.9%	98.7%	98.6%	99.5%	95.8%	98.5%	99.3%	97.3%	98.2%
Williamsburg Family Medical Clinic	95%	98.6%	98.0%	98.3%	96.4%	98.5%	96.9%	99.0%	98.3%	97.8%	97.5%	98.4%	97.7%	98.0%
Williamsburg Family Medical Clinic-*General Surgery*	95%	x	x	x	x	x	x	x	x	x	x	x	x	-

*HCHAPS YTD Section is based on rolling 12 month average.

Annual Evaluation: PIP-Quality Pillar Outcomes

For FY25, CMH set goals for 138 performance metrics including national/state best practices, patient safety metrics, chart review/documentation requirements and quality control metrics. CMH set an organizational goal to meet or exceed 95% of the 138 metrics set. These metrics are reported monthly, and results are analyzed for trends and implement corrective action if needed.

CMH ended the year with 96% of the 138 organization quality metrics met. Table 6.1 reflects all the quality performance metrics and outcome data for FY 2025. Table 6.2 on page 31 includes the contracted services QA metrics for FY2025.

Annual Evaluation: PIP-Quality Pillar Outcomes

Table 6.1 Organizational Wide Quality Pillar Metrics

Compass Memorial Healthcare
FY 2025 Quality Pillar Dashboard

COMPASS MEMORIAL HEALTHCARE
An Affiliate of UnityPoint Health

STATE & NATIONAL PATIENT SAFETY/QUALITY METRICS AND OUTCOMES	FY 25 Goal	July	August	September	October	November	December	January	February	March	April	May	June	FY25 YTD
CMS/MBQIP OUTPATIENT ED- AMI														
AMI (STEMI only) patients average (median) time in minutes from ED arrival to transfer	</=61	75	63	x	x	68	x	x	x	55	x	x	x	65.3
CMS/MBQIP OUTPATIENT - ED Efficiency Measures														
Median time from ED arrival to ED departure for patients discharged from the ED	</=155	110	105	115	121	117	121	118	108	120	120	104	110	114
Percent of ED patients that left against medical advice (AMA)	</=2.0	0.67%	0.58%	1.35%	0.26%	0.57%	0.97%	1.06%	0.00%	0.55%	0.00%	0.64%	0.55%	0.66%
MBQIP- ED COMMUNICATION WITH TRANSFERING FACILITY MEASURES														
Percent of transfers where nurse/nurse, provider/provider communication occurred	>/=90%	100%	100%	95.0%	100%	95.0%	97.0%	91.0%	90.0%	91.0%	100%	89.0%	100%	95.7%
Percent of transfers where all patient demographic/insurance information was communicated	>/=90%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Percent of transfers where all records with vital signs from ED visit was communicated	>/=90%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Percent of transfers where medication/allergy information was communicated	>/=90%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Percent of transfers where all physician generated treatment information was communicated	>/=90%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Percent of transfers where all nurse generated treatment information was communicated	>/=90%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Percent of transfers where all procedures and tests were communicated	>/=90%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
CMS OUTPATIENT ED- STROKE														
Average (mean) time (minutes) from ED arrival to head CT interpretation for stroke patients	</=45	x	x	x	69	x	x	36	26	34	42	30	x	40
Iowa Healthcare Collaborative Patient Safety Outcome Measures														
ADE: Inpatient Adverse Drug Event Rate	<1.44%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
Antibiotic Stewardship: Antimicrobial Days of Therapy (DOT)	<590	434	470	433	526	577	422	371	459	392	443	403	449	448
CAUTI: Inpatient hospital acquired catheter associated urinary tract infection rate	<2.0%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
Pressure Ulcer: Inpatient Hospital Acquired Pressure Ulcer Rate-Stage II	<0.06%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
Pressure Ulcer: Inpatient Hospital Acquired Pressure Ulcer Rate-Stage III+	<0.67%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
Readmissions: Unplanned All-Cause, 30 Day Unplanned Readmission Rate-Same Hospital	<6.6%	4.80%	0.00%	0.00%	23.80%	11.40%	9.50%	8.00%	9.09%	5.26%	0.00%	0.00%	3.57%	6.18%
Sepsis: Post Operative Sepsis Rate	<1.49%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
SSI: All Procedure Surgical Site Infection Rate	<2.0%	0.00%	0.00%	0.00%	0.00%	1.11%	3.39%	0.00%	1.15%	1.20%	1.75%	0.98%	0.00%	0.80%
VTE: Post-Operative DVT or PE Rate	<2.5%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
Falls: Patient Falls with Minor Injury Rate	<1.37%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	5.10%	0.00%	0.00%	0.43%
Falls: Patient Falls Resulting in Fracture or Dislocation Rate	<0.35%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
Falls: Overall Fall Rate (Falls with or without Injury)	<5.27%	0.00%	0.00%	0.00%	8.69%	0.00%	4.58%	3.98%	12.2%	0.00%	15.30%	0.00%	0.00%	3.73%

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Table 6.1 Organizational Wide Quality Pillar Metrics Continued....

Iowa Healthcare Collaborative Patient Safety Process Measures														
ADE: Inpatients with INRs Greater > 5	<2.77	0.00%	0.00%	0.00%	5.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	5.80%	0.00%	0.90%
ADE: Inpatients with Blood Glucose < 50	<0.37	0.00%	0.00%	1.03%	0.00%	0.00%	1.02%	0.00%	0.00%	0.75%	0.00%	0.82%	0.00%	0.30%
ADE: High Dose Opioid Prescriptions at IP Discharge >90MME	<37.7	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	12.50%	1.04%
C-Diff: Hand Hygiene Compliance Rate	>/= 78.3	88.0%	100%	80.0%	x	87.0%	95.0%	90.0%	95.0%	95.0%	96.0%	88.0%	98.5%	92.0%
CAUTI: Unnecessary IP Urinary Catheters	<2.60	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
Pressure Ulcer: Inpatients w/ Risk Assessment completed within 24 hours of admission	>96.0	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Pressure Ulcer: Inpatients w/ Skin Assessment completed within 24 hours of admission	>98.0	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Readmissions: Post-Hospital Follow Up Appointment Made prior to Discharge	>76.0	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
SSI: Surgical Safety Checklist Compliance Rate	>99.0	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
VTE: Appropriate Prophylaxis	>92.0	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Falls: Fall risk assessment completed on admission (IP)	>97.5	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
EMR Patient Safety Medication Administration Measures														
% of medications scanned prior to administration (all areas)	>/=95%	98%	98%	99%	99%	98%	99%	99%	98%	98%	98%	98%	98%	98.3%
% of patients scanned prior to administration of medication (all areas)	>/=95%	99%	99%	99%	98%	99%	99%	99%	99%	99%	99%	99%	99%	98.9%
CMS CAH IP ACUTE-LENGTH OF STAY STATISTICS														
Average Length of Acute Stay (measured in hours)	<96	82.46	71.34	64.58	95.43	75.43	74.46	92.81	67.76	77.88	91.31	74.37	72.35	78.35
DEPARTMENT SPECIFIC QUALITY METRICS AND OUTCOMES														
Activities Department Quality Measures														
Maintain percent of activity assessments completed on skilled patients within 72 hours of	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Maintain percent of skilled patients meeting their activity goal stated within the care plan.	>/=80%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Anesthesia Quality Measures														
# of Anesthesia Adverse Events	<2%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
% of chart reviews meeting Anesthesia Pre-Procedure Assessment Guidelines	>/=95%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100.0%	100%
Business Office Quality Measures														
To decrease days in AR (PB/HB)	</=48	36.13	39.65	35.66	38.26	37.66	43.15	43.38	42.82	39.52	41.47	39.25	39.56	39.13
Decrease denial rate by the end of FY25 HB.	</=11%	11.8%	10.6%	12.4%	13.0%	14.6%	15.3%	14.6%	14.6%	11.9%	11.4%	14.80%	13.20%	13.18%
Decrease denial rate by the end of FY25 PB.	</=11%	4.7%	4.3%	4.50%	3.00%	3.80%	5.10%	3.60%	4.80%	5.90%	6.70%	3.20%	4.30%	4.49%
Maintain uncompensated care rate at 5% or less.	</=5%	0.8%	1.7%	1.5%	0.4%	0.9%	1.1%	1.7%	2.5%	1.8%	1.2%	1.6%	1.40%	1.4%
Cardiac Rehab Quality Measures														
Compliance on cardiac rehab chart audit documentation requirements.	>/=90%	100%	100%	100%	100%	100%	100%	100%	x	x	x	x	100.0%	100.0%
Central Supply Department Quality Measures														
Reduce # of incidents related to in-hospital patient care supplies unavailable per month.	</=2	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Reduce out of date monthly inventory expense	$150	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	0.00
Emergency Department Quality Measures														
Nurse to Nurse handoff was performed and documented on all transfer patients	>/=90%	100%	100%	95.0%	100.0%	95.0%	97.0%	91.0%	90.0%	91.0%	100.0%	89.0%	100%	95.7%
Nursing Documentation Compliance	>/=95%	100%	99%	99%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100%	100%	99.8%
Medication and Patient Barcode scanning compliance rate (excluding emergent admins)	>/=95%	98.5%	97.0%	97.0%	98.5%	99.5%	99.0%	98.5%	96.5%	96.0%	98.0%	96.5%	96.0%	97.6%
Medication Error Rate	</=2%	0.00%	0.25%	0.00%	0.35%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.27%	0.07%
Mean Arrival to Room Time	</=15 min	8	7	9	10	7	7	9	9	7	9	7	8	7
Median Time from ED Arrival to Provider Contact for Emergency Department Patients	</= 30min	12	13	15	16	17	12	16	17	13	17	15	14	14
80% of Trauma incidents should be entered in image trend within 60 days of discharge.	>/=80%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%

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Table 6.1 Organizational Wide Quality Pillar Metrics Continued....

Employee Health Quality Measures														
Percent of employees that received their influenza immunization following hospital policy	>/=95%	x	x	x	99.0%	99.0%	99.0%	100.0%	100.0%	100.0%	x	x	x	99.5%
Decrease HAI rate	</=2%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
Increase compliance rate for hand hygiene	>/= 78.3%	88.0%	100%	80.0%	x	87.0%	95.0%	90.0%	95.0%	95.0%	96.0%	88.0%	87.0%	91.0%
Increase isolation precaution compliance rate	>/=93%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100.0%
Decrease the # of needlesticks by 50% for FY25	</=3	0	0	0	0	1	1	0	0	0	0	0	0	2
Decrease the # of recordable employee injuries for FY25	</=8	0	0	0	1	1	2	0	0	1	0	0	0	5
Facilities Department Quality Measures														
Maintain completion rate for all scheduled maintenance quality control metrics	>/=98%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Completion of all monthly/quarterly/bi-annual/annual scheduled utility inspections	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Completion of all scheduled fire drills (quarterly)	100%			86%			100%			100%			100%	96.5%
Family Medical Clinic Department Quality Measures														
Increase percent of patients who had their follow up instructions included in the AVS at discharge.	>/=90%	95.0%	97%	100.0%	100.0%	95.0%	100.0%	100.0%	100.0%	98.0%	98.0%	100.0%	97.0%	98.3%
Increase the percent of patients aged 12 years and older who were screened for clinical depression on the date of their encounter using an age appropriate depression screening tool AND if positive, a follow-up plan is documetned on the date of the positive screen.	>/=75%					68.0%	68.0%	66.0%	72.0%	73.0%	73.0%	70.0%	76.3%	76.3%
Increase the percent of patients with Medicare who have completed their Medicare AWV Exam in the last 366 days.	>/=35%					20.0%	20.0%	22.0%	22.0%	22.0%	23.0%	23.0%	24.0%	24.0%
Food and Nutrition Services Quality Measures														
Incorrect diet rate (meals that reach the patient)	</=1%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	1.00%	0.00%	0.00%	0.00%	0.08%
At least 98% of audit trays will be rated as "Excellent" or "Good"	>/=98%	100%	100%	100.0%	99.0%	100.0%	98.0%	100.0%	99.0%	100.0%	100.0%	98.0%	98.00%	99.33%
Inpatient Dietician Assessment Completion Rate	>/=98%	100%	100%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Sanitation Checklist Completion Rate	>/=98%	100%	100%	99.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	99.0%	100.0%	99.8%
Health Information Department Quality Measures														
Uncoded Charts (% of Gross Rev) - HB	</=3%	1.69%	0.81%	0.59%	0.67%	0.90%	1.90%	0.80%	1.80%	1.46%	1.19%	1.30%	0.59%	1.14%
Scanning Accuracy Rate	>/=98%	99.86%	98.76%	99.44%	99.30%	99.66%	99.49%	99.76%	99.79%	99.11%	99.43%	99.09%	99.41%	99.43%
Medical Record Provider Delinquency Rate (overall)	</=8%	1.35%	1.33%	0.46%	1.34%	3.38%	1.22%	2.31%	1.14%	1.51%	2.29%	2.44%	2.80%	1.80%
Coding Audit Results - Haugen *Reported Bi-Monthly	>/=75%	x	x	x	x	x	x	x	x	x	x	x	x	x
Coding Audit Results - UnityPoint Pro Fees Audit *Reported Quarterly	>/=75%	x	x	x	x	x	x	x	x	x	x	x	x	x
Housekeeping Department Quality Measures														
90% of inpatients rooms will be cleaned with the Xenex robot after discharge	>/=90%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100.0%
90% of ED rooms will be cleaned with the Xenex Robot 1X per week.	>/=90%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100.0%
90% of ORs will be cleaned with the Xenex robot after surgical procedures are complete for the	>/=90%	100%	100%	100%	100%	96%	100%	100%	100%	100%	100%	100%	100%	99.7%
Human Resources Quality Measures														
Percent of exit interviews completed on voluntary resignations	>/=95%	100%	100%	100%	100%	99.0%	100%	100%	100%	100%	100%	100%	100%	99.9%
Maintain employee turnover rate	</=4.5%	0.88%	0.88%	0.44%	0.00%	0.86%	0.87%	0.43%	0.43%	0.00%	0.85%	0.43%	0.43%	0.54%
Imaging Services Quality Measures														
Head CT results back within 45 minutes from the time of arrival on all qualified stroke patients.	</=45 min	x	x	x	69	x	x	36	20	34	42	30	x	39
Maintain pregnancy documentation rate	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100.0%
To maintain imaging repeat rate	</=3%	3.00%	3.40%	1.40%	1.65%	0.90%	1.45%	2.60%	2.46%	2.30%	2.60%	2.40%	1.94%	2.18%
Mammography patients receiving result letters within 30 days	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100.0%
DLP documentation compliance on all CT patients	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100.0%

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Table 6.1 Organizational Wide Quality Pillar Metrics Continued....

Inpatient Nursing Department Quality Measures														
Percent of charts reviewed that met nursing documentation and care requirements	>/=90%	100%	99.0%	100.0%	100.0%	100.0%	100.0%	99.0%	100.0%	100.0%	100.0%	99.0%	98.5%	99.6%
Fall Rate-w/injury	</=2.5%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	5.10%	0.00%	0.00%	0.43%
Pressure Ulcer Rate	</=0.04%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
Maintain barcoding compliance rate (patient scan/medication scan)	>/=95%	99.0%	99.5%	99.0%	99.5%	99.0%	99.5%	99.5%	98.5%	98.5%	99.0%	99.5%	99.0%	99.1%
Maintain medication administration error rate	</=3%	0.00%	0.00%	0.00%	0.03%	0.00%	0.03%	0.03%	0.03%	0.00%	0.00%	0.00%	0.00%	0.01%
IT Department Quality Measures														
Percent of high level service tickets that were addressed within 4 hours of reporting.	4 hours	0	0	0	0	0	0	0	0	0	0	0	0	0
Percent of medium level service tickets that were addressed within 3 business days.	3 days	1.0	1.0	1.0	1.0	1.0	0.0	0.0	1.0	1.1	1.0	1.0	1.0	1
Percent of low level service tickets that were addressed within 5 business days.	5 days	0	0	0	0	0	0	1.0	0	0	0	0	1.0	2
Phishing Test Passing Rate	>/=97.5%	91.18%	99.57%	99.57%	99.15%	97.01%	99.18%	99.59%	99.60%	96.86%	100%	100%	98.37%	98.3%
Lab Department Quality Measures														
Maintain blood culture contamination rate	<3%	0.00%	0.90%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.08%
Critical labs reported within the defined time frames to the ordering providers.	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100.0%	100%
Accuracy rate of nightly chart audits	>/=97%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100.0%	100%
Completion rate of Microscan Checklist	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100.0%	100%
Completion rate of Analyzer Checklist	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100.0%	100%
Completion rate of Kit Test Checklist	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100.0%	100%
Oncology														
Chemotherapy related medication error rate.	</=2%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
Documentation Compliance Rate (chart audits)	>/=95%	94.0%	96.0%	94.5%	95.0%	99.0%	97.0%	98.0%	99.0%	99.0%	99.0%	97.0%	96.0%	97.0%
Barcoding compliance rate (patient scan/medication scan)	>/=95%	99%	99%	98.5%	100%	98.5%	99.5%	99.5%	99.0%	100.0%	97.0%	100.0%	99.5%	99.1%
Pain Specialty Clinic Quality Measures														
Barcoding compliance rate (patient scan/medication scan)	>/=95%	83%	91%	99.5%	100.0%	100%	100%	100%	99.5%	100.0%	98.5%	99.5%	100%	97.5%
Adverse Events	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Patient Access Quality Measures														
Increase Point of Service collection rate-ER	>/=30%	46.6%	38.2%	43.0%	45.6%	56.7%	44.3%	43.1%	48.9%	48.1%	40.3%	43.1%	47.0%	45.4%
Increase Point of Service collection rate-Clinics	>/=95%	98.7%	98.7%	98.6%	98.6%	99.6%	98.5%	98.8%	98.5%	98.2%	98.1%	98.7%	99.3%	98.7%
Increase benefit verification	>/=90%	97.6%	98.2%	97.4%	96.3%	93.1%	97.4%	97.5%	98.5%	97.4%	95.0%	97.0%	98.9%	97.0%
Increase registration accuracy	>/=90%	95.3%	99.0%	96.9%	98.2%	98.6%	98.3%	98.6%	95.6%	98.8%	98.2%	96.7%	97.6%	97.7%
Maintain ED Conversion Rate of Uninsured Patient to 3rd Party Funding Source	>/=33%	72.0%	66.7%	58.8%	71.4%	85.0%	53.3%	76.5%	68.4%	41.7%	76.9%	50.0%	48.0%	64.1%
Maintain HB POS Collection Rate	>/=95%	87.7%	84.9%	93.8%	91.1%	95.6%	92.2%	90.9%	97.3%	97.0%	98.1%	98.7%	100.0%	93.9%
Pharmacy Department Quality Measures														
Accuracy Rate on Monthly Omnicell Audits	>/=95%	100%	95%	99%	99%	100%	98.00%	100%	99.0%	100%	99.0%	99.0%	100.0%	99%
Maintain medication error rate related to packaging, labeling or dispensing	</=2%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
Average time for pharmacy to verify medication orders - CMH	</=60 min	32.0	29	12.8	19	17.9	25	23	10	17.3	14.6	18.8	13.0	19.4
Average time for pharmacy to verify medication orders - UPH	</=60 min	25.7	30.3	13.6	20	33	17.00	23	20	28.3	27.6	27.4	29.0	24.6
Anticoagulation Visits	>/=50	62	50	47	64	58	63	66	54	77	68	67	54	61
Retail Pharmacy - Total # of Scripts Filled (CMH Pharmacy & CMH Pharmacy North English)	1100	1215	1196	1107	1,211	1135	1417	1373	1256	1,319	1,319	1,378	1,262	1286

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Table 6.1 Organizational Wide Quality Pillar Metrics Continued....

RT/Pulmonary Rehab Quality Measures														
Median EKG time for patients presenting to the ER with Chief Complaint of Chest Pain	</=10 min	8	9	7	5	3.5	6	7	6	6	6	7	7	6.5
Percent of inpatient tobacco users who received smoke cessation counseling during their IP stay	>/=95%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100.0%
Barcoding compliance rate (patient scan/medication scan)	>/=95%	98.5%	98.0%	97.0%	99.5%	99.0%	98.5%	98.5%	97.0%	98.5%	98.5%	98.0%	99.0%	98.3%
YTD Percent of patients with COPD enrolled in pulmonary rehabilitation (PR) increased their functional capacity by at least 30 meters, as measured by a standardized 6 minute walk test within one week of PR program entry and again within one week of PR program completion.	>/=85%	x	x	100%	x	100%	x	100%	50%	100%	x	x	100%	92%
Senior Life Solutions Quality Measures														
Overall quartlery audit score	>/=90%			97.5%			96.1%			96.0%			99.0%	97.1%
Sleep Lab Quality Measures														
Maintain in-house sleep study satisfaction rate (measured by MSS and reported quarterly)	3.5			4.99%			4.98%			5.00%			4.99%	4.99%
To meet or exceed the Inter-scorer reliability for each sleep tech at 80% or greater as measured monthly by Midwest Sleep Studies (reported quarterly).	80%			87%			94.6%			90%			88%	89.9%
95% of studies will meet the 7-day turnaround time for the final sleep study report sent to the referring provider as measured by Midwest Sleep Studies (reported quarterly).	95%			100%			100%			100%			100%	100.0%
90% compliance rate on chart review/documentation for all chart reviews completed by Midwest Sleep Studies (reported quarterly).	90%			100%			100%			100%			100%	100.0%
# of Repeat Exams	0	0	0	0	0	0	0	0	0	0	0	0	0	0
# of Adverse Events	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Social Services /Discharge Planning Quality Measures														
% of patients who answered yes to: "during your hospital stay, did doctors, nurses or other hospital staff talk with you about whether you would have the help you needed when you left the	>/=88%	100%	78%	95%	75%	89%	100%	91%	90%	100.0%	71%	89%	100%	90.0%
Percent of acute patients that received discharge assessment within 2 business days of	>/=98%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100.0%
Percent of skilled patients that received discharge assessment within 7 days of admission.	>/=98%	100%	x	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100.0%
Surgical Services Quality Measures														
Barcoding compliance rate (patient scan/medication scan)	>/=95%	97.0%	95.0%	99.0%	98.5%	98.5%	97.0%	98.0%	97.0%	98.0%	97.5%	99.0%	98.0%	97.7%
% of documentation completed within 60 minutes of event	>/=95%	89.0%	95.0%	98.0%	95.0%	98.0%	97.0%	99.0%	97.0%	96.0%	98.0%	98.0%	99.0%	96.6%
Documentation Compliance Rate (chart audits)	>/=95%	99.0%	96.0%	99.0%	99.5%	100%	98.0%	100.0%	100%	99.0%	99.0%	97.0%	99.0%	98.8%
Immediate Use Cycles	</=25%	0.00%	0.00%	0.00%	0.00%	0.00%	3.0%	0.00%	2.0%	0.00%	2.0%	0.00%	0.00%	0.58%
Surgical Site Infection Rate	</=2.0%	0.00%	0.00%	0.00%	0.00%	1.11%	3.39%	0.00%	1.15%	1.20%	1.75%	0.98%	0.00%	0.80%
Therapy Services (PT/OT/ST) Department Quality Measures														
Percent of therapy evaluations completed for skilled patients within 24 normal business hours.	100%	100%	x	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100.0%
Maintain outpatient documentation compliance rate at >/=95% (PT/OT/ST)	>/=95%	100%	99.0%	99.0%	100%	100%	100%	99.0%	100%	100%	100%	99.0%	99.0%	99.5%

Table 6.2 CMH Contracted Services Quality Metrics Dashboard FY25

Contracted Services Quality Performance Dashboard FY2025 (July 2024-June 2025)							
	Goal	Q1	Q2	Q3	Q4	YTD	
Impact Life Blood Services							
Total Blood Orders		27	33	24	36	120	
The Ability to Meet Patient Need	100%	100%	100%	100%	100%	100%	
Safety Concerns reported to Impact Life		0	0	0	0	0	
Midwest Sleep Services							
Turn Around Time for Final Report with 7 Days	100%	100%	100%	100%	100.0%	100.0%	
Patient Satisfaction	>/=3.5	4.99	4.98	5.00	4.99	4.99	
Chart Review/Completeness	>90%	100%	100%	100%	100%	100%	
Sleep Lab Safety Checks/Incident Reports	>98%	100%	100%	100%	100%	100%	
Cedar Valley Pathology							
Surgical Reports Completed/Signed within 3 Days	>98%	98.3%	99.2%	99.0%	100%	99.0%	
Pathology Report Turnaround Time-90% of reports complete within 3 Days	>90%	97.0%	96.0%	97%	95%	96.3%	
% of Frozen Section Path DX concur with Clinician DX	>98%	99%	99.0%	100.0%	100%	99.5%	
Caring Enterprises (Ultrasound)							
# of Exams		364	331	329	382	1406	
Incomplete Exam Rate	<1%	0%	0%	0%	0%	0%	
Rescan Rate	<1%	0%	0%	0%	0%	0%	
Shared Medical Services (PET CT)							
Number of Exams		8	10	20		38	
Incomplete Exam Rate	<15%	0%	0%	10%		3%	
Rescan Rate	<5%	0%	0%	0%		0%	
Radiology Management Services (RMS)							
Total Exams Reviewed		198	297	197	270	962	
% of Clinically Significant Discrepancies	<.50%	0.00%	0.00%	0.00%	0.00%	0.00%	
% of Discrepanices	<5%	3.00%	4.00%	4.00%	2.30%	3.33%	
ITP-Telehealth Psychiatric Services							
Number of Consults		3	5	2	5	15	
Total # of Patients Admitted to Mental Health Facility		2	2	1	3	8	
Average # of Hours for Bed Placement (for inpatient tx)	<24hrs	15 hrs	1.5 hrs	31 min	2.6 hrs	4.8 hrs	

Annual Evaluation: PIP-Quality Pillar-Assessment of Quality and Treatment Furnished by APP

485.641(b)(3) The quality and appropriateness of the diagnosis and treatment furnished by nurse practitioners, Clinical nurse specialists and physician assistants at the CAH are evaluated by a member of the CAH staff who is a doctor of medicine or osteopathy.

An advanced practice provider (APP) is defined as a Physician Assistant (PA) and Advanced Practice Registered Nurse (APRN): (Nurse Practitioner, Pediatric NP, Family NP, Certified Nurse Specialist, Certified Midwife Specialist, etc.) excluding a Certified Registered Nurse Anesthetist (CRNA) with special regulations. The advanced practice provider at CMH is subject to the same internal quality review and internal/external practitioner peer review as the on-staff physicians. Table 6.3 includes FY25 peer review statistics for AAP's.

Table 6.3 AAP Peer Review Statistics FY25

Peer Review Trigger	# of Reviews	Category I	Category II	Category III	Category 0
Appropriateness of Care	8	8			
Acute Re-Admission within 30 days (same DX)	0				
Return to ER within 48 hours (Same DX)	37	36	1		
Code	11	9	2		
Chest tube/ Intubation	0				
Total Reviews	**56**	**53**	**3**		

In addition to the internal/external review requirements, advanced practice providers that provide care on the inpatient unit at CMH, an MD/DO is on call to the APP. When there is an admission to CMH, the APP must contact the supervising physician and document this in the patient record.

The supervising physicians are available to the APP on a continuous basis either in person, by telephone, or by telecommunications to support the APP's to ensure quality patient care. The supervising physician also reviews 100% of inpatient charts where the APP was the admitting and attending provider through the patient's hospitalization. The organizational performance department audits the APP review process to ensure that the process is completed. The data is reported to the Medical Care Evaluation Committee and provided to the Credentialing Committee via the practitioner quality profile.

Table 6.4 AAP Inpatient Plan of Care Review by MD/DO FY25

Measure	Type	# of Admissions	# of Admissions Reviewed	% Cases Reviewed	Standard Met
Attending and Admitting APP IP (Acute) Plan of Care Review	Open	7	7	100%	☒

Annual Evaluation: PIP-Quality Pillar-Assessment of Quality and Treatment Furnished by MD/DO

485.641(b)(4) the quality and appropriateness of the diagnosis and treatment furnished by MD/DO at CAH are Evaluated

External Peer Review is conducted monthly or as triggered on the following cases: codes (all cases); acute re-admission with same diagnosis within 30 days (all cases); return to the emergency room within 48 hours with same diagnosis (all cases); unscheduled returns to surgery; Surgical Complications; Patient complaints regarding care rendered (appropriateness of care); violation of rules and regulations of the medical staff by-laws; sentinel events; demeanor or conduct issues; or any other reported concerns.

External Peer Review records are sent to St. Luke's Hospital, which is our CAH network hospital. Once the external peer review is complete the reviews are reported to the MCEC for review and final approval. All documentation regarding peer review proceedings are maintained in MCEC minutes. Information specific to each provider shall be kept in their re-credentialing profile which is maintained in the organizational performance office. All documents are privileged and confidential and are protected by the Iowa Code 147.135.

Table 6.5 MD/DO Peer Review Statistics FY25

Peer Review Trigger	# of Reviews	Category I	Category II	Category III	Category 0
Appropriateness of Care	47	47			
Acute Re-Admission within 30 days (same DX)	27	27			
Return to ER within 48 hours (Same DX)	29	29			
Unscheduled Return to Surgery	3	3			
Surgical Complications	0				
Code	7	7			
Mortality Review	0				
Radiology Review	3	3			
Total Reviews	**116**	**116**			

Annual Evaluation: PIP-Finance Pillar Outcomes

As a part of the Organizational Performance Improvement Program, financials are reviewed and reported monthly to Department Managers, Leadership, and the Board of Trustees. Department budgets and financial statements are analyzed for trends, and when applicable, action plans are implemented. CMH's organizational goal was to have a positive bottom line for FY2025, which was exceeded by 13.63% as reflected in Table 7.1 below. These financials are considered preliminary until the audit is reported and approved by the BOT in September of 2025.

Table 7.1 FY2024 Year-End Financial Statement

COMPASS MEMORIAL HEALTHCARE
Statement of Revenue and Expenses
Fiscal Year Ending June 30, 2025

	June 2025 PRELIMINARY Actual	June 2025 Budget	June 2025 Variance Fav/(Unfav)	Jun-24 Actual	June 2025 YEAR TO DATE 12 Months Ended PRELIMINARY Actual	June 2025 YEAR TO DATE 12 Months Ended Budget	June 2025 YEAR TO DATE 12 Months Ended Variance Fav/(Unfav)	Jun-24 YTD Actual
REVENUE:								
Acute Room	113,695	109,094	4,601	107,832	1,690,444	1,692,314	(1,870)	1,506,129
Skilled Room	24,180	8,886	15,294	1,772	328,044	479,663	(151,619)	406,968
Transitional Care Room	3,558	2,501	1,057	2,630	44,236	44,296	(60)	39,872
Inpatient Ancillary	233,506	341,987	(108,481)	177,731	3,644,562	4,282,503	(637,941)	3,728,151
Outpatient	5,341,362	5,211,241	130,122	4,615,056	58,558,581	61,478,228	(2,919,647)	54,411,550
Surgery	1,459,154	1,515,780	(56,626)	1,122,422	16,646,946	16,432,845	214,100	14,000,433
Colonies Clinic	108,205	97,321	10,884	66,896	1,162,311	1,184,075	(21,764)	971,643
Marengo Clinic	399,325	484,351	(85,027)	405,811	5,717,285	5,892,942	(175,657)	5,372,150
North English Clinic	132,626	120,735	11,891	119,655	1,449,413	1,468,942	(19,529)	1,355,004
Williamsburg Clinic	213,682	311,484	(97,801)	257,538	3,820,629	3,789,717	30,912	3,418,381
Victor Clinic	102,087	124,628	(22,541)	87,971	1,320,161	1,516,304	(196,143)	1,390,415
North English Pharmacy	70,890	52,323	18,567	39,135	721,126	636,595	84,531	504,627
Total Patient Service Revenue	$ 8,202,270	$ 8,380,331	$ (178,061)	$ 7,004,449	$ 95,103,738	$ 98,898,424	$ (3,794,687)	$ 87,105,323
Deduction for Contractual Allowances	4,418,858	4,153,119	(265,739)	2,664,101	48,136,561	49,081,782	945,221	43,087,192
Deduction for Bad Debts/Charity Care	116,490	153,450	36,960	269,076	1,298,582	1,866,975	568,393	1,777,511
Net Patient Service Revenue	3,666,922	4,073,762	(406,839)	4,071,271	45,668,594	47,949,667	(2,281,073)	42,240,620
Other Operating Revenue	140,538	191,219	(50,680)	172,299	2,155,507	2,180,338	(24,831)	2,132,562
NET OPERATING REVENUE	$ 3,807,461	$ 4,264,981	$ (457,520)	$ 4,243,570	$ 47,824,102	$ 50,130,005	$ (2,305,904)	$ 44,373,182
EXPENSES:								
Salaries	1,247,982	1,259,973	11,991	1,139,635	14,745,484	15,064,186	318,702	12,957,694
Provider Salaries	332,420	435,688	103,268	497,318	4,667,943	5,103,638	435,695	4,573,911
Payroll Taxes	108,095	113,701	5,606	97,542	1,320,923	1,383,365	62,442	1,163,783
Total Salary Costs	1,688,497	1,809,362	120,865	1,734,495	20,734,350	21,551,189	816,839	18,695,387
Employee Benefits/PERS	161,555	667,530	505,975	392,735	7,289,547	7,878,282	588,735	6,571,149
Supplies	162,038	181,342	19,304	157,146	2,440,123	2,230,665	(209,458)	2,034,441
Drugs	309,064	437,072	128,008	213,453	4,352,998	4,977,039	624,041	4,585,525
Professional Fees	24,355	16,945	(7,410)	1,518	297,289	268,172	(29,117)	276,346
Maintenance	20,246	17,318	(2,929)	8,091	184,366	210,697	26,331	152,144
Utilities	50,919	74,003	23,085	64,234	730,674	866,915	136,241	667,969
Advertising/Marketing	18,940	14,432	(4,508)	13,930	140,027	175,590	35,562	170,299
Insurance	26,312	25,665	(646)	30,259	307,130	312,263	5,133	309,305
Interest Service Charges	128,154	56,938	(71,217)	106,108	1,102,678	692,717	(409,962)	859,451
Depreciation	152,676	245,481	92,805	338,985	2,874,462	2,951,513	77,051	2,735,032
Contracted Services	581,528	538,917	(42,611)	422,469	6,537,504	6,439,624	(97,880)	5,608,188
Other Expenses	137,407	89,433	(47,974)	96,892	823,609	890,832	67,223	686,960
TOTAL EXPENSES	$ 3,461,690	$ 4,174,438	$ (712,747)	$ 3,580,316	$ 47,814,759	$ 49,445,498	$ (1,630,739)	$ 43,352,197
OPERATING INCOME/(LOSS)	$ 345,770	$ 90,543	$ 255,228	$ 663,255	$ 9,343	$ 684,508	$ (675,165)	$ 1,020,985
OPERATING MARGIN	9.08%	2.12%		-0.70%	0.02%	1.37%		-0.70%
Non Operating Revenue	71,767	(8,423)	80,190	58,882	847,075	390,580	456,495	701,547
NET INCOME/(LOSS) PRIOR TO DIRECTED PAYMENTS	$ 417,537	$ 82,120	$ 335,418	$ 722,137	$ 856,418	$ 1,075,088	$ (218,670)	$ 1,722,532
MARGIN PRIOR TO DIRECTED PAYMENTS	10.97%	1.93%		17.02%	1.79%	2.14%		3.88%
Medicaid Directed Payments	298,057	290,250	7,807	1,943,624	5,661,945	3,200,000	2,461,945	4,155,836.00
TOTAL NET INCOME/(LOSS) AFTER DIRECTED PAYMENTS	$ 715,594	$ 372,370	$ 343,225	$ 2,665,761	$ 6,518,363	$ 4,275,088	$ 2,243,275	$ 5,878,368
TOTAL MARGIN	18.79%	8.73%		62.82%	13.63%	8.53%		13.25%

Annual Evaluation: PIP-Growth Pillar Outcomes

As a part of the Organizational Performance Improvement Program, service statistics are reviewed and reported monthly to Leadership, Medical Staff and the Board of Trustees. Service volumes are analyzed for trends and when applicable, action plans are implemented.

For service volumes/growth pillar outcomes for FY2025, please refer to pages 5-6 and table 1.1 within.

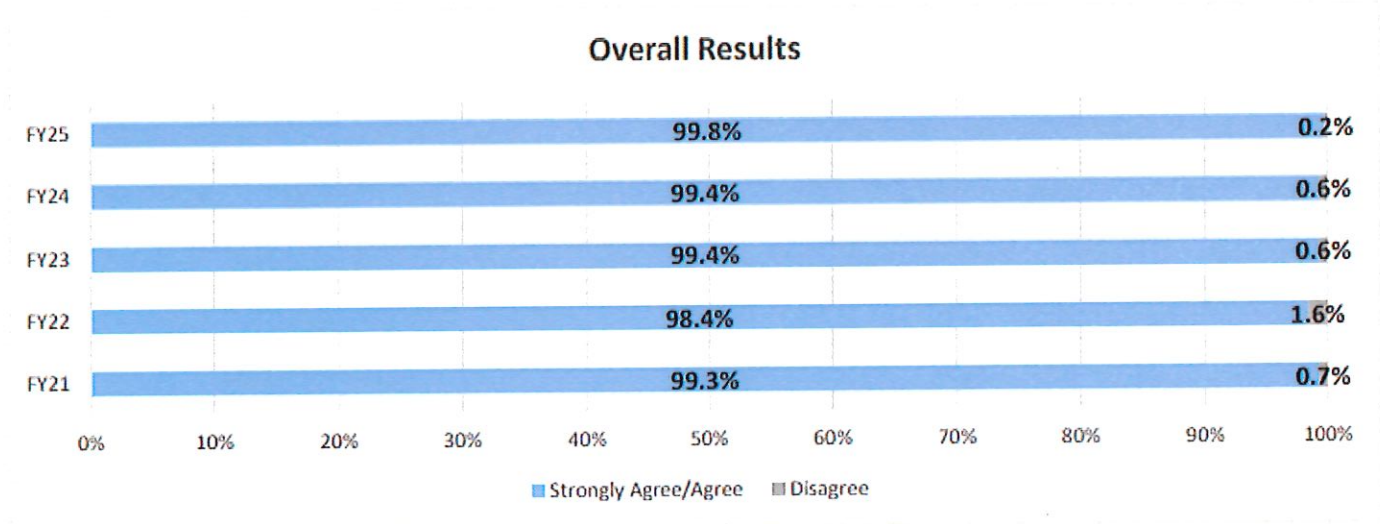
Annual Evaluation: PIP-People Pillar Outcomes

As a part of the Organizational Performance Improvement Program, employees are surveyed annually to determine their satisfaction with their employment at CMH. Staff were surveyed on seven main topics and results are reviewed by the leadership team to determine if action plans are needed. In addition, all staff received the results of the satisfaction survey along with any action plans being addressed as a result of the survey. CMH set a goal to maintain employee satisfaction at 98% and exceeded that goal by ending FY25 with 99.8% of employees satisfied with their employment at CMH. We had 171 employees complete the survey, resulting in a response rate of 75%.

As a comparison to FY24, six of the seven main topic areas had 100% of employees answer strongly agree/agree to the questions asked. Confidence and utilize services offered by CMH was the only category in which 1.17% of respondents answered disagree. Upon further investigation with those who disagreed, it was discovered that the respondents hold insurance outside of the CMH provided health insurance which impacts their coverage for services received at CMH.

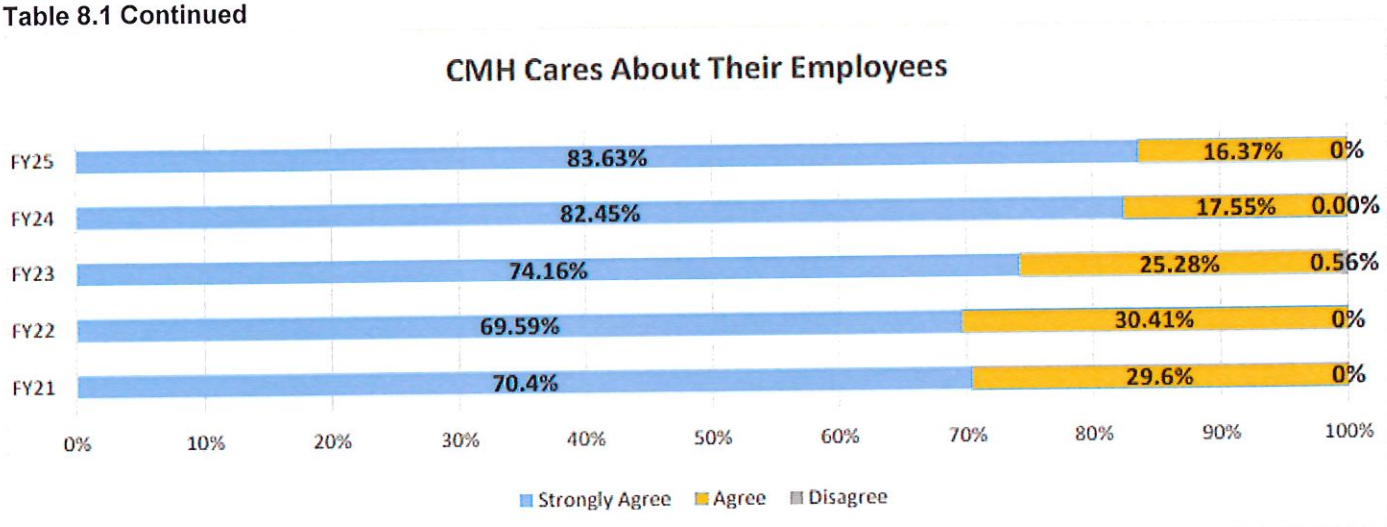
Table 8.1 shows the employee satisfaction results for FY25 compared to FY21-FY24 satisfaction results.

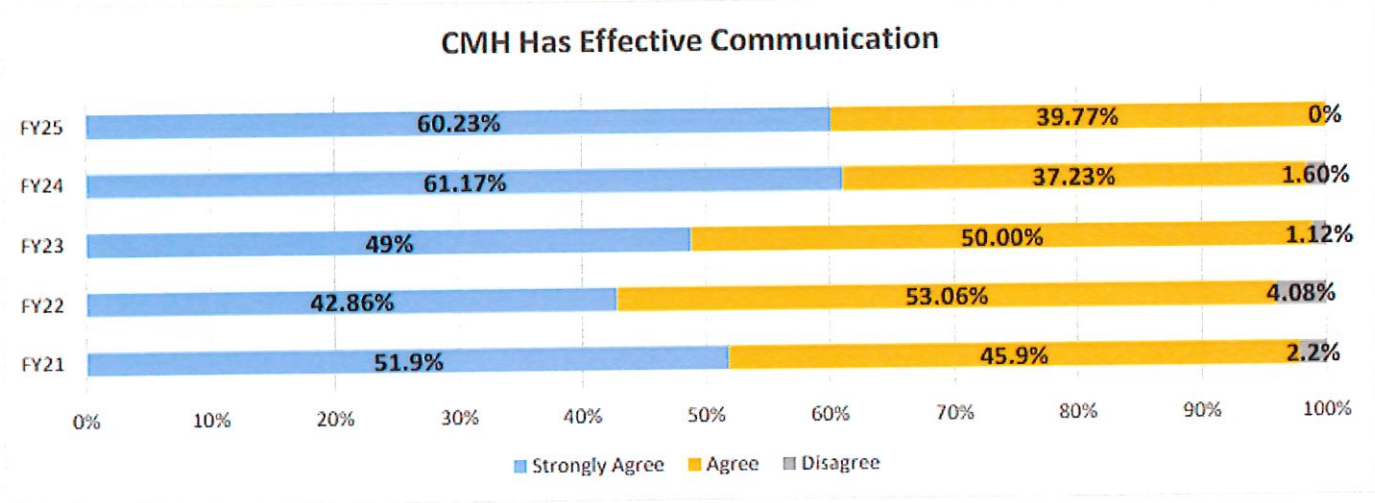
Table 8.1 Employee Satisfaction Survey Results

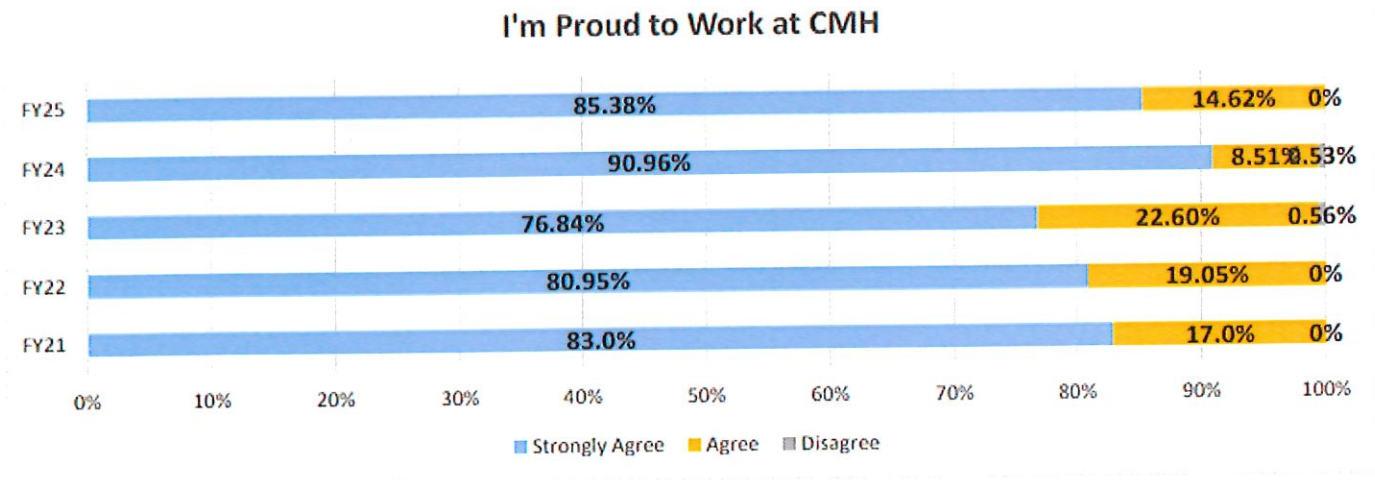


Surveys Returned/Response Rate: FY25=171 (75%); FY24 =188 (86%); FY23=178 (86%); FY22=148 (80%); FY21=135 (73%)

Table 8.1 Continued







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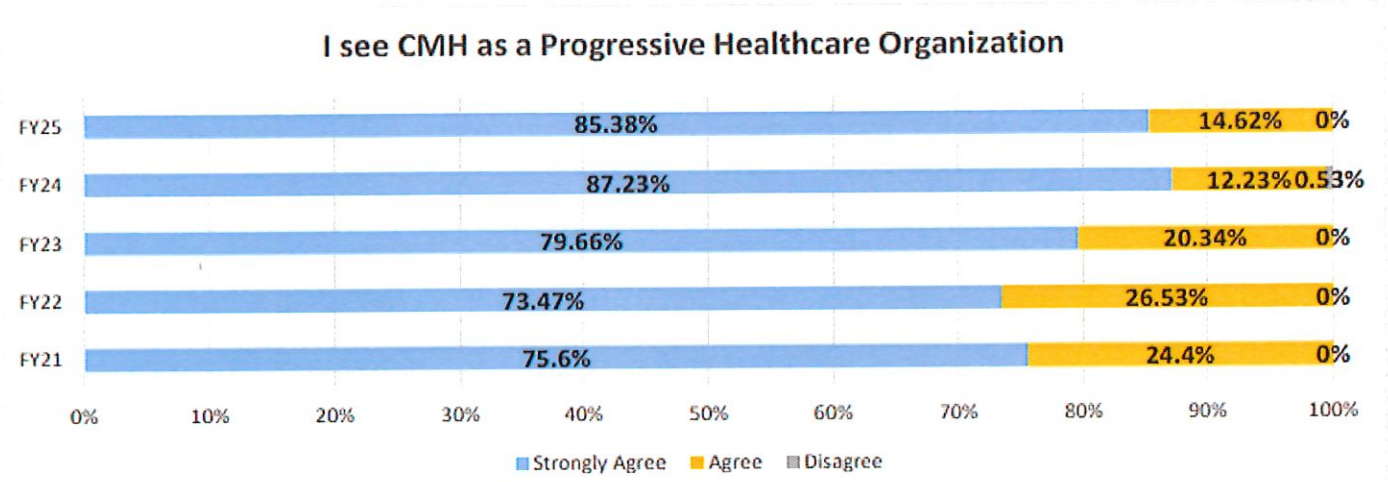
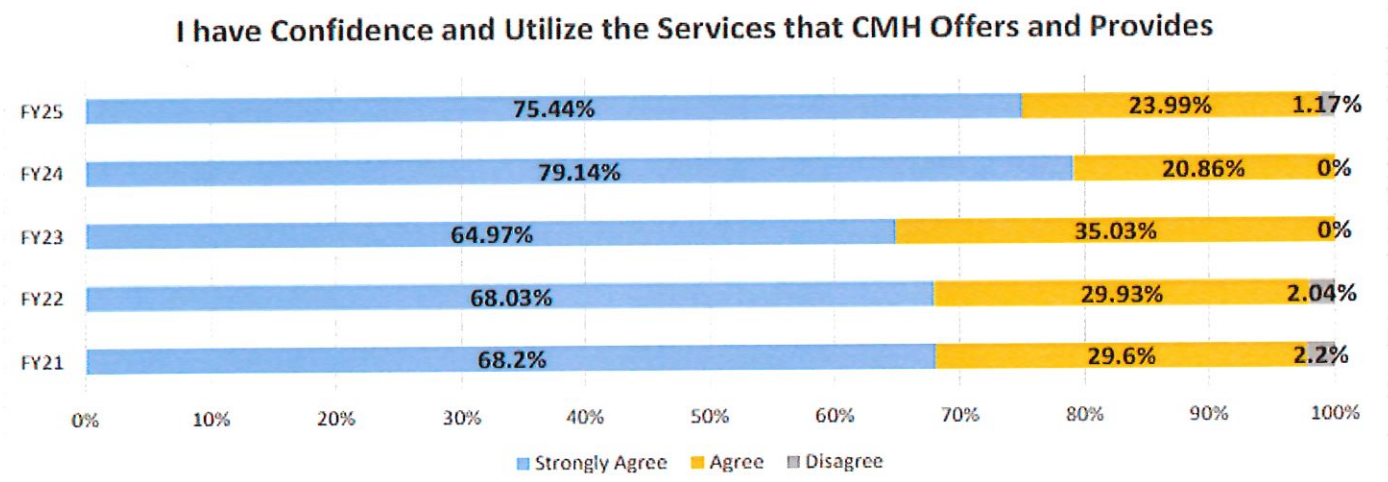




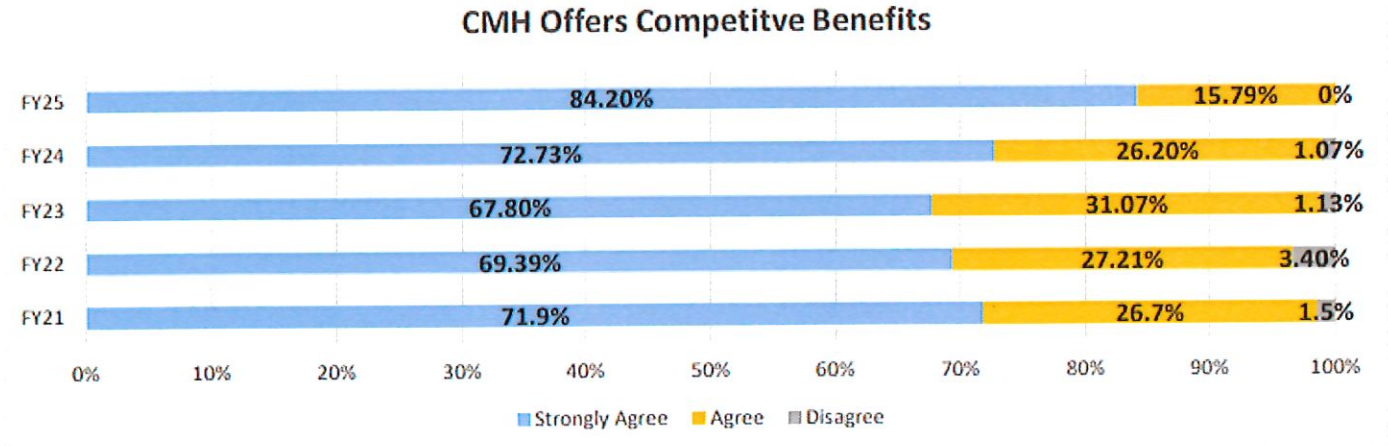
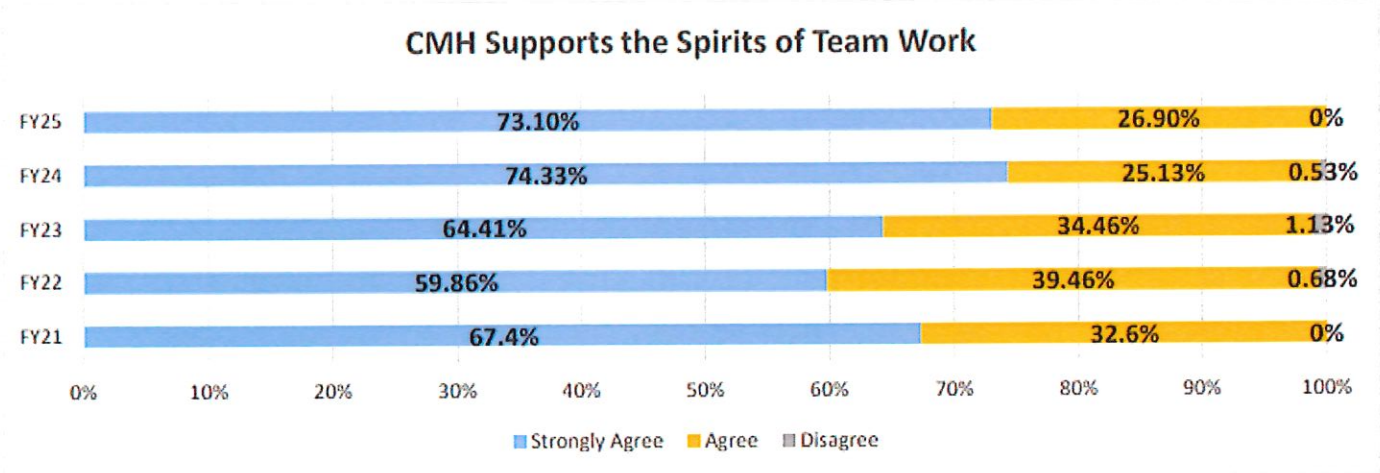
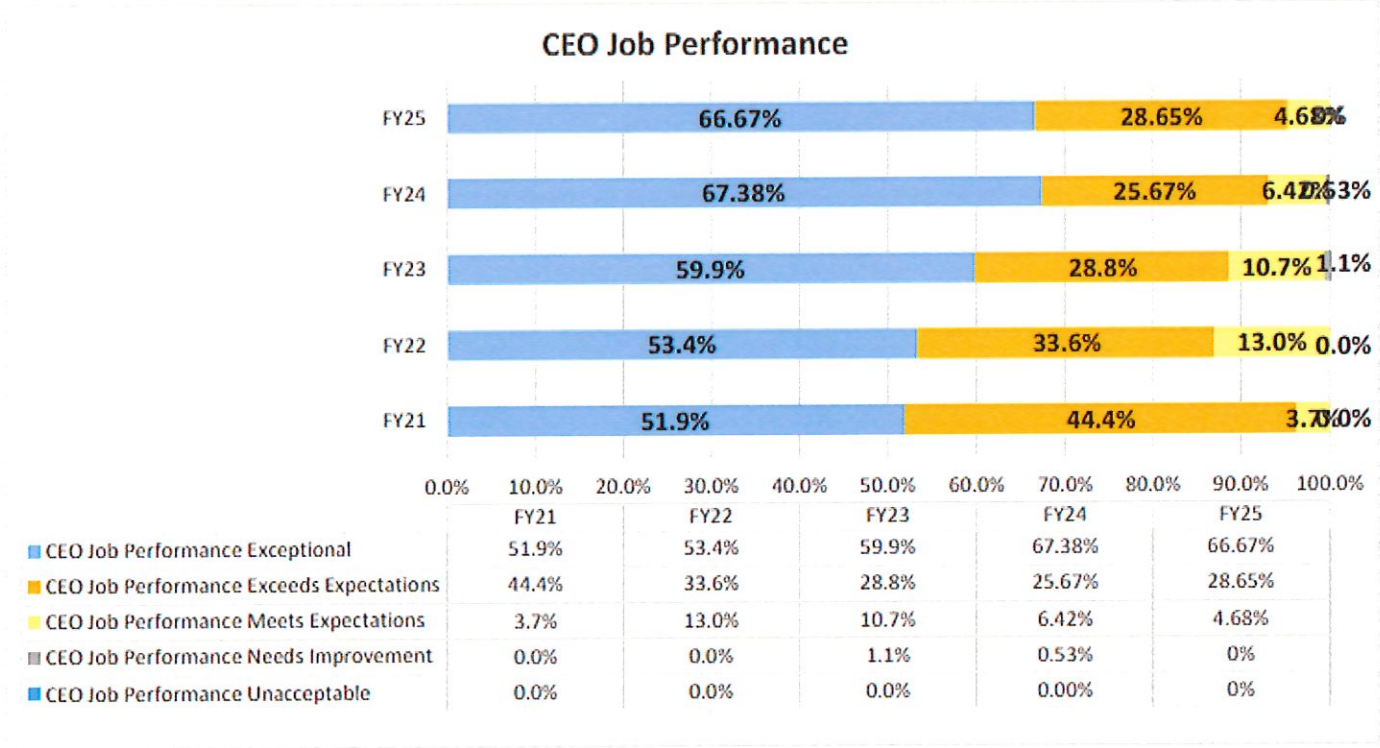


Table 8.1 Continued





Annual Evaluation: PIP-Community Pillar Outcomes

Each year, CMH sets a goal based on the target number of community events that we want to provide for the year. In FY2025, our goal was to provide 120 community-related events. CMH exceeded this goal by providing or participating in 182 events by the end of FY25. Below is a list of all the community events provided, or staff were involved in FY2025.

July 2024 Event List (18)
IV Foundation/JC
IV School Board/ JC
Marengo Board
Kiwanis/Barry
Kiwanis/Wendy
Lavender Out BB/SB
Sports Physicals
Williamsburg 4th Parade
Belle Plaine 4th Parade
Marengo 3rd Parade
July 3rd Activities
NE Fun Day Parade
Iowa County Fair
Sports Physicals at EV
Sports Physicals at HLV
HLV Booster Club Golf Tournament
Victor's Firemen's Golf Tournament
Triathlon Meeting

August 2024 Event List (18)
IV Foundation/JC
IV School Board/JC
Marengo Board
Kiwanis/Barry
Kiwanis/Wendy
Amana Society/Barry
Bike Trail/Barry
Sports Physicals/ WB
EV Booster Golf
Hope Golf Tournament
5K
5K Breakfast
Iowa Valley Golf Tournament
Belle Plaine Golf Tournament
Iowa State Fair
School Supply Drive
Sports Physical at BP
Sports Physical at BGM
Sports Physical at IV
Iowa Task Force Prevention/ Mary & Sarah

September 2024 Event List (18)
IV Foundation/JC
IV School Board/JC
Marengo Board
Kiwanis/Barry
Kiwanis/Wendy
Bike Trial
Amana Society
Williamsburg Homecoming Parade
Belle Plaine Homecoming Parade
Iowa Valley Homecoming Parade
EV Homecoming Parade
Cruise for A Cause
Amana Society Dinner
HLV Lavender Out Football
Marengo Business Mixer
BGM Lavender Out FB
BGM Lavender Out VB
ICCD Doose Hotel Meeting

October 2024 Event List (26)
IV Foundation/JC
IV School Board/ JC
Marengo Board
Bike Trial
Amana Society/BG
BP Lavender Out FB
EV Lavender Out FB
IV Lavender Out FB
Octoberfest Parade
EV Lavender Out VB
WB Lavender Out FB
IV Lavender Out VB
BGM Homecoming Parade
HLV Lavender Out VB
HLV Homecoming Parade
Octoberfest Food Booth
IV Education Class- Ben Miller
WB Lavender Out VB
Fall Festival Trunk or Treat
Fall Festival Casserole Sale
Fall Festival Apple Sales
English Valley Trunk or Trest
Williamsburg Truck or Treat
Belle Plaine Truck or Treat
Ladies Night Out
Childcare MarenGO Bd.

November 2024 Event List (12)
IV Foundation/JC
IV School Board/JC
Marengo Board
Bike Trial
Amana Society/ BG
Hope Breakfast

Thanksgiving Dinner
Tannenbaum Forest Guide/Set up
Career Fair
Coat/Hat/Gloves
Dietary Education
Night on the Square/ Hot Cocoa

December 2024 Event List (24)
IV Foundation/JC
IV School Board/JC
Marengo Board
Kiwanis/Barry
Amana Society BG
Caroling Amana
Caroling North English
Caroling Williamsburg
Caroling Marengo
Caroling Victor
Jingle Parade
Jingle on the Square/ Hot Cocoa
Santa Supper
Jingle on the Square/Casserole Sale
Tannenbaum Forest Greeters
Give Til it Hurts
Cookie Walk
LO EV Wrestling
LO WB Basketball
LO WB Wrestling
LO EV Basketball
Bike Trail
Childcare Board
Miracles on Marion

January 2025 Event List (12)
IV Foundation/JC
IV School Board/JC
Marengo Board
Kiwanis/Barry
Amana Society/BG
BGM Wrestling LO
BGM Basketball LO
IV Wrestling LO
Dual EV Wrestling
Raider Swim LO
BP Basketball LO
MarenGO Trails

February 2025 Event List (8)
IV Foundation/JC
IV School Board/JC
Marengo Board
Kiwanis/Barry
Amana Society/BG
WB Wrestling Concession
WB Wrestling Baked Goods
Meals on Wheels

March 2025 Event List (8)
IV Foundation/JC
IV School Board/JC
Marengo Board
Kiwanis/Barry
Amana Society/BG
IV PTO Carnival
WB Mary Welsh Family Fun Night
Marengo Trials

April 2025 Event List (14)
IV Foundation/JC
IV School Board /JC
Marengo Board
Kiwanis/Barry
Amana Society/BG
Scrub Sale
Gala Gift Baskets
Foundation Gala
IV Track Meet x2
BP Track Meet
Stem Fest
WHS Track Meet
Welcome to Medicare Seminar

May 2025 Event List (12)
IV Foundation/JC
IV School Board /JC
Marengo Board
Kiwanis/Barry
Amana Society/ BG
Child Care Meeting
WB Track Meet
Maifest Parade
WB Track Meet
IV Track Meet
BP Bio Cell Planting Day
STEM Festival at CCA

June 2025 Event List (12)
IV Foundation/JC
IV School Board/JC
Marengo Board
Kiwanis/Barry
Amana Society/BG
Hope Golf Baskets
Lavender Out Game WB
Lavender Out Game EV
Lavender Out Game BP
Lavender Out Game IV
Lavender Out Game BGM
Lavender Out Game HLV

Annual Evaluation: Corrective Action on External Evaluations

485.641(b)(5)(i) the CAH staff considers the findings of the evaluations, including any findings or recommendations of the QIO and takes corrective action if needed.

CMH considers the findings of evaluations from external sources very seriously, such as the Department of Inspections and Appeals or the QIO. When corrective action is identified, an audit to monitor the actions are set up and completed by the department and/or areas responsible. The audit results and corrective action plans are reported and monitored by the Quality Steering Committee.

Annual Evaluation: Corrective Action on Quality Improvement Program

485.641(b)(5)(ii) the CAH also takes appropriate remedial action to address deficiencies found through the quality assurance program.
CMH will use the PDSA Model as a systematic way to evaluate existing processes and improve outcomes by redesigning existing processes or developing new processes when necessary.

485.641 (B)(5)(iii) the CAH documents the outcome of all remedial action.
All corrective action plans are documented and stored within the organizational performance office.

COLONIES
FAMILY MEDICAL CLINIC

OPERATED BY COMPASS MEMORIAL HEALTHCARE

Colonies Family Medical Clinic

Rural Health Clinics Annual Program Evaluation FY2025

July 1st, 2024-June 30th, 2025

COLONIES
FAMILY MEDICAL CLINIC
OPERATED BY COMPASS MEMORIAL HEALTHCARE

Rural Health Clinic Annual Evaluation Report

Report Period: July 1st, 2024- June 30th, 2025

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COLONIES
FAMILY MEDICAL CLINIC
OPERATED BY COMPASS MEMORIAL HEALTHCARE

Annual Evaluation: Introduction

This annual evaluation report is prepared to evaluate the services and the effectiveness of the Colonies Family Medical Rural Health Clinic program operated by Compass Memorial Healthcare. The evaluation includes:

- review of the utilization of clinic services, including the volume of patients served.
- review of active and closed records; and
- review of policies and procedures.

Through this evaluation, it is determined whether our utilization of services was appropriate, if our established policies and procedures are followed and if any changes are needed. Any findings of the evaluation are developed into corrective action plan if necessary.

Annually, the Director of Organizational Performance is responsible for conducting the program evaluation for the Colonies Family Medical Clinic. Upon completion, the Director of Organizational Performance will present the annual review to the Family Medical Clinic staff and the Board of Trustees.

COLONIES
FAMILY MEDICAL CLINIC
OPERATED BY COMPASS MEMORIAL HEALTHCARE

Annual Evaluation: Services Provided

The primary services of the Colonies Family Medical Clinic are provided by Madelyn Kussmann, PA-C. These services are performed under the medical direction provided by Angela Fults, DO.

The following services are furnished directly within the clinic:

- Taking complete medical histories
- Performing complete physical examinations including well child examinations
- Assessments of health status
- Routine lab tests (waived)
- Diagnosis and treatment for common acute and chronic health problems and medical conditions
- Basic imaging services
- Immunization programs including vaccines for children
- Women's health services/family planning
- Basic emergency medical care

The following services are provided by RHC practitioners:

- SNF services
- Nursing Home Services

Arrangements have been made with Compass Memorial Healthcare for clinic patients to receive the following services if required:

- Specialized laboratory testing
- Specialized diagnostic testing and imaging
- Specialized therapy
- Inpatient hospital care
- Hospital/specialty physician services
- Outpatient services
- Emergency care when the clinic is not operating
- Patients will be referred to the hospital in the event that there is a medical cause where the services of the clinic would not be sufficient to care for the patient

COLONIES
FAMILY MEDICAL CLINIC
OPERATED BY COMPASS MEMORIAL HEALTHCARE

Annual Evaluation: Service Area Defined

Colonies Family Medical Clinic (CFMC) is a provider-based rural health clinic located in Iowa County, Iowa. CMFC was granted certification to function as a Rural Health Clinic in December 2021. Currently, CFMC is certified through the QUAD A. Iowa County is a governor-designated Health Professional Shortage Area, which allows CFMC to continue to be eligible for Rural Health Clinic status.

Demographically, the area served the following populations:

City or Town	Population
Amana Colonies (all colonies)	1,721
Iowa County	16,568

Source:
US Census Bureau, Profile of General Population and Housing Characteristics: 2021 (Amana Colonies)
US Census Bureau, 2021 estimate People Quick Facts (Iowa County)

Location	Zip Code	FY24 Patient Count	FY24 Visit Count	FY25 Patient Count	FY25 Visit Count
Amana	52203	166	472	172	555
West Amana	52203	15	69	18	96
South Amana	52234	41	114	39	125
Middle Amana	52307	13	57	11	41
Homestead	52236	40	114	60	178
Walford	52351	24	149	26	143
Marengo	52301	323	498	354	659
Williamsburg	52361	183	265	157	266
Victor	52347	21	31	29	43
North English	52316	15	19	23	31
Belle Plaine	52208	47	78	42	80
Blairstown	52209	40	74	38	78
Norway	52318	35	118	37	133
Watkins	52354	8	24	13	37
Cedar Rapids	52405	34	104	46	141
Ladora	52251	18	28	20	38
Keystone	52249	3	10	4	19
Conroy	52220	19	32	14	35
Tiffin	52340	13	24	15	52
Parnell	52325	17	46	22	45
Coralville/Iowa City	52240-46	24	59	23	66
Palo	52324	0	0	0	0
Oxford	52322	62	229	61	288
Shellsburg	52332	1	7	2	9
Fairfax	52228	11	19	10	31
Swisher	52338	7	21	7	32
Miscellaneous (outside service area)	-	91	161	109	252
Total Count	**-**	**1,271**	**2,822**	**1,352**	**3,473**

COLONIES
FAMILY MEDICAL CLINIC
OPERATED BY COMPASS MEMORIAL HEALTHCARE

Annual Evaluation: Services Statistics

Overall Colonies Family Medical Clinic had a total of 3,473 visits in FY2025, compared to 2,822 visits in FY2024, showing an overall growth of 23.1% over the last fiscal year.

The clinic's total visit fiscal year comparison by specialty is shown in Table 1.1:

Table 1.1: Total Visit Comparison FY24 to FY25 by Specialty

	FY2024	FY2025	Trend	% Growth
Family Practice	2576	2,920	344	13.4%
Lab/Injection	246	349	103	41.9%
X-ray Visits	-	204	204	-
Total Visits	**2,822**	**3,473**	**651**	**23.1%**

The clinic's total visit fiscal year comparison by provider is shown in Table 1.2:

Table 1.2: Total Visit Comparison FY24 to FY25 by Provider

	FY2024	FY2025	Trend
Madelyn Kussmann, PA-C	2147	2,528	**381**
Angela Fults, DO	85	67	(18)
Benjamin Miller, DO	58	54	(4)
Taylor Felker, DNP	150	133	(17)
Brandon Phelps, DO	54	56	2
Kathryn Upah, PA-C	82	9	(73)
Victoria Rowlands, ARNP	-	73	73
Lab/ Injections	246	349	103
X-ray Visits	-	204	204
Total Visits	**2,822**	**3,473**	**651**

The clinic's total visits per provider per month for FY25 is shown in Table 1.3:

Table 1.3 Total Visits by Month/Provider FY25

	Kussmann	Felker	Fults	B. Miller	Phelps	Upah	Rowlands	Nurse Visits	X-ray Visits	Total
July	220	-	18	-	11	-	-	24	-	**273**
August	238	-	-	-	-	-	-	30	-	268
September	211	-	12	-	-	-	-	31	-	254
October	207	24	-	-	-	-	-	38	-	269
November	190	21	-	-	-	-	-	29	-	240
December	182	35	14	16	16	9	-	37	25	334
January	236	-	-	-	-	-	-	31	29	296
February	205	41	-	-	17	-	-	22	26	311
March	239	10	-	-	-	-	-	29	24	302
April	210	2	-	-	12	-	-	33	30	287
May	204	-	23	38	-	-	-	25	38	328
June	186	-	-	-	-	-	73	20	32	311
FY25 Total	**2,528**	**133**	**67**	**54**	**56**	**9**	**73**	**349**	**204**	**3,473**

Annual Evaluation: Services Statistics Continued...

The clinic's total visits comparison by visit type is reflected in Table 1.4:

Table 1.4 Total Visit Comparison by Visit Type

Visit Type	FY2024	FY2025	Trend
Office Visit	409	494	85
Urgent/Same Day	898	1,064	166
New Patient	358	179	(179)
Follow up	620	677	57
Physical	65	102	37
Procedure	49	56	7
Well Child	80	112	32
Telemedicine New	0	0	-
Telemedicine Follow-Up	0	0	-
Pre-Op	23	32	9
Post Op	0	0	-
Pain New Patient	0	1	1
Pain Follow-Up Patient	17	64	47
Pap and Pelvic	6	21	15
Initial OB	0	0	-
Routine Prenatal Care	0	1	1
Welcome to Medicare	2	1	(1)
Annual Wellness Visit	11	24	13
Nursing Home Visit	0	0	-
Diabetes Initial	1	4	3
Diabetes Follow up	32	86	54
Telemedicine Nursing Home	0	0	-
Consult	0	0	-
DOT Physical	3	1	(2)
Nurse Visit	246	350	104
X-ray Visits	0	204	204
Occupational Health Physical	2	0	(2)
Visit Total	**2822**	**3,473**	**651**

COLONIES
FAMILY MEDICAL CLINIC
OPERATED BY COMPASS MEMORIAL HEALTHCARE

Annual Evaluation: Patient Satisfaction Outcomes

Colonies Family Medical Clinic also finds patient satisfaction outcomes as an area to measure to ensure that our patients are satisfied with the service and quality of care they received during their visit. The tables below reflect the average mean score per question in the fiscal year. We will continue to provide patients with satisfaction surveys at the end of every visit to provide them with the opportunity to provide feedback for each visit experience.

CFMC Patient Satisfaction Results FY24/FY25 Comparison	Goal	FY24 YTD	FY25 YTD	Trend
	95%	98.9%	99.0%	0.1%
# of Surveys Returned		**248**	**387**	139
Ease of scheduling your appointment		98.8%	99.2%	0.4%
Courtesy of registration staff		99.2%	99.2%	-
Wait time at clinic		98.3%	98.3%	-
Friendliness of nurse		99.3%	99.4%	0.1%
Providers explanation of diagnosis/condition		98.6%	98.8%	0.2%
Staff worked together to care for you		99.1%	99.1%	-
Friendliness of all staff you encountered		99.2%	99.5%	0.3%

COLONIES
FAMILY MEDICAL CLINIC
OPERATED BY COMPASS MEMORIAL HEALTHCARE

Annual Evaluation: Chart Review

As a part of the Organizational Performance Improvement Program, chart reviews are completed monthly, and results are analyzed for trends and corrective action if needed. Both active and closed reviews were conducted for completeness, accuracy, and adherence to policy standards, protocols, and standards of clinical care. Outcomes are reported either monthly or quarterly to the appropriate committees and performance improvement initiatives are discussed if corrective action is needed.

Table 1.5 below includes outcomes from our monthly medical record audit. The purpose of this audit is to assess the level of compliance with established standards within the clinic based on medical record documentation.

Table 1.5 Medical Record Documentation Chart Review Outcomes for FY2025

Medical Record Review Measures	% Cases Reviewed	# of Charts Reviewed	FY25 Outcome	Met Threshold
General Consent for Treatment on Chart	2%	60	100%	☒
Vitals Documented (height, weight, BP, Pulse)	2%	60	86.7%	☐
Medication allergies and adverse reactions reviewed/noted	2%	60	100%	☒
Current medications, dose, and frequency reviewed/noted	2%	60	100%	☒
Past medical history documented	2%	60	100%	☒
Surgical history documented	2%	60	100%	☒
Family history documented	2%	60	100%	☒
Socioeconomic history documented	2%	60	100%	☒
Reason for visit documented	2%	60	100%	☒
Physical exam documented	2%	60	100%	☒
Treatment plans documented	2%	60	100%	☒
Informed consent completed for procedures	2%	60	100%	☒
Problem list updated	2%	60	100%	☒
Diagnosis documented	2%	60	100%	☒
Documented plan for follow up	2%	60	100%	☒
Discharge instructions provided to the patient (AVS)	2%	60	100%	☒
Health Maintenance Items addressed	2%	60	100%	☒
In house test and orders completed	2%	60	100%	☒
Orders for imaging/blood work entered	2%	60	100%	☒
Follow-up instructions documented in the appropriate location in EPIC to reflect on AVS	2%	60	98.8%	☒
Follow up appointment scheduled	2%	60	100%	☒
Ordered tests results follow up with patient	2%	60	100%	☒
Assessment: 60 medical records were reviewed for FY25. The overall documentation compliance rate for FY25 was 99.2%. The content of medical records was found to be in compliance with the majority of the charts either meeting or exceeding standards for record-keeping and medical documentation. Per policy, height, weight, blood pressure, and pulse are to be taken every visit. Height was missing from a significant number of adult patient visits. Ongoing education and monthly feedback are provided to staff to ensure compliance with medical record documentation as well as continued education and feedback on vitals taken at every visit. Policy review and updates may occur according to best practice for height assessment at each vs. compared to annually, as prompted in EMR.				

Annual Evaluation: Chart Review Continued…

In consideration of the regulatory requirement 491.8(c), Physician Assistant and Nurse Practitioner (advance practice providers) clinic staff will participate in periodic chart review of the patient's health record with the clinic's Medical Director. Participation of the periodic review may be face to face or via telephone with a note in the patient's health record signed by the medical director indicating the review was completed.

Table 1.6 below reflects the advance practice provider (APP) review for FY2025.

Table 1.6 APP Periodic Review for FY25

Measure	Review Type	# of Cases	% of Cases Reviewed	Standard Met
Review of Physician Assistant: Madelyn Kussmann, PA-C	Mid-Level/Concurrent	48	2%	☒
Review of Physician Assistant: Kathryn Upah, PA-C	Mid-Level/Concurrent	2	22%	☒
Review of Physician Assistant: Taylor Felker, DNP	Mid-Level/Concurrent	10	8%	☒

Assessment: 60 charts were periodically reviewed in FY25 in conjunction with the medical director. Both advanced practice providers performed as expected with no clinic or administrative actions requested.

Action Plan for FY25: Continue APP review of at least 2 charts per month and provide any feedback necessary for improvement.

Annual Evaluation: Policy and Procedures

Annually, staff at Colonies Family Medical Clinic perform a comprehensive review of the policies and procedures at the clinic. Table 1.7 below provides a summary of the review and changes made to the policies throughout the fiscal year.

Table 1.7 Policy and Procedure Updates for FY2025

Policy Number	Policy Name	Action	Reason for Change
CFMC 4002	CFMC Emergency Preparedness Plan	Revised	Deleted hospital radios from policy

Annual Evaluation: Conclusion

As indicated by the data and information within, Colonies Family Medical Clinic is appropriately providing services while following established policies and procedures. Colonies Family Medical Clinic is productive in benefiting the health care of the patients we serve and will continue to provide high quality healthcare to our patients with a focus on preventative health, disease management and care coordination.

COLONIES
FAMILY MEDICAL CLINIC
OPERATED BY COMPASS MEMORIAL HEALTHCARE

Annual Evaluation: Signature Approval Page

Signatures below attest that the attached information was reviewed and approved by the Colonies Family Medical Clinic medical staff and Compass Memorial Healthcare Board of Trustees in September 2025.

_____

Tessa Wade, Board of Trustees President

_____

Barry Goettsch, Chief Executive Officer

_____

Angela Fults, DO, Medical Director

MARENGO
FAMILY MEDICAL CLINIC

OPERATED BY COMPASS MEMORIAL HEALTHCARE

Marengo Family Medical Clinic

Rural Health Clinics Annual Program Evaluation FY 2025

July 1st, 2024-June 30th, 2025

Rural Health Clinic Annual Evaluation Report

Report Period: July 1st, 2024- June 30th, 2025

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Annual Evaluation: Introduction

This annual evaluation report is prepared to evaluate the services and the effectiveness of the Marengo Family Medical Rural Health Clinic program operated by Compass Memorial Healthcare. The evaluation includes:

- review of the utilization of clinic services, including the volume of patients served.
- review of active and closed records; and
- review of policies and procedures.

Through this evaluation, it is determined whether our utilization of services was appropriate, if our established policies and procedures are followed and if any changes are needed. Any findings of the evaluation are developed into a corrective action plan if necessary.

Annually, the Director of Organizational Performance is responsible for conducting the program evaluation for the Marengo Family Medical Clinic. Upon completion, the Director of Organizational Performance will present the annual review to the Family Medical Clinic staff and the Board of Trustees.

Annual Evaluation: Services Provided

Primary care services of the Marengo Family Medical Clinic are provided by Ben Miller, DO, Angela Fults, DO, Taylor Felker, DNP, and Mark Siebrecht, DPM. Specialty clinic services are provided by George Miller, MD, Ross Doehrmann, MD, and Daniel Lee, MD. These services are performed under the medical direction provided by Benjamin Miller, DO.

The following services are furnished directly within the clinic:

- Taking complete medical histories
- Performing complete physical examinations including well-child examinations
- DOT physicals
- Medicare physicals
- Assessments of health status
- Routine lab tests (waived)
- Diagnosis and treatment for common acute and chronic health problems and medical conditions
- Immunization programs including vaccines for children
- Women's health services/family planning/prenatal care
- Basic emergency medical care
- Podiatry services including treatment of foot and ankle injuries, fungal nails, ingrown toenails, diabetic foot care, corns/calluses, warts, tendonitis, and neuromas
- General Surgery specialty clinic services
- Wound specialty clinic services
- Orthopedic specialty clinic services
- Urology specialty clinic services

Arrangements have been made with Compass Memorial Healthcare for clinic patients to receive the following services if required:

- Specialized laboratory testing
- Specialized diagnostic testing and imaging
- Specialized therapy
- Inpatient hospital care
- Hospital/specialty physician services
- Outpatient services
- Emergency care when the clinic is not operating
- Patients will be referred to the hospital in the event that there is a medical cause where the services of the clinic would not be sufficient to care for the patient

MARENGO
FAMILY MEDICAL CLINIC
OPERATED BY COMPASS MEMORIAL HEALTHCARE

Annual Evaluation: Service Area Defined

Marengo Family Medical Clinic (MFMC) is a provider-based rural health clinic located in Iowa County, Iowa. MFMC was granted certification to function as a Rural Health Clinic on January 5, 2015. Currently, MFMC is certified through the Iowa Department of Inspections and Appeals/CMS. Iowa County is a governor-designated Health Professional Shortage Area, which allows MFMC to continue to be eligible for Rural Health Clinic status.

Demographically, the area served has the following populations:

City or Town	Population
Marengo, Iowa	2,435
Iowa County	16,568

Source:
US Census Bureau, Profile of General Population and Housing Characteristics: 2021 (Marengo)
US Census Bureau, 2021 estimate People Quick Facts (Iowa County)

Location	Zip Code	FY24 Patient Count	FY24 Visit Count	FY25 Patient Count	FY25 Visit Count
Marengo	52301	1,590	6,052	1,568	5,855
Belle Plaine	52208	503	1,799	517	1,795
Williamsburg	52361	478	1,148	523	1,270
Victor	52347	249	660	241	648
Amana (All Colonies)	52203	184	492	183	531
Ladora	52251	141	476	136	414
Blairstown	52209	169	532	172	563
Grinnell	50112	91	299	104	308
North English	52316	160	338	156	348
Brooklyn	52211	79	160	81	194
Conroy	52220	30	88	33	88
Norway	52318	47	154	46	133
Homestead	52236	45	132	41	130
Chelsea	52215	35	78	32	85
Hartwick	52232	37	89	35	102
Keystone	52249	47	134	47	127
Luzerne	52257	37	95	39	124
Deep River	52222	27	83	34	118
Parnell	52325	36	81	44	108
Guernsey	52221	23	86	28	97
Vinton	52349	312	785	330	725
Watkins	52354	25	70	29	78
Millersburg	52308	25	47	20	41
South English	52334	25	42	30	50
Elberon	52225	32	108	28	108
Oxford	52322	39	100	49	111
Sigourney	52591	19	45	16	54
Van Horne	52346	34	66	34	67
Shellsburg	52332	16	32	19	38
Montezuma	50171	9	24	12	30
Miscellaneous (outside service area)	-	489	1,110	505	1,161
Total Count	**-**	**5,033**	**15,405**	**5,132**	**15,501**

Evaluation: Services Statistics

Marengo Family Medical Clinic (MFMC) had a total of 15,501 visits for FY2025, compared to 15,405 visits in FY2024, showing an overall growth of 0.6% over the last fiscal year. Dr. Ross Doehrmann stepped in as our Orthopedic specialist to take over for Dr. Cooper due to retirement.

The clinic's total visit fiscal year comparison by specialty is shown in Table 1.1:

Table 1.1: Total Visit Comparison FY24 to FY25 by Specialty

	FY2024	FY2025	Trend	% Growth
Family Practice	8,489	8,219	(270)	-3.2%
Podiatry	2,873	2,786	(87)	-3.0%
Podiatry Virginia Gay Clinic	673	671	(2)	-0.3%
General Surgery	706	812	106	15.0%
General Surgery Virginia Gay Clinic	188	191	3	1.6%
Orthopedics	602	835	233	38.7%
Wound	484	580	96	19.8.%
Urology	318	361	43	13.5%
Lab/Injections	1,072	1,046	(26)	-2.4%
Total Visits	**15,405**	**15,501**	**96**	**0.6%**

The clinic's total visit fiscal year comparison by provider is shown in Table 1.2:

Table 1.2: Total Visit Comparison FY24 to FY25 by Provider

	FY2024	FY2025	Trend
Benjamin Miller, DO-Family Practice	3,392	3,458	66
Angela Fults, DO-Family Practice	3,179	3,485	306
Taylor Felker, DNP-Family Practice	1,905	1,242	(663)
Amy Leitch, DNP-Family Practice	5	3	(2)
Madelyn Kussmann, PA-C-Family Practice	-	9	9
Phelps, Brandon, DO-Family Practice	8	16	8
Stephanie Healy, DNP-Family Practice	-	6	6
Mark Siebrecht, DPM-Podiatry & Wound	3,874	3,788	(86)
Chirantan Ghosh, MD-Oncology/Hematology	-	-	-
Mindy Martin, ARNP-Oncology/Hematology	-	-	-
George Miller, MD-General Surgery & Wound	1,050	1,252	202
Douglas Cooper, MD-Orthopedics	365	1	(364)
Ross Doehrmann, DO-Orthopedics	237	834	597
Lee, Daniel, MD-Urology	318	361	43
Lab/Injections	1,072	1,046	(26)
Total Visits	**15,405**	**15,501**	**96**

MARENGO
FAMILY MEDICAL CLINIC
OPERATED BY COMPASS MEMORIAL HEALTHCARE

Annual Evaluation: Services Statistics Continued...

The clinic's total visits per provider per month for FY25 is shown in Table 1.3:

Table 1.3 Total Visits by Month/Provider FY25

	Miller	Fults	Felker	Leitch	Kussmann	Phelps	Healy	Lee	Siebrecht	G. Miller	Cooper	Doehrmann	Nurse Visits	Total Per Month
July	250	248	35	-	-	16	-	23	344	126	-	56	74	1,172
August	330	348	97	-	-	-	-	19	361	92	1	57	76	1,381
September	302	218	138	1	-	-	-	28	275	90	-	92	93	1,237
October	283	327	211	-	-	-	-	16	365	100	-	92	148	1,542
November	269	291	136	-	-	-	-	31	293	100	-	53	105	1,278
December	282	298	102	1	-	-	-	26	321	96	-	61	91	1,278
January	328	311	176	1	-	-	-	41	313	111	-	84	79	1,444
February	328	278	143	-	-	-	-	44	265	96	-	50	83	1,287
March	290	353	90	-	-	-	-	21	356	99	-	76	102	1,387
April	342	323	106	-	-	-	-	42	255	130	-	60	64	1,322
May	193	302	8	-	-	-	-	39	320	126	-	78	72	1,138
June	261	188	-	-	9	-	6	31	320	86	-	75	59	1,035
FY25 Total	**3,458**	**3,485**	**1,242**	**3**	**9**	**16**	**6**	**361**	**3,788**	**1,252**	**1**	**834**	**1,046**	**15,501**

Annual Evaluation: Services Statistics Continued...

The clinic's total visits comparison by visit type is reflected in table 1.4:

Table 1.4 Total Visit Comparison by Visit Type

Visit Type	FY24	FY25	Trend
Office Visit	3,127	3,279	152
Urgent/Same Day	1,744	1,484	(260)
New Patient	792	611	(181)
Follow up	2,639	2,590	(49)
Physical	226	239	13
Procedure	1,455	1,436	(19)
Well Child	513	522	9
Telemedicine New	0	0	-
Telemedicine Follow-Up	0	0	-
Pre-Op	174	226	52
Post-Op	175	209	34
Pain New Patient	9	2	(7)
Pain Follow-Up	75	75	-
Pap and Pelvic	9	8	(1)
Initial OB	6	10	4
Routine Prenatal Care	52	30	(22)
Welcome to Medicare	6	14	8
Annual Wellness Visit	128	143	15
Nursing Home Visit	1,687	1,605	(82)
Telemedicine Nursing Home	0	0	-
Consult	687	850	163
DOT Physical	26	34	8
Wound Care	361	548	187
Diabetic Follow up	421	525	104
Vasectomy	12	7	(5)
Home Visit	5	1	(4)
Nurse Visit	1,072	1,046	(26)
Diabetic Initial Visit	1	5	4
Occupational Health Physical	2	0	(2)
Post Hospital Establish Patient	1	1	-
Visit Total	**15,405**	**15,501**	**96**

MARENGO
FAMILY MEDICAL CLINIC
OPERATED BY COMPASS MEMORIAL HEALTHCARE

Annual Evaluation: Patient Satisfaction Outcomes

Marengo Family Medical Clinic also finds patient satisfaction outcomes as an area to measure to assure that our patients are satisfied with the service and quality of care they received during their visit. The tables below reflect the average mean score per question for the fiscal year for each specialty. We will continue to provide patients with satisfaction surveys at the end of every visit to provide them with the opportunity to provide feedback for each visit experience.

MFMC Patient Satisfaction Results FY24/FY25 Comparison	Goal	FY24 YTD	FY25 YTD	Trend
	95%	97.7%	98.2%	0.5%
# of Surveys Returned		350	719	369
Ease of scheduling your appointment		97.0%	98.4%	1.4%
Courtesy of registration staff		97.9%	98.6%	0.7%
Wait time at clinic		96.1%	96.8%	0.7%
Friendliness of nurse		98.9%	98.8%	(0.1%)
Providers explanation of diagnosis/condition		97.8%	98.3%	0.5%
Staff worked together to care for you		98.1%	98.3%	0.2%
Friendliness of all staff you encountered		98.5%	98.3%	(0.2%)

%

MFMC Wound Clinic Patient Satisfaction Results FY24/FY25 Comparison	Goal	FY24 YTD	FY25 YTD	Trend
	95%	99.4%	97.8%	(1.6%)
# of Surveys Returned		4	241	237
Ease of scheduling your appointment		95.8%	99.1%	3.3%
Courtesy of registration staff		100%	99.3%	(0.7%)
Wait time at clinic		100%	98.4%	(1.6%)
Friendliness of nurse		100%	99.3%	(0.7%)
Providers explanation of diagnosis/condition		100%	98.6%	(1.4%)
Staff worked together to care for you		100%	99.3%	(0.7%)
Friendliness of all staff you encountered		100%	98.8%	(1.2%)

MFMC General Surgery Patient Satisfaction Results FY24/FY25 Comparison	Goal	FY24 YTD	FY25 YTD	Trend
	95%	98.4%	96.2%	(2.2%)
# of Surveys Returned		25	52	27
Ease of scheduling your appointment		98.4%	96.4%	(2.0%)
Courtesy of registration staff		100%	95.8%	(4.2%)
Wait time at clinic		100%	95.4%	(4.6%)
Friendliness of nurse		96.9%	96.7%	(0.2%)
Providers explanation of diagnosis/condition		96.9%	97.1%	0.2%
Staff worked together to care for you		96.9%	96.4%	(0.5%)
Friendliness of all staff you encountered		99.6%	97.9%	(1.7%)

Annual Evaluation: Patient Satisfaction Outcomes Continued…

MFMC Ortho Clinic Patient Satisfaction Results FY24/FY25 Comparison	Goal	FY24 YTD	FY25 YTD	Trend
	95%	98.2%	94.1%	(4.1%)
# of Surveys Returned		17	126	109
Ease of scheduling your appointment		98.3%	89.7%	(8.6%)
Courtesy of registration staff		98.3%	94.9%	(3.4%)
Wait time at clinic		97.3%	88.1%	(9.2%)
Friendliness of nurse		95.0%	95.5%	0.5%
Providers explanation of diagnosis/condition		100%	97.7%	(2.3%)
Staff worked together to care for you		100%	97.8%	(2.2%)
Friendliness of all staff you encountered		98.2%	97.2%	(1.0%)

MFMC Urology Clinic Patient Satisfaction Results FY24/FY25 Comparison	Goal	FY24 YTD	FY25 YTD	Trend
	95%	100%	98.6%	(1.4%)
# of Surveys Returned		2	31	29
Ease of scheduling your appointment		100%	97.5%	(2.5%)
Courtesy of registration staff		100%	99.2%	(0.8%)
Wait time at clinic		100%	98.5%	(1.5%)
Friendliness of nurse		100%	99.2%	(0.8%)
Providers explanation of diagnosis/condition		100%	97.2%	(2.8%)
Staff worked together to care for you		100%	99.2%	(0.8%)
Friendliness of all staff you encountered		100%	99.2%	(0.8%)

Annual Evaluation: Chart Review

As a part of the Organizational Performance Improvement Program, chart reviews are completed monthly, and results are analyzed for trends and implement corrective action if needed. Both active and closed reviews were conducted for completeness, accuracy, and adherence to policy standards, protocols, and standards of clinical care. Outcomes are reported either monthly or quarterly to the appropriate committees and performance improvement initiatives are discussed if corrective action is needed.

Table 1.5 below includes outcomes from our monthly medical record audit. The purpose of this audit is to assess the level of compliance with established standards within the clinic based on medical record documentation.

Table 1.5 Medical Record Documentation Chart Review Outcomes for FY2025

Medical Record Review Measures	% Cases Reviewed	# of Charts Reviewed	FY24 Outcome	Met Threshold
General Consent for Treatment on Chart	2%	360	100%	☒
Vitals Documented (height, weight, BP, Pulse)	2%	360	85%	☐
Medication allergies and adverse reactions documented/reviewed	2%	360	100%	☒
Current medications, dose, and frequency documented/ reviewed	2%	360	100%	☒
Past medical history documented	2%	360	99.2%	☒
Surgical history documented	2%	360	99.7%	☒
Family history documented	2%	360	99.2%	☒
Socioeconomic history documented	2%	360	100%	☒
Reason for visit documented	2%	360	100%	☒
Physical exam documented	2%	360	100%	☒
Treatment plans documented	2%	360	100%	☒
Informed consent completed for procedures	2%	360	100%	☒
Problem list updated	2%	360	100%	☒
Diagnosis documented	2%	360	100%	☒
Documented plan for follow up	2%	360	99.7%	☒
Discharge instructions provided to the patient (AVS)	2%	360	99.7%	☒
Health Maintenance Items addressed	2%	360	100%	☒
In house tests and orders completed	2%	360	100%	☒
Orders for imaging/blood work entered	2%	360	100%	☒
Follow-up instructions documented in the appropriate location in EPIC to reflect on AVS	2%	360	99.7%	☒
A follow-up appointment scheduled	2%	360	100%	☒
Ordered test results follow up with the patient	2%	360	100%	☒
Assessment: 360 medical records were reviewed for FY25. The overall documentation compliance rate for FY25 was 99.0%. The content of medical records was found to be in compliance with the majority of the charts either meeting or exceeding standards for record-keeping and medical documentation. Per policy, height, weight, blood pressure, and pulse are to be taken every visit. Height was missing from a significant number of adult patient visits. Ongoing education and monthly feedback are provided to staff to ensure compliance with medical record documentation as well as continued education and feedback on vitals taken at every visit. Policy review and updates may occur according to best practice for height assessment at each vs. compared to annually, as prompted in EMR.				

Annual Evaluation: Chart Review Continued...

In consideration of the regulatory requirement 491.8(c), Physician Assistant and Nurse Practitioner (advance practice providers) clinic staff will participate in periodic chart review of the patient's health record with the clinic's Medical Director. Participation of the periodic review may be face to face or via telephone with a note in the patient's health record signed by the medical director indicating the review was completed.

Table 1.6 below reflects the advance practice provider (APP) review for FY2025.

Table 1.6 APP Periodic Review for FY2025

Measure	Review Type	# of Cases	% of Cases Reviewed	Standard Met
Review of Nurse Practitioner: Taylor Felker, DNP	APP/Concurrent	22	2%	☒

Assessment: 22 were periodically reviewed in FY25 in conjunction with the medical director. Both advanced practice providers performed as expected with no clinic or administrative actions requested.

Action Plan for FY25: Continue APP review of at least 2 charts per month and provide any feedback necessary for improvement.

Annual Evaluation: Policy and Procedures

Annually, staff at Marengo Family Medical Clinic perform a comprehensive review of all policies and procedures at the clinic. There were no policy updates for FY2025.

Annual Evaluation: Conclusion

As indicated by the data and information within, Marengo Family Medical Clinic is appropriately providing services while following established policies and procedures. Marengo Family Medical Clinic is productive in benefiting the healthcare of the patients we serve and will continue to provide high-quality healthcare to our patients with a focus on preventative health, disease management, and care coordination.

MARENGO
FAMILY MEDICAL CLINIC

OPERATED BY COMPASS MEMORIAL HEALTHCARE

Annual Evaluation: Signature Approval Page

Signatures below attest that the attached information was reviewed and approved by the Marengo Family Medical Clinic medical staff and Compass Memorial Healthcare Board of Trustees in September 2025.

_____

Tessa Wade, Board of Trustees President

_____

Barry Goettsch, Chief Executive Officer

_____

Ben Miller, DO, Medical Director

NORTH ENGLISH
FAMILY MEDICAL CLINIC

OPERATED BY COMPASS MEMORIAL HEALTHCARE

North English Family Medical Clinic

Rural Health Clinics Annual Program Evaluation FY 2025

July 1, 2024-June 30th, 2025

NORTH ENGLISH
FAMILY MEDICAL CLINIC

OPERATED BY COMPASS MEMORIAL HEALTHCARE

Rural Health Clinic Annual Evaluation Report

Report Period: July 1, 2024-June 30th, 2025

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Annual Evaluation: Introduction

This annual evaluation report is prepared to evaluate the services and the effectiveness of the North English Family Medical Rural Health Clinic program operated by Compass Memorial Healthcare. The evaluation includes:

- review of the utilization of clinic services, including the volume of patients served.
- review of active and closed records; and
- review of policies and procedures.

Through this evaluation, it is determined whether our utilization of services was appropriate, if our established policies and procedures are followed and if any changes are needed. Any findings of the evaluation are developed into corrective action plan if necessary.

Annually, the Director of Organizational Performance is responsible for conducting the program evaluation for the North English Family Medical Clinic. Upon completion, the Director of Organizational Performance will present the annual review to the Family Medical Clinic staff and the Board of Trustees.

Annual Evaluation: Services Provided

The primary services of the North English Family Medical Clinic are primarily provided by Stephanie Healy, DNP. These services are performed under the medical direction provided by Brandon Phelps, DO.

The following services are furnished directly within the clinic:

- Taking complete medical histories
- Performing complete physical examinations including well-child examinations
- Assessments of health status
- Routine lab tests (waived)
- Diagnosis and treatment for common acute and chronic health problems and medical conditions
- Immunization programs including vaccines for children
- Women's health services/family planning
- Basic emergency medical care

The following services are provided by RHC practitioners:

- SNF services
- Nursing Home Services

Arrangements have been made with Compass Memorial Healthcare for clinic patients to receive the following services if required:

- Specialized laboratory testing
- Specialized diagnostic testing and imaging
- Specialized therapy
- Inpatient hospital care
- Hospital/specialty physician services
- Outpatient services
- Emergency care when the clinic is not operating
- Patients will be referred to the hospital in the event that there is a medical cause where the services of the clinic would not be sufficient to care for the patient

NORTH ENGLISH
FAMILY MEDICAL CLINIC

OPERATED BY COMPASS MEMORIAL HEALTHCARE

Annual Evaluation: Service Area Defined

North English Family Medical Clinic (NEFMC) is a provider-based rural health clinic located in Iowa County, Iowa. NEMFC was granted certification to function as a Rural Health Clinic on July 22, 2020. Currently, NEFMC is certified through the Iowa Department of Inspections and Appeals/CMS. Iowa County is a governor-designated Health Professional Shortage Area, which allows NEFMC to continue to be eligible for Rural Health Clinic status.

Demographically, the area served has the following populations:

City or Town	Population
North English, Iowa	1,049
Iowa County	16,568

Source:
US census Bureau, Profile of General Population and Housing Characteristics: 2021 (North English)
US Census Bureau, 2021 estimate People Quick Facts (Iowa County)

Location	Zip Code	FY24 Patient Count	FY24 Visit Count	FY25 Patient Count	FY25 Visit Count
North English	52316	566	1,806	558	1,770
Williamsburg	52361	339	519	332	465
Sigourney	52591	106	241	87	220
South English	52334	116	380	120	361
Marengo	52301	117	149	97	141
Parnell	52325	77	114	73	124
Webster	52355	58	179	64	182
Ladora	52251	18	23	20	26
Millersburg	52308	41	98	34	77
Deep River	52222	30	52	33	79
Keswick	50136	60	165	58	115
What Cheer	50268	31	73	29	73
Keota	52248	4	10	5	9
Victor	52347	31	42	36	42
Belle Plaine	52208	16	22	22	35
Harper	52231	22	54	24	58
Delta	52550	6	11	6	7
Amana (All Colonies)	52203	6	7	5	5
Brooklyn	52211	4	4	12	37
Homestead	52236	3	3	4	4
Hartwick	52232	2	3	1	1
Conroy	52220	12	20	9	11
Washington	52353	5	7	3	5
Blairstown	52209	6	6	1	1
Luzerne	52257	0	0	3	3
Montezuma	50171	0	0	2	4
Kinross	52335	7	24	8	21
Hedrick	52563	3	5	3	5
Brighton	52540	2	4	2	5
Oskaloosa	52577	1	3	2	2
Miscellaneous (outside service area)	-	96	166	92	192
Total Count	-	**1,785**	**4,190**	**1,745**	**4,080**

Annual Evaluation: Services Statistics

Overall North English Family Medical Clinic had a total of 4,080 visits in FY25, compared to 4,190 in FY24 with an overall percent decrease of 2.6%. The clinic will continue to focus on preventative health and care coordination and will continue to market services available to the service area.

The clinic's total visit fiscal year comparison by specialty is shown in Table 1.1:

Table 1.1: Total Visit Comparison FY24 to FY25				
	FY2024	FY2025	Trend	% Growth
Family Practice	3637	3,605	(32)	-0.9%
Lab/Injection	553	475	(78)	-14.1%
Total Visits	**4190**	**4,080**	**(110)**	**-2.6%**

The Clinic's total visit fiscal year comparison by provider is shown in Table 1.2:

Table 1.2: Total Visit Comparison FY24 to FY25 by Provider			
	FY2024	FY2025	Trend
Stephanie Healy, DNP	2,230	2,432	202
Brandon Phelps, DO	153	117	(36)
Michelle Malloy, ARNP	994	877	(117)
Kathryn Upah, PA-C	221	149	(72)
Amy Leitch, DNP	0	0	-
Taylor Felker, DNP	39	30	(9)
Madelyn Kussmann, PA-C	0	0	-
Lab/Injection	553	475	(78)
Total Visits	**4,190**	**4,080**	**(110)**

The clinic's total visits per provider per month for FY25 is shown in Table 1.3:

	Table 1.3 Total Visits by Month/Provider FY25						
	Healy	Felker	Malloy	Phelps	Upah	Nurse	Total Per Month
July	196	-	101	8	14	51	370
August	215	-	114	-	-	44	373
September	178	12	76	-	27	44	337
October	193	-	37	-	27	63	320
November	224	-	83	-	-	56	363
December	204	-	64	15	37	26	346
January	262	-	66	-	-	36	364
February	208	8	76	8	-	34	334
March	163	10	83	6	12	25	299
April	194	-	81	-	-	27	302
May	217	-	52	17	32	38	356
June	178	-	44	63	-	31	316
FY25 Total	**2,432**	**30**	**877**	**117**	**149**	**475**	**4,080**

Annual Evaluation: Services Statistics Continued…

The clinic's total visits comparison by visit type if reflected in table 1.4:

Table 1.4 Total Visit Comparison by Visit Type

Visit Type	FY2024	FY2025	Trend
Office Visit	573	705	132
Same Day	1,136	964	(172)
New Patient	271	173	(98)
Follow up	994	998	4
Physical	155	201	46
Procedure	47	80	33
Well Child	232	209	(23)
Telemedicine Follow-Up	0	0	-
Pre-Op	29	40	11
Pain New Patient	0	1	1
Pain Follow-Up Patient	2	6	4
Pap and Pelvic	5	5	-
Diabetes Initial Visit	0	2	2
Diabetes Follow-Up	70	60	(10)
Welcome to Medicare	3	4	1
Annual Wellness Visit	100	120	20
Nursing Home Visit	17	32	15
Telemedicine Nursing Home	0	0	-
DOT Physical	1	5	4
Nurse Visit	555	475	(80)
Visit Total	**4,190**	**4,080**	**(110)**

Annual Evaluation: Patient Satisfaction Outcomes

North English Family Medical clinic also finds patient satisfaction outcomes as an area to measure to assure that our patients are satisfied with the service and quality of care they received during their visit. Table 1.5 below reflects the average mean score per question for the fiscal year. We will continue to provide patients with satisfaction surveys at the end of every visit to provide them with the opportunity to provide feedback for each visit experience.

Table 1.5 Patient Satisfaction Result Comparison

NEFMC Patient Satisfaction Results FY24/FY25 Comparison	Goal	FY24 YTD	FY25 YTD	Trend
	95%	97.4%	98.4%	1.0%
# of Surveys Returned		**312**	**337**	25
Ease of scheduling your appointment		96.8%	98.5%	1.7%
Courtesy of registration staff		97.8%	98.7%	0.9%
Wait time at clinic		96.0%	97.0%	1.0%
Friendliness of nurse		97.9%	98.9%	1.0%
Providers explanation of diagnosis/condition		97.4%	97.4%	-
Staff worked together to care for you		97.8%	98.9%	1.1%
Friendliness of all staff you encountered		98.0%	99.1%	1.1%

Annual Evaluation: Chart Review

As a part of the Organizational Performance Improvement Program, chart reviews are completed monthly, and results are analyzed for trends and implement corrective action if needed. Both active and closed reviews were conducted for completeness, accuracy, and adherence to policy standards, protocols, and standards of clinical care. Outcomes are reported either monthly or quarterly to the appropriate committees and performance improvement initiatives are discussed if corrective action is needed.

Table 1.6 below includes outcomes from our monthly medical record audit. The purpose of this audit is to assess the level of compliance with established standards within the clinic based on medical record documentation.

Table 1.6 Medical Record Chart Review Outcomes FY2025

Medical Record Review Measures	% Cases Reviewed	# of Charts Reviewed	FY25 Outcome	Met Threshold
General Consent for Treatment on Chart	2%	61	100%	☒
Vitals Documented (height, weight, BP, Pulse)	2%	61	96.7%	☒
Medication allergies and adverse reactions reviewed/noted	2%	61	100%	☒
Current medications, dose, and frequency reviewed/noted	2%	61	100%	☒
Past medical history documented	2%	61	100%	☒
Surgical history documented	2%	61	100%	☒
Family history documented	2%	61	100%	☒
Socioeconomic history documented	2%	61	100%	☒
Reason for visit documented	2%	61	100%	☒
Physical exam documented	2%	61	100%	☒
Treatment plans documented	2%	61	100%	☒
Informed consent completed for procedures	2%	61	100%	☒
Problem list updated	2%	61	100%	☒
Diagnosis documented	2%	61	100%	☒
Documented plan for follow up	2%	61	100%	☒
Discharge instructions provided to the patient (AVS)	2%	61	100%	☒
Health Maintenance Items addressed	2%	61	100%	☒
In house test and orders completed	2%	61	100%	☒
Orders for imaging/blood work entered	2%	61	100%	☒
Follow-up instructions documented in the appropriate location in EPIC to reflect on AVS	2%	61	100%	☒
Follow up appointment scheduled	2%	61	100%	☒
Ordered tests results follow up with patient	2%	61	100%	☒
Assessment: 61 medical records were reviewed for FY25. The overall documentation compliance rate for FY25 was 99.8%. The content of medical records was found to be in compliance with the majority of the charts either meeting or exceeding standards for record-keeping and medical documentation. All chart review results are forwarded to the Director of Ambulatory Clinics who is responsible for the corrective action plans associated with non-compliance. Ongoing education and follow-up with staff is provided on a month-to-month basis to ensure overall compliance.				

Annual Evaluation: Chart Review Continued…

In consideration of the regulatory requirement 491.8(c), Physician Assistant and Nurse Practitioner (advance practice providers) clinic staff will participate in periodic chart review of the patient's health record with the clinic's Medical Director. Participation of the periodic review may be face to face or via telephone with a note in the patient's health record signed by the medical director indicating the review was completed.

Table 1.7 below reflects the advanced practice provider (APP) review for 2025.

Table 1.7 APP Periodic Review for FY2025

Measure	Review Type	# of Cases	% of Cases Reviewed	Standard Met
Review of Nurse Practitioner: Michelle Malloy, ARNP	Mid-Level/Concurrent	24	3%	☒
Review of Nurse Practitioner: Stephanie Healy, DNP	Mid-Level/Concurrent	48	2%	☒

Assessment: 72 charts were periodically reviewed in FY25 in conjunction with the medical director. Both advanced practice providers performed as expected with no clinic or administrative actions requested.

Action Plan for FY25: Continue APP review of at least 2 charts per month and provide any feedback necessary for improvement.

Annual Evaluation: Policy and Procedures

Annually, staff at North English Family Medical Clinic perform a comprehensive review of the policies and procedures at the clinic. There were no policy updates for FY2025.

Annual Evaluation: Conclusion

As indicated by the data and information within, North English Family Medical Clinic is appropriately providing services while following established policies and procedures. North English Family Medical Clinic is productive in benefiting the health care of the patients we serve and will continue to provide high quality healthcare to our patients with a focus on preventative health, disease management and care coordination.

NORTH ENGLISH
FAMILY MEDICAL CLINIC

OPERATED BY COMPASS MEMORIAL HEALTHCARE

Annual Evaluation: Signature Approval Page

Signatures below attest that the attached information was reviewed and approved by the North English Family Medical Clinic medical staff and Compass Memorial Healthcare Board of Trustees in September 2025.

_____

Tessa Wade, Board of Trustees President

_____

Barry Goettsch, Chief Executive Officer

_____

Brandon Phelps, DO, Medical Director

VICTOR
FAMILY MEDICAL CLINIC
OPERATED BY COMPASS MEMORIAL HEALTHCARE

Victor Family Medical Clinic

Rural Health Clinics Annual Program Evaluation FY2025

July 1st, 2024-June 30th, 2025

VICTOR
FAMILY MEDICAL CLINIC
OPERATED BY COMPASS MEMORIAL HEALTHCARE

Rural Health Clinic Annual Evaluation Report

Report Period: July 1st, 2024-June 30th, 2025

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Annual Evaluation: Introduction

This annual evaluation report is prepared to evaluate the services and the effectiveness of the Victor Family Medical Rural Health Clinic program operated by Compass Memorial Healthcare. The evaluation includes:

- review of the utilization of clinic services, including the volume of patients served.
- review of active and closed records; and
- review of policies and procedures.

Through this evaluation, it is determined whether our utilization of services was appropriate, if our established policies and procedures are followed and if any changes are needed. Any findings of the evaluation are developed into corrective action plan if necessary.

Annually, the Director of Organizational Performance is responsible for conducting the program evaluation for the Victor Family Medical Clinic. Upon completion, the Director of Organizational Performance will present the annual review to the Family Medical Clinic staff and the Board of Trustees.

VICTOR
FAMILY MEDICAL CLINIC
OPERATED BY COMPASS MEMORIAL HEALTHCARE

Annual Evaluation: Services Provided

In FY2025, services of the Victor Family Medical Clinic were primarily provided by Amy Leitch, DNP and Taylor Felker, DNP. These services are performed under the medical direction provided by Ben Miller, MD.

The following services are furnished directly within the clinic:

- Taking complete medical histories
- Performing complete physical examinations including well-child examinations
- Assessments of health status
- Routine lab tests (waived)
- Diagnosis and treatment for common acute and chronic health problems and medical conditions
- Immunization programs including vaccines for children
- Women's health services/family planning
- Basic emergency medical care

The following services are provided by RHC practitioners:

- SNF services
- Nursing Home Services

Arrangements have been made with Compass Memorial Healthcare for clinic patients to receive the following services if required:

- Specialized laboratory testing
- Specialized diagnostic testing and imaging
- Specialized therapy
- Inpatient hospital care
- Hospital/specialty physician services
- Outpatient services
- Emergency care when the clinic is not operating
- Patients will be referred to the hospital in the event that there is a medical cause where the services of the clinic would not be sufficient to care for the patient

VICTOR
FAMILY MEDICAL CLINIC
OPERATED BY COMPASS MEMORIAL HEALTHCARE

Annual Evaluation: Service Area Defined

Victor Family Medical Clinic (VFMC) is a provider-based rural health clinic located in Iowa County, Iowa. VMFC was granted certification to function as a Rural Health Clinic in September of 2021. Currently, VFMC is certified through the Iowa Department of Inspections and Appeals/CMS. Iowa County is a governor-designated Health Professional Shortage Area, which allows VFMC to continue to be eligible for Rural Health Clinic status.

Demographically, the area served has the following populations:

City or Town	Population
Victor, Iowa	875
Iowa County	16,475

Source:
US Census Bureau, Profile of General Population and Housing Characteristics: 2020 (Victor)
US Census Bureau, 2022 estimate People Quick Facts (Iowa County)

Location	Zip Code	FY24 Patient Count	FY24 Visit Count	FY25 Patient Count	FY25 Visit Count
Victor	52347	541	1,875	543	1,709
Marengo	52301	192	343	252	421
Belle Plaine	52208	123	251	142	274
Brooklyn	52211	112	346	100	273
Ladora	52251	93	255	90	197
Hartwick	52232	80	221	88	230
Williamsburg	52361	46	67	74	100
Guernsey	52221	41	145	44	154
Deep River	52222	25	72	33	87
Montezuma	50171	6	21	7	34
Blairstown	52209	16	20	16	28
North English	52316	12	12	13	27
Chelsea	52215	12	17	14	31
Malcom	50157	12	51	13	51
Grinnell	50112	11	16	8	11
South English	52335	6	13	2	8
What Cheer	50268	2	4	3	5
Barnes City	50027	0	0	0	0
Parnell	52325	5	11	5	7
Vinton	52349	3	4	1	1
Luzerne	52257	7	9	7	8
Millersburg	52308	0	0	3	3
Amana	52203	0	0	4	5
West Amana	52203	0	0	0	0
Norway	52318	2	3	0	0
Conroy	52220	3	5	6	8
Keystone	52249	2	3	0	0
Miscellaneous (outside service area)	-	65	118	69	108
Total Count	**-**	**1,417**	**3,882**	**1,537**	**3,780**

VICTOR
FAMILY MEDICAL CLINIC
OPERATED BY COMPASS MEMORIAL HEALTHCARE

Annual Evaluation: Services Statistics

Overall, Victor Family Medical Clinic had a total of 3,780 visits in FY2025, compared to 3,882 visits in FY2024, showing an overall percent decrease of 2.6% over the last fiscal year.

The clinic's total visit fiscal year comparison by specialty is shown in Table 1.1:

Table 1.1: Total Visit Comparison FY24 to FY25 by Specialty

	FY2024	FY2025	Trend	% Growth
Family Practice	3,484	3,455	(29)	-0.8%
Lab/Injection	398	325	(73)	-18.3%
Total Visits	**3,882**	**3,780**	**(102)**	**-2.6%**

The clinic's total visit fiscal year comparison by provider is shown in Table 1.2:

Table 1.2: Total Visit Comparison FY24 to FY25 by Provider

	FY2024	FY2025	Trend
Amy Leitch, DNP	2,646	1,879	(767)
Taylor Felker, DNP	691	1,131	440
Ben Miller, DO	88	151	63
Angela Fults, DO	-	20	20
Brandon Phelps, DO	18	191	173
Madelyn Kussmann, PA-C	-	-	-
Stephanie Healy, DNP	10	-	(10)
Kathryn Upah, PA-C	31	18	(13)
Victoria Rowlands, ARNP	-	65	65
Lab/ Injections	398	325	(73)
Total Visits	**3,882**	**3,780**	**(102)**

The clinic's total visits by month by provider is shown in Table 1.3:

Table 1.3: Total Visit Comparison by Provider by Month FY25

	A. Leitch	T. Felker	B. Miller	A. Fults	B. Phelps	K. Upah	V. Rowlands	Nurse	Total Per Month
July	38	188	16	-	33	-	-	19	**294**
August	120	195	-	-	-	-	-	29	344
September	187	57	-	-	-	-	-	38	282
October	227	69	-	-	-	-	-	39	335
November	212	51	-	-	-	-	-	43	306
December	211	106	10	-	-	-	-	22	349
January	243	78	-	-	-	-	-	32	353
February	246	82	-	-	-	-	-	20	348
March	211	27	18	3	21	18	-	16	314
April	111	113	-	-	22	-	-	19	265
May	73	165	-	-	36	-	-	23	297
June	-	-	107	17	79	-	65	25	293
FY25 Total	**1,879**	**1,131**	**151**	**20**	**191**	**18**	**65**	**325**	**3,780**

Annual Evaluation: Services Statistics Continued...

The clinic's total visits comparison by visit type is reflected in table 1.4:

Table 1.4 Total Visit Comparison by Visit Type

Visit Type	FY2024	FY2025	Trend
Office Visit	460	603	143
Same Day	1,251	1,330	79
New Patient	189	112	(77)
Follow up	1,020	858	(162)
Physical	86	82	(4)
Procedure	115	70	(45)
Well Child	136	163	27
Pre-Op	42	50	8
Pain New Patient	3	0	(3)
Pain Follow-Up Patient	20	12	(8)
Pap and Pelvic	4	2	(2)
Welcome to Medicare	2	7	5
Annual Wellness Visit	35	28	(7)
Nursing Home Visit	1	2	1
Diabetes Initial Visit	0	4	4
Diabetes Follow-Up Visit	77	107	30
DOT Physical	42	25	(17)
DTC Alternative Follow-Up	0	0	-
Nurse Visit	398	325	(73)
Occupational Health Physical	1	0	(1)
Visit Total	**3,882**	**3,780**	**(102)**

VICTOR
FAMILY MEDICAL CLINIC
OPERATED BY COMPASS MEMORIAL HEALTHCARE

Annual Evaluation: Patient Satisfaction Outcomes

Victor Family Medical clinic also finds patient satisfaction outcomes as an area to measure to assure that our patients are satisfied with the service and quality of care they received during their visit. The tables below reflect the average mean score per question for each specialty in the fiscal year. We will continue to provide patients with satisfaction surveys at the end of every visit to provide them with the opportunity to provide feedback for each visit experience.

VFMC Patient Satisfaction Results FY24/FY25 Comparison	Goal	FY24 YTD	FY25 YTD	Trend
# of Surveys Returned	**95%**	**390**	**414**	**24**
Ease of scheduling your appointment		97.4%	98.8%	1.4%
Courtesy of registration staff		98.2%	98.8%	0.6%
Wait time at clinic		95.9%	97.1%	1.2%
Friendliness of nurse		98.2%	98.8%	0.6%
Providers explanation of diagnosis/condition		96.5%	98.3%	1.8%
Staff worked together to care for you		97.4%	98.5%	1.1%
Friendliness of all staff you encountered		98.0%	98.8%	0.8%
Overall Average		97.3%	98.2%	0.9%

Annual Evaluation: Chart Review

As a part of the Organizational Performance Improvement Program, chart reviews are completed monthly, and results are analyzed for trends and corrective action if needed. Both active and closed reviews were conducted for completeness, accuracy, and adherence to policy standards, protocols, and standards of clinical care. Outcomes are reported either monthly or quarterly to the appropriate committees and performance improvement initiatives are discussed if corrective action is needed. Table 1.5 below includes outcomes from our monthly medical record audit.

Table 1.5 Medical Record Documentation Chart Review Outcomes for FY2025

Medical Record Review Measures	% Cases Reviewed	# of Charts Reviewed	FY25 Outcome	Met Threshold
General Consent for Treatment on Chart	3%	120	100%	☒
Vitals Documented (height, weight, BP, Pulse)	3%	120	80.8%	☐
Medication allergies and adverse reactions reviewed	3%	120	100%	☒
Current medications, dose, and frequency reviewed	3%	120	100%	☒
Past medical history documented	3%	120	100%	☒
Surgical history documented	3%	120	100%	☒
Family history documented	3%	120	100%	☒
Socioeconomic history documented	3%	120	100%	☒
Reason for visit documented	3%	120	100%	☒
Physical exam documented	3%	120	100%	☒
Treatment plans documented	3%	120	100%	☒
Informed consent completed for procedures	3%	120	100%	☒
Problem list updated	3%	120	100%	☒
Diagnosis documented	3%	120	100%	☒
Documented plan for follow up	3%	120	100%	☒
Discharge instructions provided to the patient (AVS)	3%	120	100%	☒
Health Maintenance Items addressed	3%	120	100%	☒
In house test and orders completed	3%	120	100%	☒
Orders for imaging/blood work entered	3%	120	100%	☒
Follow-up instructions documented in the appropriate location in EPIC to reflect on AVS	3%	120	98.3%	☒
Follow-up appointment scheduled	3%	120	95.8%	☒
Ordered tests results follow up with the patient	3%	120	100%	☒

Assessment: 120 medical records were reviewed for FY25 with an overall compliance rate of 98.7%. The content of medical records was found to be in compliance with the majority of the charts either meeting or exceeding standards for record-keeping and medical documentation. Per policy, height, weight, blood pressure, and pulse are to be taken every visit. Height was missing from a significant number of adult patient visits. Ongoing education and monthly feedback are provided to staff to ensure compliance with medical record documentation as well as continued education and feedback on vitals taken at every visit. Policy review and updates may occur according to best practice for height assessment at each vs. compared to annually, as prompted in EMR.

Annual Evaluation: Chart Review Continued…

In consideration of the regulatory requirement 491.8(c), Physician Assistant and Nurse Practitioner (advance practice providers) clinic staff will participate in periodic chart review of the patient's health record with the clinic's Medical Director. Participation of the periodic review may be face to face or via telephone with a note in the patient's health record signed by the medical director indicating the review was completed.

Table 1.6 below reflects the advance practice provider (APP) review for FY2025.

Table 1.6 APP Periodic Review for FY25

Measure	Review Type	# of Cases	% of Cases Reviewed	Standard Met
Review of Nurse Practitioner: Amy Leitch, DNP	Mid-Level/Concurrent	44	2%	☒
Review of Physician Assistant: Taylor Felker, DNP	Mid-Level/Concurrent	44	4%	☒

Assessment: 88 charts were periodically reviewed in FY25 in conjunction with the medical director. Both advanced practice providers performed as expected with no clinic or administrative actions requested.

Action Plan for FY25: Continue APP review of at least 2 charts per month and provide any feedback necessary for improvement.

Annual Evaluation: Policy and Procedures

Annually, staff at Victor Family Medical Clinic perform a comprehensive review of the policies and procedures at the clinic. There were no policy changes that occurred within this fiscal year.

Annual Evaluation: Conclusion

As indicated by the data and information within, Victor Family Medical Clinic is appropriately providing services while following established policies and procedures. Victor Family Medical Clinic is productive in benefiting the health of the patients we serve and will continue to provide high-quality healthcare to our patients with a focus on preventative health, disease management, and care coordination.

VICTOR
FAMILY MEDICAL CLINIC
OPERATED BY COMPASS MEMORIAL HEALTHCARE

Annual Evaluation: Signature Approval Page

Signatures below attest that the attached information was reviewed and approved by the Victor Family Medical Clinic medical staff and Compass Memorial Healthcare Board of Trustees in September 2025.

Tessa Wade, Board of Trustees President

Barry Goettsch, Chief Executive Officer

Ben Miller, DO, Medical Director

WILLIAMSBURG
FAMILY MEDICAL CLINIC

OPERATED BY COMPASS MEMORIAL HEALTHCARE

Williamsburg Family Medical Clinic

Rural Health Clinics Annual Program Evaluation FY2025

July 1st, 2024-June 30th, 2025

WILLIAMSBURG
FAMILY MEDICAL CLINIC

OPERATED BY COMPASS MEMORIAL HEALTHCARE

Rural Health Clinic Annual Evaluation Report

Report Period: July 1st, 2024- June 30th, 2025

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Annual Evaluation: Introduction

This annual evaluation report is prepared to evaluate the services and the effectiveness of the Williamsburg Family Medical Rural Health Clinic program operated by Compass Memorial Healthcare. The evaluation includes:

- review of the utilization of clinic services, including the volume of patients served.
- review of active and closed records; and
- review of policies and procedures.

Through this evaluation, it is determined whether our utilization of services was appropriate, if our established policies and procedures are followed and if any changes are needed. Any findings of the evaluation are developed into corrective action plan if necessary.

Annually, the Director of Organizational Performance is responsible for conducting the program evaluation for the Williamsburg Family Medical Clinic. Upon completion, the Director of Organizational Performance will present the annual review to the Family Medical Clinic staff and the Board of Trustees.

Annual Evaluation: Services Provided

The primary services of the Williamsburg Family Medical Clinic are primarily provided by Brandon Phelps, DO; Michelle Malloy ARNP; Kathryn Upah, PA-C; Mark Siebrecht, DMP; and George Miller, MD. These services are performed under the medical direction provided by Brandon Phelps, DO.

The following services are furnished directly within the clinic:

- Taking complete medical histories
- Performing complete physical examinations including well-child examinations
- Assessments of health status
- Routine lab tests (waived)
- Diagnosis and treatment for common acute and chronic health problems and medical conditions
- Immunization programs including vaccines for children
- Women's health services/family planning
- Basic emergency medical care
- Podiatry services including treatment of foot and ankle injuries, fungal nails, ingrown toenails, diabetic foot care, corns/calluses, warts, tendonitis, and neuromas
- Basic Imaging Services
- General Surgery specialty clinic services

The following services are provided by RHC practitioners:

- SNF services
- Nursing Home Services

Arrangements have been made with Compass Memorial Healthcare for clinic patients to receive the following services if required:

- Specialized laboratory testing
- Specialized diagnostic testing and imaging
- Specialized therapy
- Inpatient hospital care
- Hospital/specialty physician services
- Outpatient services
- Emergency care when the clinic is not operating
- Patients will be referred to the hospital in the event that there is a medical cause where the services of the clinic would not be sufficient to care for the patient

Annual Evaluation: Service Area Defined

Williamsburg Family Medical Clinic (WFMC) is a provider-based rural health clinic located in Iowa County, Iowa. WMFC was granted certification to function as a Rural Health Clinic on February 13, 2015. Currently, WFMC is certified through the Iowa Department of Inspections and Appeals/CMS. Iowa County is a governor-designated Health Professional Shortage Area, which allows WFMC to continue to be eligible for Rural Health Clinic status.

Demographically, the area served has the following populations:

City or Town	Population
Williamsburg, Iowa	3,364
Iowa County	16,568

Source:
US census Bureau, Profile of General Population and Housing Characteristics: 2021 (Williamsburg)
US Census Bureau, 2021 estimate People Quick Facts (Iowa County)

Location	Zip Code	FY24 Patient Count	FY24 Visit Count	FY25 Patient Count	FY25 Visit Count
Williamsburg	52361	1,580	5,303	1,708	5,655
Marengo	52301	518	1,281	556	1,345
North English	52316	259	677	262	694
Parnell	52325	166	421	173	466
Victor	52347	143	322	151	394
Belle Plaine	52208	109	222	91	179
Sigourney	52591	76	159	65	142
Conroy	52220	52	181	55	155
Ladora	52251	58	143	60	155
Deep River	52222	50	131	42	128
South English	52334	54	142	57	153
Amana (All Colonies)	52203	52	117	54	103
Brooklyn	52211	56	132	48	125
Homestead	52236	34	85	40	90
Millersburg	52308	36	97	28	71
Hartwick	52232	17	27	9	22
Blairstown	52209	16	35	25	62
Chelsea	52215	19	40	17	38
Luzerne	52257	10	18	8	12
Guernsey	52221	5	14	7	19
Montezuma	50171	3	5	9	31
Keystone	52249	5	12	6	7
Norway	52318	4	6	4	13
Elberon	52225	1	1	2	2
Grinnell	50112	7	15	5	12
Van Horne	52346	0	0	0	0
Vinton	52349	5	5	1	1
Miscellaneous (outside service area)	-	349	805	384	927
Total Count	**-**	**3,684**	**10,396**	**3,867**	**11,001**

Annual Evaluation: Services Statistics

Overall Williamsburg Family Medical Clinic had a total of 11,001 visits in FY2025, compared to 10,396 visits in FY2024, showing an overall increase of 5.8% or 605 visits over the last fiscal year.

The clinic's total visit fiscal year comparison by specialty is shown in Table 1.1:

Table 1.1: Total Visit Comparison FY24 to FY25 by Specialty

	FY2024	FY2025	Trend	% Growth
Family Practice	7,942	8,327	385	4.8%
General Surgery	212	115	(97)	-45.8%
Podiatry	387	412	25	6.5%
Lab/Injection	1,199	1,276	77	6.4%
X-ray Visits	656	871	215	32.8%
Total Visits	**10,396**	**11,001**	**605**	**5.8%**

The clinic's total visit fiscal year comparison by provider is shown in Table 1.2:

Table 1.2: Total Visit Comparison FY24 to FY25 by Provider

	FY2024	FY2025	Trend
Angela Fults, DO-Family Practice	34	122	88
Benjamin Miller, DO-Family Practice	-	23	23
Michelle Malloy, ARNP- Family Practice	2,694	2,927	233
Kathryn Upah, PA-C-Family Practice	2,649	2,626	(23)
Amy Leitch, DNP-Family Practice	-	9	9
Phelps, Brandon, DO-Family Practice	2,191	2,329	138
Stephanie Healy, DNP-Family Practice	374	291	(83)
Taylor Felker, DNP-Family Practice	-	-	-
Madelyn Kussmann, PA-C-Family Practice	-	-	-
Mark Siebrecht, DPM-Podiatry	387	412	25
George Miller, MD-General Surgery	212	115	(97)
Lab/ Injections	1,199	1,276	77
X-ray Visits	656	871	215
Total Visits	**10,396**	**11,001**	605

Annual Evaluation: Services Statistics Continued...

The clinic's total visits per provider per month for FY25 is shown in Table 1.3:

Table 1.3 Total Visits by Month/Provider FY25

	B. Miller	Fults	Healy	Leitch	Malloy	Phelps	Upah	Siebrecht	G. Miller	Nurse Visits	X-ray Visits	Total Per Month
July	-	-	57	-	253	124	242	36	13	93	73	891
August	-	-	64	-	261	211	261	43	9	116	85	1,050
September	-	-	29	-	247	180	211	37	11	108	82	905
October	-	14	14	-	273	214	276	16	10	175	77	1,069
November	-	-	14	-	178	227	282	47	-	108	54	910
December	-	40	14	-	266	178	229	14	8	116	77	942
January	-	-	20	9	256	258	305	52	9	99	50	1,058
February	-	-	8	-	261	205	257	10	9	94	67	911
March	-	-	20	-	278	218	232	36	8	94	77	963
April	-	-	18	-	255	141	262	56	13	85	104	934
May	-	-	17	-	201	217	69	26	17	83	72	702
June	23	68	16	-	198	156	-	39	8	105	53	666
FY25 Total	**23**	**122**	**291**	**9**	**2,927**	**2,329**	**2,626**	**412**	**115**	**1,276**	**871**	**11,001**

Annual Evaluation: Services Statistics Continued...

The clinic's total visits comparison by visit type is reflected in table 1.4:

Table 1.4 Total Visit Comparison by Visit Type

Visit Type	FY2024	FY2025	Trend
Office Visit	911	1,465	554
Urgent/Same Day	2,533	2,315	(218)
New Patient	422	413	(9)
Follow up	1,979	1,782	(197)
Physical	412	428	16
Procedure	443	488	45
Well Child	622	695	73
Telemedicine New	0	0	-
Telemedicine Follow-Up	0	0	-
Pre-Op	117	122	5
Post Op	13	9	(4)
Pain New Patient	0	0	-
Pain Follow-Up Patient	8	5	(3)
Pap and Pelvic	8	8	-
Initial OB	0	1	1
Routine Prenatal Care	0	1	1
Welcome to Medicare	8	17	9
Annual Wellness Visit	121	176	55
Nursing Home Visit	532	604	72
Telemedicine Nursing Home	0	0	-
Diabetes Initial	4	5	1
Diabetes Follow Up	120	127	7
Consult	196	105	(91)
DOT Physical	88	87	(1)
Nurse Visit	1,199	1,276	76
X-ray Visits	656	871	215
Home Visit	1	1	-
Wound Care	1	0	(1)
Occupational Health Physical	1	0	(1)
Visit Total	**10,396**	**11,001**	**605**

Annual Evaluation: Patient Satisfaction Outcomes

Williamsburg Family Medical Clinic also finds patient satisfaction outcomes as an area to measure to assure that our patients are satisfied with the service and quality of care they received during their visit. The tables below reflect the average mean score per question for each specialty in the fiscal year. We will continue to provide patients with satisfaction surveys at the end of every visit to provide them with the opportunity to provide feedback for each visit experience.

WFMC Patient Satisfaction Results FY24/FY25 Comparison	Goal	FY24 YTD	FY25 YTD	Trend
	95%	98.6%	98.0%	(0.06%)
# of Surveys Returned		452	711	259
Ease of scheduling your appointment		98.1%	98.1%	-
Courtesy of registration staff		98.9%	98.3%	(0.6%)
Wait time at clinic		97.5%	96.6%	(0.9%)
Friendliness of nurse		98.8%	98.1%	(0.7%)
Providers explanation of diagnosis/condition		98.9%	98.0%	(0.9%)
Staff worked together to care for you		98.8%	98.2%	(0.6%)
Friendliness of all staff you encountered		99.1%	98.4%	(0.7%)

WFMC General Surgery Patient Satisfaction Results FY24/FY25 Comparison	Goal	FY24 YTD	FY25 YTD	Trend
	95%	100%	100%	-
# of Surveys Returned		2	3	1
Ease of scheduling your appointment		100%	100%	-
Courtesy of registration staff		100%	100%	-
Wait time at clinic		100%	100%	-
Friendliness of nurse		100%	100%	-
Provider's explanation of diagnosis/condition		100%	100%	-
Staff worked together to care for you		100%	100%	-
Friendliness of all staff you encountered		100%	100%	-

Annual Evaluation: Chart Review

As a part of the Organizational Performance Improvement Program, chart reviews are completed monthly, and results are analyzed for trends and implement corrective action if needed. Both active and closed reviews were conducted for completeness, accuracy, and adherence to policy standards, protocols, and standards of clinical care. Outcomes are reported either monthly or quarterly to the appropriate committees and performance improvement initiatives are discussed if corrective action is needed.

Table 1.5 below includes outcomes from our monthly medical record audit. The purpose of this audit is to assess the level of compliance with established standards within the clinic based on medical record documentation.

Table 1.5 Medical Record Documentation Chart Review Outcomes for FY2025

Medical Record Review Measures	% Cases Reviewed	# of Charts Reviewed	FY25 Outcome	Met Threshold
General Consent for Treatment on Chart	2%	180	100%	☒
Vitals Documented (height, weight, BP, Pulse)	2%	180	87.8%	☐
Medication allergies and adverse reactions reviewed/noted	2%	180	100%	☒
Current medications, dose, and frequency reviewed/noted	2%	180	100%	☒
Past medical history documented	2%	180	100%	☒
Surgical history documented	2%	180	100%	☒
Family history documented	2%	180	99.4%	☒
Socioeconomic history documented	2%	180	100%	☒
Reason for visit documented	2%	180	100%	☒
Physical exam documented	2%	180	100%	☒
Treatment plans documented	2%	180	100%	☒
Informed consent completed for procedures	2%	180	100%	☒
Problem list updated	2%	180	100%	☒
Diagnosis documented	2%	180	100%	☒
Documented plan for follow-up	2%	180	99.4%	☒
Discharge instructions provided to the patient (AVS)	2%	180	100%	☒
Health Maintenance Items addressed	2%	180	100%	☒
In-house test and orders completed	2%	180	100%	☒
Orders for imaging/blood work entered	2%	180	100%	☒
Follow-up instructions documented in the appropriate location in EPIC to reflect on AVS	2%	180	98.9%	☒
Follow up appointment scheduled	2%	180	98.4%	☒
Ordered tests results follow up with patient	2%	180	100%	☒

Assessment: 180 medical records were reviewed for FY25. The overall documentation compliance rate for FY25 was 99.1%. The content of medical records was found to be in compliance with the majority of the charts either meeting or exceeding standards for record-keeping and medical documentation. Per policy, height, weight, blood pressure, and pulse are to be taken every visit. Height was missing from a significant number of adult patient visits. Ongoing education and monthly feedback are provided to staff to ensure compliance with medical record documentation as well as continued education and feedback on vitals taken at every visit. Policy review and updates may occur according to best practice for height assessment at each vs. compared to annually, as prompted in EMR.

Annual Evaluation: Chart Review Continued…

In consideration of the regulatory requirement 491.8(c), Physician Assistant and Nurse Practitioner (advance practice providers) clinic staff will participate in periodic chart review of the patient's health record with the clinic's Medical Director. Participation of the periodic review may be face to face or via telephone with a note in the patient's health record signed by the medical director indicating the review was completed.

Table 1.6 below reflects the advanced practice provider (APP) review for FY2025.

Table 1.6 APP Periodic Review for FY25

Measure	Review Type	# of Cases	% of Cases Reviewed	Standard Met
Review of Nurse Practitioner: Michelle Malloy, ARNP	Mid-Level/Concurrent	48	2%	☒
Review of Physician Assistant: Kathryn Upah, PA-C	Mid-Level/Concurrent	44	2%	☒

Assessment: 92 charts were periodically reviewed in FY25 in conjunction with the medical director. Both advanced practice providers performed as expected with no clinic or administrative actions requested.

Action Plan for FY25: Continue APP review of at least 2 charts per month and provide any feedback necessary for improvement.

Annual Evaluation: Policy and Procedures

Annually, staff at Williamsburg Family Medical Clinic perform a comprehensive review of the policies and procedures at the clinic. Table 1.7 below provides a summary of the review and changes made to the policies throughout the fiscal year.

Table 1.7 Policy and Procedure Updates for FY2025

Policy Number	Policy Name	Action	Reason for Change
WFMC 3001	WFMC Emergency Preparedness Plan	Revised	Change in utility company

Annual Evaluation: Conclusion

As indicated by the data and information within, Williamsburg Family Medical Clinic is appropriately providing services while following established policies and procedures. Williamsburg Family Medical Clinic is productive in benefiting the health care of the patients we serve and will continue to provide high quality healthcare to our patients with a focus on preventative health, disease management and care coordination.

WILLIAMSBURG
FAMILY MEDICAL CLINIC

OPERATED BY COMPASS MEMORIAL HEALTHCARE

Annual Evaluation: Signature Approval Page

Signatures below attest that the attached information was reviewed and approved by the Williamsburg Family Medical Clinic medical staff and Compass Memorial Healthcare Board of Trustees in September 2025.

_____

Tessa Wade, Board of Trustees President

_____

Barry Goettsch, Chief Executive Officer

_____

Brandon Phelps, DO, Medical Director