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Insert Logo Here

Healthcare Organization

Quality and Risk Management Plan

2015

Reviewed by the Quality Improvement Committee

Date: _____

Approved by the Board of Directors

Date: _____



Community Health Center Quality and Risk Management Plan

I. PHILOSOPHY & PURPOSE:

Community Health Center (CHC) develops and implements policies and procedures that insure continuous measurable quality improvement in patient care, CHC clinical processes, risk management and patient safety, efficiency and effectiveness of clinical services and management, community and financial accountability. Policies and procedures are designed to directly support CHC's Mission, Values and Strategic Plan. CHC's Quality Improvement/Quality Assurance (QI/QA) and risk management (RM) procedures are imbedded in the day-to-day operations of CHC, involve all staff, and contribute to a culture of clinical and operational excellence.

QI/QA and RM performance measures address clinical services and management, quality of care and services, patient access, patient experience, health care costs, care coordination, compliance, network quality, adverse events, utilization of services.

QA/QI activities will incorporate those measures/ standards required by insurers, funders, and regulators. CHC will include the elements required for FTCA qualification and meaningful use of our EHR. In addition, QA/QI will provide measures of excellence to justify third party quality recognition. QA/QI will support CHC to move toward Patient-Centered Medical Home accreditation offered by HRSA in partnership with the NCQA. We aspire to be compliant by design while individualizing the QI/QA process to meet our unique needs.

CHC wishes to measure progress toward/success meeting the "Triple Aim" of improving the health of our community, patient satisfaction and retention, and reducing the per capita cost of care. Doing so will support CHC's desire to move gradually from a fee for service model to a population based reimbursement model.

II. Guiding Principles

Quality Improvement/Quality Assurance: The key attributes that support CHC's vision of a health delivery system describes a system that promotes excellence in patient safety, risk prevention and management, quality care and services. This system is:

- Is centered upon treating people with dignity
- Focuses on patient-centered care
- Provides an integrated continuum of care
- Demands service excellence
- Focuses on the triple aim concepts of improving patient care, improving the patient experience, and reducing costs
- Requires effective communication and information sharing
- Continually improves its operating and clinical practices
- Integrate with risk management principles and practice

- Is best achieved by teamwork
- Uses resources optimally
- Is scientific and results oriented
- Provides a safe environment for clients, visitors, and staff
- Delivers care based on the best scientific evidence combined with judgment of expert clinicians

Risk Management: RM is an overarching, conceptual framework that guides the development of a systematic approach to management of risk management and patient safety initiatives and activities. The plan is operationalized through a formal, written risk management and patient safety plan. RM activities support CHC's philosophy that patient safety and risk management is everyone's responsibility. Teamwork and participation among management, providers, volunteers, and staff are essential for an efficient and effective patient safety and risk management program. The program will be implemented through compliance with all policies relevant to patient safety and risk management, the coordination of multiple organizational functions and the activities of multiple departments.

CHC supports the establishment of a just culture that emphasizes implementing evidence-based best practices, learning from error analysis, and providing constructive feedback, rather than blame and punishment. In a just culture, unsafe conditions and hazards are readily and proactively identified, medical or patient care errors are reported and analyzed, mistakes are openly discussed, and suggestions for systemic improvements are welcomed. Individuals are still held accountable for compliance with patient safety and risk management policies and practices. As such, if evaluation and investigation of an error or event reveal reckless behavior or willful violation of policies, disciplinary actions can be taken.

Through RM CHC stimulates the development, review, and revision of the organization's policies, practices and protocols in light of identified risks and chosen loss prevention and reduction strategies. Principles of CHC's RM provide the foundation for developing key policies and procedures for day-to-day risk management activities, including:

- Claims management
- Complaint resolution
- Confidentiality and release of information
- Event investigation, root-cause analysis, and follow-up
- Failure mode and effects analysis
- Referral Management
- Infection Control
- Clinical supervision and back-up of clinical and non-clinical staff
- Provider and staff education, competency validation, and credentialing requirements
- Reporting and management of adverse events and near misses
- Trend analysis of events, near misses, and claims

III. Quality and Risk Management Structure

A. Scope and Key Functions

The Quality and Risk Management (QRM) program is multi-disciplinary and involves clinicians, clinical support staff across all service areas, allied health disciplines, community service agencies as appropriate, administrators, managers, and others that provide care or services to the population we serve. The program focuses on improving key client and organizational functions within CHC. The key functions are assessed by collecting and analyzing data related to one or more dimensions of performance, which includes but may not be limited to efficacy, appropriateness, availability, timeliness, effectiveness, continuity, safety, efficiency, and respect and caring. The key functional areas within the scope of the CHC QRM Program are:

1. *Population Health Management (Care Management)* – biological, social, and/or quality of life consequences of clinical and social evaluation and management of care and services in areas such as preventive health, acute or chronic conditions, high risk/complex, and behavioral health
2. *Patient Safety* – capabilities to promote a safe environment for clients by evaluation in areas such as client and provider education, policy and procedures, continuity and coordination of care
3. *Access and Availability* – capabilities and effectiveness in providing appropriate access during and after hours.
4. *Network Quality* – periodic peer review assessments of client records by physicians or by other licensed health professionals under the supervision of physicians of the appropriateness of the utilization of services and the quality of services provided or proposed to be provided to individuals served; capabilities, satisfaction, accessibility and availability of healthcare and human services, including monitoring and evaluation of quality of care/quality service complaints, credentialing/recredentialing, and adverse occurrence tracking
5. *Client Satisfaction* – ability to meet the needs of CHC customers
6. *Customer Service* – capabilities, satisfaction, accessibility of the provision of customer service.

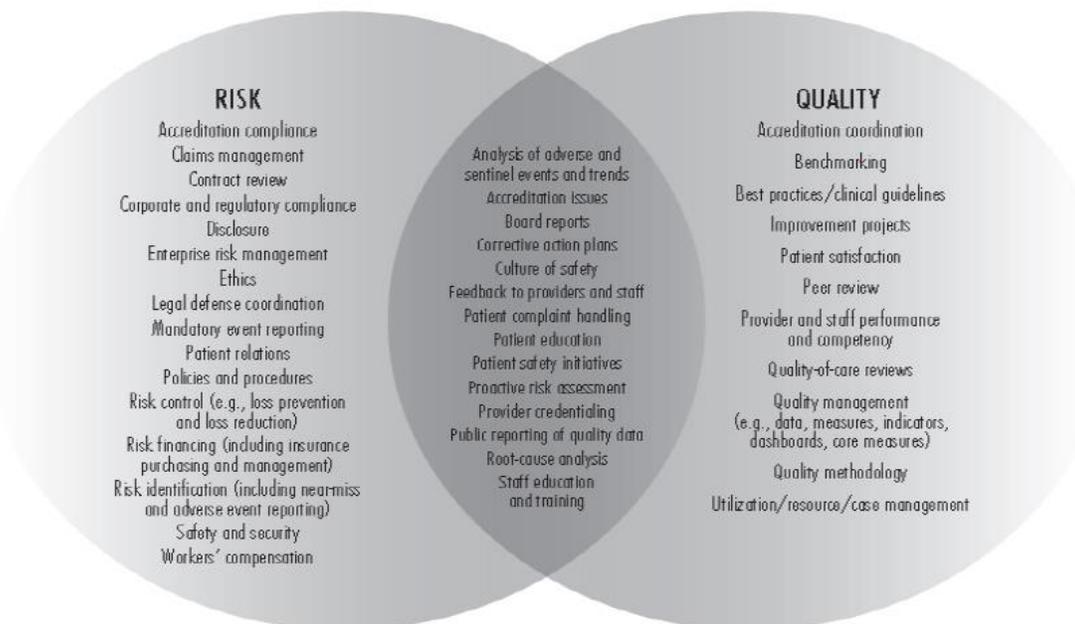
Specific risk management functional responsibilities that integrate with the above functional areas include:

- Developing systems for and overseeing the reporting of adverse events, near misses, and potentially unsafe conditions. Reporting responsibilities may include internal reporting as well as external reporting to regulatory, governmental, or voluntary agencies. This includes the development and implementation of event-reporting policies and procedures.
- Ensuring the collection and analysis of data to monitor the performance of processes that involve risk or that may result in serious adverse events (e.g., preventive screening, diagnostic testing, medication use processes, perinatal care). Proactive risk assessment can include the use of failure mode and effects analysis, system analysis, and other tools.

- Overseeing the organization’s systems for data collection and processing, information analysis, and generation of statistical trend reports for the identification and monitoring of adverse events, claims, finances, and effectiveness of the risk management plan. This system may utilize and include, but is not limited to, the following:
 - Attorney requests for medical records, x-rays, laboratory reports
 - Committee reports and minutes
 - Criteria-based outcome studies
 - Event, incident, or near miss reports
 - Medical record reviews
 - Monitoring systems based on objective criteria
 - Notice letters, lawsuits
 - Patient complaints
 - Physician and other medical professionals’ input
 - Results of failure mode and effects analysis of high risk processes
 - Root-cause analyses of sentinel events
- Analyzing data collected on adverse events, near misses, and potentially unsafe conditions; providing feedback to providers and staff; and using this data to facilitate systems improvements to reduce the probability of occurrence of future related events. Root-cause analysis and systems analysis can be used to identify causes and contributing factors in the occurrence of such events.
- Ensuring compliance with data collection and reporting requirements of governmental, regulatory, and accrediting agencies.
- Facilitating and ensuring the implementation of patient safety initiatives such as improved tracking systems for preventive screenings and diagnostic tests, medication safety systems, and falls prevention programs.
- Facilitating and ensuring provider and staff participation in educational programs on patient safety and risk management.
- Facilitating a culture of safety in the organization that embodies an atmosphere of mutual trust in which all providers and staff members can talk freely about safety problems and potential solutions without fear of retribution.
- Proactively advising the organization on strategies to reduce unsafe situations and improve the overall environmental safety of patients, visitors, staff, and volunteers, as applicable.
- Reducing the probability of events that may result in losses to the physical plant and equipment (e.g., biomedical equipment maintenance, fire prevention).
- Preventing and minimizing the risk of liability to the organization, and protecting the financial, human, and other tangible and intangible assets of the organization.
- Decreasing the likelihood of claims and lawsuits by developing a patient and family communication and education plan. This includes communicating and disclosing errors and events that occur in the course of patient care with a plan to manage any adverse effects or complications.
- Decreasing the likelihood of lawsuits through effective claims management, and investigating and assisting in claim resolution to minimize financial exposure in coordination with the liability insurer and its representatives.

- Reporting claims to medical malpractice insurance providers and other insurers in accordance with the requirements of the insurance policy/contract.
- Supporting quality assessment and improvement programs throughout the organization.
- Implementing programs that fulfill regulatory, legal, and accreditation requirements, as appropriate.
- Ongoing patient safety/risk management assessment and recommendations through QIC processes.
- Monitoring the effectiveness and performance of risk management and patient safety actions. Performance monitoring data may include:
 - ✓ Claims and claim trends
 - ✓ Event trending data
 - ✓ Ongoing risk assessment information
 - ✓ Patient's and/or family's perceptions of how well the organization meets their needs and expectations
 - ✓ Quality performance data
 - ✓ Research data
- Completing insurance and deeming applications.
- Developing and monitoring effective handoff (transitions) processes for continuity of patient care.

B. Quality and Risk Management Overlap



C. Key Definitions

Quality: Defined as “systematic and continuous actions that lead to measurable improvement in health care services and the health status of targeted patient groups” (HRSA)

Continuous Quality Improvement (CQI): A system that seeks to improve the provision of services with an emphasis on future results. CQI uses a set of statistical tools to understand subsystems and uncover problems, but its emphasis is on maintaining quality in the future, not just controlling a process. Once a process that needs improvement is identified, a team of knowledgeable individuals is gathered to research and document each step of that process. Once specific expectations and the means to measure them have been established, implementation aims at preventing future failures and involves the setting of goals, education, and the measurement of results. If necessary, the plan may be revised on the basis of the results, so that the improvement is ongoing

PDSA: Plan-Do-Study-Act

Risk Management: A function of CHC directed toward identification, evaluation, and correction of potential risks that could lead to injury to patients, staff members, or visitors and result in property loss or damage.

Adverse event or incident: An undesired outcome or occurrence, not expected within the normal course of care or treatment, disease process, condition of the patient, or delivery of services.

Claims management: Activities undertaken to exert control over potential or filed claims against the organization and/or its providers. These activities include identifying potential claims early, notifying the organization’s liability insurance carrier and/or defense counsel of potential claims and lawsuits, evaluating liability and associated costs, identifying and mitigating potential damages, assisting with the defense of claims by scheduling individuals for deposition, providing documents or answers to written interrogatories, implementing alternate dispute-resolution tactics, and investigating adverse events or incidents.

Failure mode and effects analysis: A proactive method for evaluating a process to identify where and how it might fail and for assessing the relative impact of different failures in order to identify the parts of the process that are most in need of improvement.

Loss control/loss reduction: The minimization of the severity of losses through methods such as claims investigation and administration, early identification and management of events, and minimization of potential loss of reputation.

Loss prevention: The minimization of the likelihood (probability) of a loss through proactive methods such as risk assessment and identification; staff and volunteer education, credentialing, and development; policy and procedure implementation, review, and

revision; preventive maintenance; quality/performance review and improvement; root-cause analysis; and others.

Near miss: An event or situation that could have resulted in an accident, injury, or illness but did not, either by chance or through timely intervention (e.g., a procedure almost performed on the wrong patient due to lapse in verification of patient identification but caught at the last minute by chance). Near misses are opportunities for learning and afford the chance to develop preventive strategies and actions. Near misses receive the same level of scrutiny as adverse events that result in actual injury.

Risk analysis: Determination of the causes, potential probability, and potential harm of an identified risk and alternatives for dealing with the risk. Examples of risk analysis techniques include failure mode and effects analysis, systems analysis, root-cause analysis, and tracking and trending of adverse events and near misses, among others.

Risk assessment: Activities undertaken in order to identify potential risks and unsafe conditions inherent in the organization or within targeted systems or processes.

Risk avoidance: Avoidance of engaging in practices or of hazards that expose the organization to liability.

Risk control: Treatment of risk using methods aimed at eliminating or lowering the probability of an adverse event (i.e., loss prevention) and eliminating, reducing, or minimizing harm to individuals and the financial severity of losses when they occur (i.e., loss reduction).

Risk identification: The process used to identify situations, policies, or practices that could result in the risk of patient harm and/or financial loss. Sources of information include proactive risk assessments, closed claims data, adverse event reports, past accreditation or licensing surveys, medical records, clinical and risk management research, walk-through inspections, safety and quality improvement committee reports, insurance company claim reports, risk analysis methods such as failure mode and effects analysis and systems analysis, and informal communication with healthcare providers.

Risk transfer: Techniques involving the process of shifting the financial burden of losses to an external party or parties (e.g., insurance, contracts).

Root-cause analysis: A process for identifying the basic or causal factor(s) that underlie the occurrence or possible occurrence of an adverse event.

Unsafe and/or hazardous condition: Any set of circumstances (exclusive of a patient's own disease process or condition) that significantly increases the likelihood of a serious adverse outcome for a patient or of a loss due to an accident or injury to a visitor, employee, volunteer, or other individual.

D. Authority and Accountability

CHC's Board of Directors (BOD) has ultimate responsibility and accountability for the QRM Program. The BOD delegates authority and responsibility for all matters relative to the QRM to the Quality Improvement Committee (QIC). The QIC delegates the operational responsibility of the QRM program to the Clinical Director or Chief Medical Officer. The Clinical Director or Chief Medical Officer delegates the day to day functions of the QRM program to Director of Clinical Services.

E. Committee Structure

Board of Directors (BOD) –The BOD is comprised of safety-net and community leaders and healthcare consumers. The BOD:

- Provides leadership, guidance, authority, and accountability for the QRM Program.
- Recommends policy decisions, reviews and evaluates the annual results of the quality management activities.
- Approves the Quality and Risk Management Policies and Procedures, Annual Program Description, Work Plan, and the Annual QRM Program Evaluation

BOD Meetings are held monthly. Minutes are created at the time of each meeting and reflect committee decisions and actions. The minutes reflect factual representation of BOD discussion, decisions, recommendations, and/or conclusions. The minutes are signed, dated, and maintained in compliance with the confidentiality requirements of CHC. The minutes are peer-review protected and not subject to disclosure to any individual or group within or outside CHC without the permission of the CEO.

Quality Improvement Committee (QIC) - The QIC is multi-disciplinary and participants represent all areas within the health center's scope of services. The Clinical Director or Chief Medical Officer is Chairperson for the QIC Committee representation includes, but may not be limited to primary care providers and clinical support staff, management and executive leadership, front office, health center consumers, BOD member(s), and administrative staff. The QIC is accountable to the BOD. The QIC:

Reviews trended quality performance data.

- Identifies opportunities to improve client care and service.
- Reviews risk management reports regularly (e.g., claims activity, risk and safety assessment results, event report summaries and trends).
- Overseeing the reporting of adverse events, near misses, and potentially unsafe conditions.
- Ensuring the collection and analysis of data to monitor the performance of processes that involve risk or that may result in serious adverse events (e.g., preventive screening, diagnostic testing, medication use processes, peer review). Proactive risk assessment can include the use of failure mode and effects analysis, system analysis, and other tools.

- Provides policy decisions, reviews and makes recommendations regarding the annual QRM Program Description, the QRM Work Plan, Policies and Procedures, and the Annual QRM Program Evaluation.
- Actively reviews the monitoring activities of the key functional areas and makes recommendations to improve performance levels.
- Analyzing data collected on adverse events, near misses, and potentially unsafe conditions; providing feedback to providers and staff; and using this data to facilitate systems improvements to reduce the probability of occurrence of future related events. Root-cause analysis and systems analysis can be used to identify causes and contributing factors in the occurrence of such events.
- Ensuring compliance with data collection and reporting requirements of governmental, regulatory, and accrediting agencies.
- Facilitating and ensuring the implementation of patient safety initiatives such as improved tracking systems for preventive screenings and diagnostic tests, medication safety systems, etc.
- Promotes evidenced-based medicine by actively participating in clinical guideline decision-making activities.
- Is responsible for assisting CHC in educating participating healthcare and human service providers regarding the quality and risk management program and then soliciting provider feedback on the effectiveness of the program.
- Serves as a review body for provider and client complaints related to service delivery or medical care issues.
- Develops, implements, monitors and evaluates processes and programs aimed at maintaining a safe environment.

Meetings are held at least six times per year. Minutes are created at the time of each meeting and reflect committee decisions and actions. The minutes will contain only de-identifiable client information. They will reflect factual representation of the Committee's discussion, decisions, recommendations, and/or conclusions. The minutes are signed, dated, and maintained in compliance with the confidentiality requirements of CHC. The QIC Minutes are peer-review protected and not subject to disclosure to any individual or group within or outside CHC without the permission of the CEO

2015 QI Committee Members:

1. A patient of CHC
2. A CHC Board member
3. Medical Director and at least one other provider.
4. The Executive Director
5. The Clinical Operations Director
6. The CFO or designate
7. The Safety Officer
8. Representative of the Nursing staff (Nurse or M.A.)
9. A member of the clinic support staff
10. A Behavioral Health Consultant

11. A Community Resources Coordinator
12. Others as needed to assure full representation of CHC's scope.

Any CHC staff member may present an area of concern or focus for QI to the Committee, either in writing or by meeting participation. Having a committee does not substitute for ongoing staff efforts to improve care and processes at all levels in our organization. These efforts will be recognized.

While Committee Members represent their various areas of team function and expertise, certain Committee members are charged with specific responsibilities:

1. Chairman: Delegated by the Medical Director and Operations Directors with responsibility of chairing meetings, preparing agendas, insuring that the QI/QA committee functions, results are disseminated throughout CHC, and responsive actions are taken to address findings.
2. CHC Board Member: liaison to the Board to insure that Quality and Risk Management efforts are in alignment with Board Mission, Values, and Strategic Plan
3. Chief Operations Director: Responsible for tabulating data measurements required for UDS, Meaningful use, FTCA, and insurer reporting so that corresponding data is captured in the EHR to the greatest extent possible.
4. CFO: Responsible for Dashboard information and financial reality check.
5. Patient Member and Community Resources Coordinator: Jointly responsible for gathering, reviewing, and responding to patient satisfaction data.
6. Medical Records: Responsible for assuring patient confidentiality and compliance with HIPAA.
7. Other roles to be established

F. Resources

Personnel

The Clinical Director or Chief Medical Officer is the chairperson of the QIC. The QIC delegates the operational responsibility of the Quality Management Program to the Clinical Director or Chief Medical Officer. The operational responsibilities include but may not be limited to:

- Provide communication of the organization's QM activities to the Board through regular reporting.
- Review of all quality of care/quality of service complaints
- Provide clinical guidance regarding quality improvement initiatives.

Add any others here.

Resource Allocation

Staff Positions	Time Allocation
Medical Director	0.2 FTE
QI Manager	1.0 FTE

Staff Positions	Time Allocation
Total	1.2 FTE

All health center staff participates in the monitoring and improvement of patient care and patient services.

Data Management

The Management of Information Systems (MIS) is crucial to the monitoring and evaluation of the quality of care and service delivered throughout CHC. The accessibility of data is provided through reporting from the MIS.

Analytic

The ability to design statistically valid and reliable quality outcome measures is provided through the analytical support of Quality Management staff and other support resources as deemed necessary. Data is collected and aggregated and visually displayed utilizing a variety of tools. Tools utilized include but are not limited to: run charts, pie charts, control charts, histograms, frequency tables, tables and graphs, dashboards, and narrative language describing the findings contained in the analytic data displays utilized.

IV. Quality and Risk Improvement Methodology

CHC uses the **FOCUS-PDSA** methodology to find, organize, clarify, define, understand, and select a problem or opportunity and implement the plan, do, study, act Deming principles before implementation of the full quality improvement process across the organization.

Initiatives within the key functional areas are developed or redesigned based on the values and guiding principles of CHC, state and regulatory requirements, accrediting or recognizing entities, and payer/grantor performance requirements, following input from the community, clients, participating healthcare and human service providers, staff, and others. The initiatives are developed or redesigned using scientific and professional resources, available guidelines and practice parameters, external benchmarks, adverse occurrence alerts, internal quality management, and sound business practices. Those directly involved in delivering the care, service or participating in the processes are closely involved in the planning and implementation phases.

As quality improvement initiatives are developed or redesigned, mechanisms to evaluate them are planned and implemented. Appropriate performance indicators are selected on the following criteria:

- The indicator identifies processes or outcomes that can be improved
- The indicator can identify the events it was intended to identify
- The indicator has a documented numerator and denominator statement of description of the population to which the measure is applicable
- The indicator has defined data elements and allowable values
- The indicator can detect changes in performance over time

- The indicator allows for comparison over time
- The data intended for collection is available
- Results can be reported in a way that is useful to Insert Organization Name and other stakeholders

Performance indicators and targets are set and monitored. Patients, care and service providers, staff, and other stakeholders are involved in the evaluation process.

Outcomes/Process Measurement

Performance monitoring and evaluation standards are system-wide, comprehensive, service line or population focused and requires the following:

- Identification of measurable indicators for monitoring the processes or outcomes of care;
- Collection of data for ongoing measurement;
- Evaluation of performance against pre-determined thresholds;
- Evaluation of effectiveness of action(s); and
- Reliance on the scientific method.

Aggregation and Analysis of Data

There is a systematic process to aggregate and analyze collected data to identify trends and/or variances in performance. Data are assessed in order to determine:

- Priorities for improvement
- Actions for improvement
- Whether changes in the process resulted in improvement
- Meeting of design specifications
- Performance and stability of important existing processes

This assessment process includes using statistical quality process control techniques, as appropriate and comparing data about processes and outcomes over time. Performance is also compared to relevant scientific, clinical and management literature, and to relevant practice guidelines/parameters, as appropriate.

Continuous Quality Improvement

The core elements of the CHC's continuous quality improvement process are outlined below.

PLAN

1. Opportunity/problem identification and desired outcomes – The opportunity or problem statement is a brief, clear statement of the issue to be studied. Ideally this will be identified through previously collected data. The opportunity statement must be specific, and describe an observable, measurable, and manageable issue. The scope should be clearly defined and addressable in a short time frame. The desired outcome is the specific, measurable objective of the project.

2. Identify most likely cause(s) through data – The cause(s) of a problem may be identified by reviewing existing data, collecting baseline data on several items thought to be most likely causes of the problem, and/or by best guesses of those individuals with the most knowledge of the issue. Tools such as fishbone diagrams, priority matrices, flow charts and barrier analyses of system, providers, and client barriers are utilized to identify barriers and establish actions to resolve.
3. Identify potential solution(s) and the data needed for evaluation – Utilizing the most likely causes identified in step 2, list the potential solutions that may result in the desired outcome(s). Such solutions may be based on experience of other, published reports, and/or best guesses with knowledge of the issue. Following this, choose one or more solutions that can be reasonably instituted. For each solution to be acted upon identify those data elements required to determine whether or not the change(s) produced the improvement desired. Data collected should be the absolute minimum and of relevance to the desired solution. Once the required data elements have been specified, the source of these data must be identified or developed.

DO

4. Implement solution(s) and collect data needed for evaluation – The solution(s) most likely to be successful should be implemented. It is often preferable to do this on a small scale to see if the change(s) will work. Make the data collection easy enough and the time frames short enough so that data collection can be repeated frequently to allow for trending of changes over time. If not already available, build in baseline measures before implementing change so that it will be possible to measure whether an improvement has been produced.

STUDY

5. Analyze the data and develop conclusions – The objective of data analysis is to measure a theory regarding whether or not the change(s) made has led to the desired outcome. It is essential that both the data elements and the anticipated analysis be planned before changes are implemented. This often requires analytical support integration.

ACT

6. Recommendation for further study/action – Action in this step depends upon the results of the data analysis. If the tested solution was shown to produce the desired change, one may wish to more broadly implement if the initial test was done on a small scale. Effectively communicating the results of the measure is important. Finally, a decision should be made regarding the continuance of data collection to monitor whether the observed improvement is sustained over time. If the tested action did not achieve the desired outcome, a return to step 2 is necessary with a repeat of the cycle to test other potential solutions.¹

¹ The Plan-Do-Study-Act (PDSA) cycle was originally developed by Walter A. Shewhart as the Plan-Do-Check-Act (PDCA) cycle. W. Edwards Deming modified Shewhart's cycle to PDSA, replacing "Check" with "Study."

V. Communication and Coordination

Notification to Patients, Health Center Staff, and Providers

Information regarding the QRM Program is made available to patients and all health center staff. Communication of clinical, utilization, care coordination, and patient experience performance is provided to patients through (Insert methods used to communicate information about the QRM program and performance results to patients). Performance data at the practice level and made available to health center staff (Insert methods used to communicate information about the QRM program and performance results to health center staff).

Data at the provider-specific level is communicated either the individual provider level or collectively as a group. Peer review data is integrated into the licensed independent providers re-privileging process as a component of decision-making criteria used to determine reappointment status.

Coordination of performance initiatives and continuous quality improvement is integrated throughout the health center using committees, the Board of Directors, task forces and work groups, client focus groups, and client involvement in other ways, when applicable. It is the responsibility of all health center employees, contractors, collaborative partners and vendors to participate in quality improvement activities.

VI. Confidentiality and Privacy of Personal Health Information

All data and recommendations associated with QRM are solely for the improvement of client care, services and safety. As such, all material is confidential and is accessible only to those parties responsible for assessing quality of care and service.

All proceedings, records, data, reports, information and any other material used in the quality management process which involves peer review shall be held in strictest confidence and considered peer review protected.

All CHC personnel as well as the QIC and the BOD must sign a statement to protect the confidentiality of a client's personal health information.

CHC will minimize the identifiability of a client's personal health information used for quality measurement to protect it from inappropriate disclosure. Reports for committee review regarding data analysis and trending do not disclose a client's personal health information.

[See Deming WE. The New Economics for Industry, Government, and Education. Cambridge, MA: The MIT Press; 2000.]

Any and all documents and records that are part of the QRM process shall be privileged and confidential to the extent provided by state and federal law. Confidentiality protections can include attorney client privilege, attorney work product, and peer review protections.

Medical providers may be able to apply the federal privilege and confidentiality protections granted by the Patient Safety and Quality Improvement Act of 2005 to its patient safety events, data, and reports—referred to in the law as patient safety work product—by creating a patient safety evaluation system, through which the organization collects patient safety work product with the intent of providing it to one or more patient safety organizations for analysis and feedback. Care must be taken to ensure that the patient safety evaluation system is developed within the context of the provider’s state laws for legal privilege and peer review as well as the new federal law.

VII. Program Review

Quality and Risk Management Program Description

- The XXXX is responsible for updating the QM Program Description.
- The QRM Program Description is reviewed and approved by the QIC and the BOD, respectively, at least every three years.

Policies and Procedures

Relevant policies include but may not be limited to clinical, quality management, risk management, and HIPAA confidentiality and security.

- The XXX is responsible for development, revision, and maintenance of QM policies and procedures.
- Relevant policies are reviewed and approved by the QIC and the BOD, respectively, at least every two years or more often if major changes are required.
- Procedures may be developed, reviewed and approved by appropriate management or leadership staff.

QRM Work Plan

- The XXX in collaboration with the Clinical Director or Chief Medical Officer is responsible for developing the QRM work plan. The work plan includes performance indicators relevant to the key functional areas. The work plan outlines the indicators to be measured, performance goals, benchmarks, and dimensions of quality being monitored, past performance results, frequency of monitoring and reporting, and departments responsible for the activity. (Please refer to Attachment A).
- The work plan is reviewed by the QIC and approved by the BOD annually.

QRM Evaluation

- XXX is responsible for completing an annual program evaluation to assess the utilization, and quality of care and services delivered. The evaluation includes a review of completed and ongoing risk management, clinical and service activities; analysis of trended performance data; barriers identified; and interventions to

improve performance when goals are not being met. Conclusions about the overall effectiveness of the program, including assessments of the adequacy of program resources and the appropriateness of the committee structure are also integral part of the evaluation.

- The Quality Management Program Evaluation is reviewed by the QIC and approved by the BOD annually.

Attachment A: 2015 QRM Performance Measures and Key Activities Work Plan

Activity/Key Performance Measures	Category	Target	Resp Person	Freq	Reports	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec
Provider Accessibility (e-CW report 1307)	Access	TBD		Monthly	QIC	x	x	x	x	x	x	x	x	x	x	x	x
No Show Rates (e-CW report 1307)	Access	15%		Monthly	QIC	x	x	x	x	x	x	x	x	x	x	x	x
Telephone Responsiveness (ASA 30 secs)	Access	85%		Monthly	QIC	x	x	x	x	x	x	x	x	x	x	x	x
Appointment Type Wait Time (e-CW report 13.09)	Access	TBD		Qtr	QIC	x			x				x			x	
Lab/Image Tracking (Completed Referrals) (FTCA/HRSA)	Care Coord	80%		Monthly	QIC	x	x	x	x	x	x	x	x	x	x	x	x
ED/Hospitalization Tracking Follow-Up (FTCA/HRSA)	Care Coord	48%		Monthly	QIC	x	x	x	x	x	x	x	x	x	x	x	x
Referral Tracking /Completed (FTCA/HRSA)	Care Coord	65%		Qtr	QIC		x			x			x			x	
Positive Depression Screen with f/u plan (UDS)	Chronic	45%		Qtr	QIC	x			x			x			x		
Adult Diabetes: Management; A1C ≤ 9% (UDS)	Chronic	53%		Qtr	QIC		x			x			x			x	
Adult HTN: BP Controlled at <140/90 (UDS)	Chronic	75%		Qtr	QIC	x			x			x			x		
HIV: Newly diagnosed with visit w/ 90 days (UDS)	Chronic	86%		Qtr	QIC		x			x			x			x	
IVD, AMI, CABG, PTCA and on ASA therapy (UDS)	Chronic	80%		Qtr	QIC	x			x			x			x		
CAD on Lipid Lowering Therapy (UDS)	Chronic	80%		Qtr	QIC		x			x			x			x	
Asthma: Prescribed Appropriate Meds (UDS)	Chronic	88%		Qtr	QIC	x			x			x			x		
Tobacco Use Cessation - Quit Smoking (UDS)	Chronic	75%		Semi-Annual	QIC		x						x				
Peer Review - Chronic Care Management	Chronic	80%		Qtr	Med Dir		x			x			x			x	
HRSA Program Requirement Compliance Assess	Compliance	na		Annual	BOD						x						
Annual Assessment- 340B Vendor Management (HRSA)	Compliance	100%		Annual	BOD								x				
2015 QI/QA Plan Approval	Compliance	na		Annual	BOD				x								
UDS Reporting	Compliance	na		Annual	BOD		x										
FTCA Deeming Application (Initial)	Compliance	na		Annual	BOD					x							
Annual QI Evaluation	Compliance	na		Annual	BOD			x									
QIC Meetings	Compliance	100%		Monthly	BOD	x	x	x	x	x	x	x	x	x	x	x	x
Board Quality Reporting	Compliance	100%		Qtr	BOD	x			x			x			x		
Clinical Visit Summaries within 3 days (Core)	MU 1	>50%		Qtr	QIC	x			x			x			x		
E-copy of record when requested within 3 days (Core)	MU 1	>50%		Qtr	QIC	x			x			x			x		
Demographics Recorded (Core)	MU 1	>50%		Qtr	QIC	x			x			x			x		
Problem List Present (Core)	MU 1	>80%		Qtr	QIC	x			x			x			x		
Vital Signs (BP, Ht, Wt) (Core)	MU 1	>50%		Qtr	QIC	x			x			x			x		
Tobacco Use -13 years and older (Core)	MU 1	>50%		Qtr	QIC	x			x			x			x		
Medication Reconciliation (Core)	MU 1	>80%		Qtr	QIC	x			x			x			x		
E-Prescribing (Core)	MU 1	>40%		Qtr	QIC	x			x			x			x		

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Activity/Key Performance Measures	Category	Target	Resp Person	Freq	Reports	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec
CPOE (Core)	MU 1	>30%		Qtr	QIC	x			x			x			x		
Depression Screening Performed (HRSA)	Prevention	80%		Qtr	QIC		x			x			x			x	
LBW< 2500 gms (UDS)	Prevention	5%		Qtr	QIC		x			x			x			x	
Prenatal Care in 1st Trimester (UDS)	Prevention	78%		Qtr	QIC	x			x			x			x		
Adults screened for colorectal cancer (UDS)	Prevention	80%		Qtr	QIC	x			x			x			x		
Tobacco Use Assessment (UDS)	Prevention	97%		Qtr	QIC		x			x			x			x	
Adult BMI and counseling (UDS)	Prevention	95%		Qtr	QIC		x			x			x			x	
Adolescent BMI with diet and activity counseling (UDS)	Prevention	65%		Qtr	QIC		x			x			x			x	
Dental Screening (Child and Adolescent) (HRSA)	Prevention	50%		Qtr	QIC	x			x			x			x		
Cervical Cancer Screening (UDS)	Prevention	65%		Qtr	QIC	x			x			x			x		
Childhood Immunizations (UDS)	Prevention	91.40%		Qtr	QIC	x			x			x			x		
Peer Review - Preventive Health	Prevention	80%		Qtr	Med Dir		x			x			x			x	
Provider Credentialing (Current Credentials and Cycle)	Risk	90%		Qtr	QIC		x			x			x			x	
Risk Management Training (FTCA)	Risk	100%		Annual	BOD									x			
Incident Management (FTCA)	Risk	< 2 mo		Qtr	QIC	x			x			x			x		
Peer Review - Chart Closure Timeliness	Risk	80%		Qtr	Med Dir		x			x			x			x	
Peer Review - Coding Accuracy	Risk	90%		Qtr	Med Dir	x			x			x			x		
Policy Review and Approval - Finance	Risk	na		Annual	BOD			x									
Policy Review and Approval - Clinical Services	Risk	na		Annual	BOD				x								
Policy Review and Approval - Quality	Risk	na		Annual	BOD					x							
Policy Review and Approval- HR	Risk	na		Annual	BOD						x						
Policy Review and Approval - Information Mgmt	Risk	na		Annual	BOD							x					
Policy Review and Approval - Administrative	Risk	na		Annual	BOD								x				
Complaint Reporting (Volume)	Satis	<2 mo		Qtr	QIC	x			x			x			x		
Complaint Management (Timeliness)	Satis	30d		Qtr	QIC	x			x			x			x		
Patient Satisfaction Survey Results	Satis	TBD		Semi-Annual	QIC		x						x				
ED Visit Rates (Primary Care Preventable)	Utilization	TBD		Semi-Annual	QIC		x						x				
Hospital Readmission Rate	Utilization	TBD		Semi-Annual	QIC		x						x				
Hospital Admission (Unplanned) Rate)	Utilization	TBD		Semi-Annual	QIC		x						x				

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