

**INSERT ORGANIZATION NAME**

**Quality Management**

**Program Description**

**Insert Year**

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## I. Overview

### Purpose

The *Insert Organization Name* program shall demonstrate through its Quality Management Program, a systematic, organization- wide approach to provide uncompromising quality care and service to clients. Through this systematic approach, the Quality Management program provides a mechanism to constantly survey the performance of *Insert Organization Name*, and provides opportunities to improve performance levels.

### Values *(May insert organization specific values when available)*

*Respect* – We believe in the value of each person. We are committed to provide respect and care with reverence to the dignity of individuals served.

*Concern* – We believe that holistic care of an individual includes meeting physical, psychosocial, and spiritual needs. Recognition and support of these needs is a motivating force in our delivery of health care and human services.

*Cooperation* – We believe that we have a responsibility to work together cooperatively, with respect, kindness, integrity, understanding and courtesy toward each other. We are further committed to reflect these beliefs in our relationships with all persons who come into our program.

*Care* – We believe that providing a caring climate enhances the quality of care and service. Because we are committed to delivering the highest quality of care and service possible, we will reflect this philosophy in our work.

### Guiding Principles for Providing Quality Care and Service

The key attributes that support our vision of a health delivery system describes a system that:

- Is centered upon treating people with dignity
- Focuses on patient-centered care
- Provides an integrated continuum of care
- Demands service excellence
- Requires effective communication and information sharing
- Continually improves its operating and clinical practices
- 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

## II. Quality Program Structure

### Scope

The *Insert Organization Name* Quality Management program is multi-disciplinary and involves clinicians, clinical support staff across all service areas (i.e. medical, dental, behavioral health, specialty care, pharmacy, etc) allied health disciplines, community service agencies, 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 *Insert Organization Name*. 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 *Insert Organization Name* Quality Management Program are:

- *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, behavioral health
- *Safety* – capabilities to promote a safe environment for clients by evaluation in areas such as client and provider education, continuity and coordination of care
- *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
- *Client Satisfaction* – ability to meet the needs of *Insert Organization Name* customers
- *Customer Service* – capabilities, satisfaction, accessibility of the provision of customer service

### Authority and Accountability

The *Insert Organization Name* Board of Directors (BOD) has ultimate responsibility and accountability for the Quality Management Program. The BOD delegates authority and responsibility for all matters relative to the Quality Management Program to the Quality Management Committee. The Quality Management Committee delegates the operational responsibility of the Quality Management Program to the Clinical Director or Chief Medical Officer. The Clinical Director or Chief Medical Officer delegates the day to day functions of the Quality Management Program to the Quality Management Manager.

### Committee Structure

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

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

BOD Meetings are held at least *Insert Meeting Frequency*. 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 *Insert Organization Name*. The minutes are peer-review protected and not subject to disclosure to any individual or group within or outside *Insert Organization Name* without the permission of the *Insert Title*.

*Quality Management Committee (QMC)* – The QMC 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 QMC. Committee representation shall include, but may not be limited to primary care, behavioral health, health center consumers, relevant physician specialties, public health, community service, and *Insert Organization Name* administrative staff. The QMC is accountable to the BOD. The QMC:

- Reviews trended quality performance data.
- Identifies opportunities to improve client care and service.
- Provides policy decisions, reviews and makes recommendations regarding the annual Quality Management Program Description, Quality Management Work Plan, Health Care and Business Plan, Policies and Procedures, and the Annual Quality Management Program Evaluation.
- Actively reviews the monitoring activities of the six key functional areas and makes recommendations to improve performance levels.
- Promotes evidenced-based medicine by actively participating in clinical guideline decision-making activities.
- Is responsible for assisting *Insert Organization Name* in educating participating healthcare and human service providers regarding the quality 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 four (4) 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 *Insert Organization Name*. The QMC Minutes are peer-review protected and not subject to disclosure to any individual or group within or outside *Insert Organization Name* without the permission of the *Insert Title*.

## Resources

### *Personnel*

The Clinical Director or Chief Medical Officer is the chairperson of the QMC. The QMC 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.

The Quality Management Manager is delegated by the Clinical Director or Chief Medical Officer to carry out the day to day functions in accordance with the Quality Management (QM) program. The QM Manager reports to the Clinical Director or Chief Medical Officer. The QM Manager:

- Provides direction to staff on quality issues.
- Responsible for the monitoring and evaluation activities associated with the quality management key functional areas.
- Identifies opportunities for improvement in the delivery of care and service to *Insert Organization Name* clients.
- Serves as a *Insert Organization Name* community ambassador.

**Add any other personnel with QM responsibilities**

#### *Data Management*

The Management of Information Systems (MIS) is crucial to the monitoring and evaluation of the quality of care and service delivered throughout *Insert Organizational Name*. The accessibility of data is provided through *Insert description of 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.

### **III. Quality Improvement Methodology**

#### **Quality Improvement Initiative Design**

Quality Improvement initiatives within the key functional areas (care management, safety, network quality, customer service, and customer satisfaction) are developed or redesigned based on the values and guiding principles of *Insert Organization Name*, 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.

#### **Performance Indicators**

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. Clients, 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, relevant to both quality of care and service performance indicators, 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 *Insert Organization Name* 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.<sup>1</sup>

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<sup>1</sup> 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." [See Deming WE. The New Economics for Industry, Government, and Education. Cambridge, MA: The MIT Press; 2000.]



## **IV. Communication and Coordination**

### **Notification to Clients, Health Center Staff, and Providers**

Information regarding the Quality Management Program is made available to clients and all health center staff. Communication of performance is provided to clients through *(Insert methods used to communicate information about the QM program and performance results to clients)*. Performance data at the practice level and made available to health center staff *(Insert methods used to communicate information about the QM program and performance results to health center staff)*.

Data at the provider-specific level is a part of the peer review process and 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.

## **V. Confidentiality and Privacy of Personal Health Information**

All data and recommendations associated with Quality Management 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 QM personnel as well as the QMC and the BOD must sign a statement to protect the confidentiality of a client's personal health information.

*Insert Organization Name* 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.

Personal Health Information obtained as a result of a client complaint or appeal is kept in a secure area and is only made available to those who have a need to know. Computer access to personal health information about a client's complaint or appeal is limited by a pass code for only those who need access.

## VI. Program Description Review

### Quality Management Program Description

The QM Manager is responsible for updating the QM Program Description.

The QM Program Description is reviewed and approved by the QMC and the BOD, respectively, at least every three years.

### Quality Management Policies and Procedures

The QM Manager is responsible for development, revision, and maintenance of QM policies and procedures.

QM Policies and Procedures are reviewed and approved by the QMC and the BOD, respectively, at least every two years or more often if major changes are required.

### Quality Management QI/QA Work Plan

The QM Manager in collaboration with the Clinical Director or Chief Medical Officer is responsible for developing the QI/QA 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 for the QI/QA Work Plan).

The work plan is reviewed by the QMC and approved by the BOD annually.

### Quality Management Program Evaluation and Statement of Effectiveness

Quality Management staff complete an annual program evaluation to assess the utilization, and quality of care and services delivered to the *Insert Organization Name*. The evaluation includes a review of completed and ongoing 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 QMC and approved by the BOD annually.

### References:

- National Association of Healthcare Quality. [www.nahq.org](http://www.nahq.org)
- HRSA/BPHC PHS 330 grant: Program Requirement #8 QI/QA Plan
- National Committee for Quality Assurance: PCMH Standards and Guidelines
- HRSA Quality Improvement Toolkit. [www.hrsa.gov](http://www.hrsa.gov)
- HRSA/BPHC FTCA Deeming Application Program Assistance Letters
- Institute for Healthcare Improvement. [www.ihl.org](http://www.ihl.org)

**REVIEWED BY QUALITY MANAGEMENT COMMITTEE**

**REVIEW DATE:** \_\_\_\_\_

**APPROVED BY BOARD OF DIRECTORS:**

**APPROVAL DATE:** \_\_\_\_\_

**BOD SIGNATURE:** \_\_\_\_\_

SAMPLE

**VII: Attachment (SAMPLE AND NOT A COMPLETE SET)**

**Attachment A: Quality Improvement Work Plan**

Performance Indicator	Performance Goal and Source/YR	Method of Collection	(Data Source)	Monitor Freq	Report Freq	Responsible Person/Depart
<b>CLINICAL CARE</b>						
<b>Diabetes Control (HbA1c ≤ 9%)</b> HRSA Required Measure	Baseline: 40% Source/YR: 2010 UDS  TARGET: 55% Source/YR: HEDIS Medicaid 2011	Random sample Chart Audit  Numerator: Number of adult patients age 18 to 75 years of age with a diagnosis of Type 1 or Type 2 diabetes whose most recent hemoglobin A1c level during the measurement year is ≤ 9%, among those patients included in the denominator.  Denominator (Universe): Number of adult patients age 18 to 75 years of age as of December 31 of the measurement year (for measurement year 2009, date of birth on or after January 1, 1934 and on or before December 31, 1991) with a diagnosis of Type 1 or Type 2 diabetes, who have been seen in the clinic at least twice during the reporting year and do not meet any of the exclusion criteria.	Clinical Record Audit – Peer Review Process	Quarterly	Quarterly	Health Services
<b>SATISFACTION</b>						
<b>Patient Satisfaction</b> (overall satisfaction) (recommend to a friend or relative)	Baseline: 90% Overall Sat; 93% Recommend) Source/YR: Internal 2010  TARGET: 95% both Source/YR: Internal 2011	Survey Instrument Convenience sample of all patients who visit the clinic during the measurement week per quarter.	Satisfaction Survey	Quarterly	Quarterly	Administrative Services
<b>UTILIZATION OF SERVICES/ACCESS</b>						
<b>Percentage of Missed Appointment with Completed Follow-Up Phone Call/Letter</b>	Baseline: 35% Source/YR: Internal 2010	Number of missed appointments with completed follow-up phone call divided by the number of missed appointments	Practice Management System	Monthly	Quarterly	Administrative Services

Performance Indicator	Performance Goal and Source/YR	Method of Collection	(Data Source)	Monitor Freq	Report Freq	Responsible Person/Depart
	TARGET: 65% Source/YR: Internal 2009					
<b>SAFETY/RISK MGMT</b>						
<b>Percent of Incidents Completed within 14 business day (by reason category)</b>	Baseline: 82 Source/YR: Internal 2010  TARGET: 90% completed within 14 business days	Number of reported completed within timeliness standard divided by the number of completed incident reports.	Incident Log	Ongoing	Quarterly	Risk Management
<b>Medical Record Documentation</b>	Baseline: 78% Source/YR: Internal 2010  TARGET: 90% Source/YR: Clinic Policy-2011	Random Sample Number of providers with score of at least 90% divided by the number of providers.	Clinical Record Audit	Quarterly	Quarterly	Medical Services
<b>Percentage of abnormal lab results reported in a timely manner</b>	Baseline: 88% Source/YR: Internal 2009  Target: 90% (panic values within 1 hour of notification) 90% (abnormal values) within 1 business days of notification)	Monthly reports of panic and abnormal findings provided from the laboratory	Laboratory Tracking	Monthly	Quarterly	Medical Services