





NATIONAL ASSOCIATION OF
COMMUNITY HEALTH CENTERS, INC.®

Monograph

Your Health Center QUALITY MANAGEMENT (QM) PLAN

Dale Benson, MD

**Vice-President of Medical Division and Medical Management
AltaMed Health Services**

-  Enter information pertaining to your Health Center
-  Explanation and Suggestions

PURPOSE: Your Health Center has a critical fiduciary duty both to ensure excellence in clinical care and to manage Health Center operations in a manner that is effective and efficient. In order to carry out these responsibilities, Your Health Center's Governing Board and staff are actively committed to assessing and continuously improving quality in everything the Center undertakes. This Quality Management (QM) Plan presents methodologies that will help achieve the Center's vision of quality on behalf of patients, families, other visitors, the Health Center Board and staff, and all appropriate funding and oversight agencies. In furtherance of this Plan, Your Health Center will also work with external partners (especially its immediate community) to increasingly broaden the Center's sphere of influence and better enable the Center to impact policies and resulting health care quality at all levels.

This QM Plan includes three interrelated sections:

- ◆ The first section describes how the organization **structures** its Quality Management activities, reflecting performance improvement guidelines mandated by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) and the Bureau of Primary Health Care (BPHC) Program Expectations.
- ◆ The second section describes the **three phases** of Quality Management activity.
- ◆ The third section describes specific **additional components** of a quality program required by many health plans.

I. STRUCTURE OF THE QUALITY MANAGEMENT PROGRAM

A. Definition Of Quality

Your Community Health Center believes that the health status of our patients is directly related to the quality of care delivered at the Center. We believe that quality includes all facets of our organization—clinical, managerial, administrative, and facility-related. All organizational improvement activities center on improving quality, and all quality-related activities ultimately have the potential to impact the health of our patients.

We affirm that the quality process begins with our organizational Mission, our quality Vision, and our core Values. All quality-related activities are focused on designing, implementing, monitoring, and improving a total system to meet these constructs.

Consistent with this focus, Your Health Center has adopted the following specific definition of quality:

“Quality is the degree of excellence of our processes, performance, decisions, and human interactions.”

– Dale Benson MD, FACPE¹

The Center’s definition and resulting application of quality, and its inclusion of appropriate Quality Assessment and Quality Improvement activities, will at all times remain consistent with BPHC Program Expectations, the ambulatory care standards of the Joint Commission on Accreditation of Healthcare Organizations, appropriate guidelines of the Federal Tort Claims Act (FTCA), and ongoing results of the BPHC Health Disparities Collaboratives.

B. Purpose

The purpose of Your Health Center’s Quality Management (QM) Program is to enhance the health of our patients and to enable us to achieve our vision of quality in all that we do, by continuously improving the degree of excellence of our Center’s processes,

provider and support staff performance, decisions, and human interactions.

(Here we succinctly describe what we intend to accomplish with this program.)

C. Scope Of Program

The scope of the program is comprehensive and includes all clinical and administrative departments and activities that have a direct or indirect influence on the quality and outcome of care delivered to all Your Health Center patients. This scope includes primary care, dental, family planning... *(all provider disciplines and patient care programs are to be included here).*

All services (and sites, as appropriate) will be approved by BPHC in order to ensure compatibility with Program Expectations and provider coverage under FTCA guidelines.

For services provided to Center patients through written agreement (specialists, hospital services, etc.), the Center will perform all necessary “due diligence” before signing the agreement. For instance, the Center will ensure that hospital-based OB providers are appropriately credentialed and privileged and that their competence has been evaluated prior to finalizing a written referral agreement. Through this mechanism, the Center will ensure that patients receive acceptable quality of care in these external settings.

(Here we document that the QM program covers all activities that have the potential to impact the health of patients, either directly or indirectly.)

D. Program Accountabilities and Responsibilities

1. Accountability

Your Health Center Governing Board is ultimately accountable for the quality of care provided at Your Health Center. The Board holds the Chief Executive Officer accountable for the efficient and effective functioning of the Quality Management program.

In addition, provider credentialing requirements (per BPHC PIN 2002-22) will be specifically detailed in

¹ While this is an excellent working definition of quality, others also exist. Each Center should select or develop the definition it feels is most appropriate.

writing by the Governing Board, based on recommendations from Center management (especially the Medical Director).

2. Responsible Individuals

- a. The **Director of Quality** has overall operational responsibility for the Quality Management program. This position reports to the Chief Executive Officer.

(Organizations should seriously consider hiring a full-time Director of Quality.)

(A frequent mistake is to have the Director of Quality report to the Medical Director; it must be remembered that quality involves the entire organization.)

- b. The **Medical Director** is specifically responsible for the provider performance assessment and improvement component of the Quality Management program. This position also reports to the Chief Executive Officer.

The Medical Director is also responsible for recommending provider credentialing requirements to the Board, in accordance with BPHC PIN 2002-22, in order to minimize the Center's exposure to malpractice claims. These recommendations will address both the requirements for credentialing and the specific application of those requirements in ongoing practice.

E. Organizational Structure

1. Governing Board

The Governing Board will take an active fiduciary role in the continual improvement of quality at **Your Health Center**. The Board reviews and approves the overall Quality Management program annually; receives and acts upon reports presented to it by the QM program; and ensures the availability of resources and systems to support all QM activities.

2. Board Quality Management Committee

The Board Quality Management Committee is a standing committee that monitors the ongoing effectiveness of the Quality Management program and ensures that the Board fully understands and is actively involved in **Your Health Center's** QM pro-

gram. It is staffed by the Center's Director of Quality and meets at the discretion of the chair (*at a minimum, every other month*).

3. Corporate Quality Committee (CQC)

The Corporate Quality Committee has the responsibility to oversee all of the Quality Assessment and Quality Improvement activities at **Your Health Center**. This Committee also addresses all corporate-level issues that relate to quality. The CQC reports its activities and findings to the Board Quality Management Committee.

Your Health Center recognizes the important role of leadership in its quality program, as well as the need for broad-based representation from all Center stakeholder groups. Accordingly, the Corporate Quality Committee comprises the members of the Executive Staff, the Medical Director, representative providers, representatives of other major job categories, and representatives of Health Center programs. The CQC meets monthly, and the chair is appointed by the Chief Executive Officer.

(Smaller organizations will have just one CQC. Larger organizations should have departmental or discipline-level Quality Committees that report up to the Corporate Quality Committee.)

F. Integration and Coordination

Your Health Center's Quality Management program is fully integrated into the Center's ongoing operations through participation of all departments, disciplines, and cross-functional groups/teams. The Risk Management and Utilization Review programs are closely coordinated with the overall QM program.

The Director of Quality coordinates the Program, with active assistance from the Chief Executive Officer, the Medical Director, the Corporate Quality Committee (CQC), and the Board Quality Management Committee.

(Integration and coordination are important to the Joint Commission. This section confirms that QM activities are integrated throughout the entire organization, and it identifies how QM activities are coordinated.)

G. Improvement Approach

Your Health Center concurs with the improvement approach described by the Joint Commission, as described in JCAHO's chapter on "Improving Organization Performance" (from the ambulatory care accreditation standards manual). Each of the five steps for organizational improvement (below) has been carefully addressed and has been built into Your Health Center's Quality Management Plan.

- Plan:** The Program is systematic, organization-wide, and collaborative.
- Design:** Process improvement activity is designed to be patient- focused; consistent with Your Health Center's Mission, Vision, and Values; as state-of-the-art as resources will allow; and complete, with built-in performance expectations.
- Measure:** Data are collected for all essential components of the Health Center's total program. Data relate to processes, performance, outcomes, appropriateness of decisions, and patient/staff satisfaction.
- Assess:** Assessment is based upon both predetermined benchmarks (internal and external) and statistical quality control techniques as appropriate.
- Improve:** Processes are continuously and systematically improved using appropriate methodologies, and are then re-assessed (through measurement) at predetermined intervals.

In addition, the program's improvement approach is consistent with FTCA guidelines, specifically the reduction of malpractice exposure through a Risk Management program which generates improvements in response to claims data (see III. C., below).

(Confirms that the Joint Commission's five steps for organizational improvement have been built into the QM plan.)

H. The Role of Management in the QM Program

(Describes the basic philosophy upon which this Plan is built.)

The philosophy of Your Health Center is that the Quality Management program focuses on both Quality Assessment activities (monitoring and evaluation of important aspects of care) and the supporting and ongoing monitoring of Quality Improvement activities. Leadership and management are responsible for ensuring that the organization is moving toward its quality vision, and for ensuring that the Quality Management program is operating effectively. Management is also responsible for all problem resolution activity.

An "Internal Roles" chart defining the role of management within the QM program can be found in the Appendix.

I. Confidentiality and Conflict of Interest

The Quality Management program will be conducted in such a manner as to ensure organizational compliance with appropriate policies concerning Confidentiality and Conflict of Interest, as well as with all HIPAA requirements concerning patient/staff confidentiality and privacy issues.

(Ensures compliance with HIPAA confidentiality requirements, as well as with the organization's Conflict of Interest policy.)

The philosophy of Your Health Center is that the Quality Management program focuses on both Quality Assessment activities (monitoring and evaluation of important aspects of care) and the supporting and ongoing monitoring of Quality Improvement activities.

II. THE ESSENTIAL COMPONENTS OF QUALITY MANAGEMENT

(Mandates ongoing assessment — through measurement — of processes, performance, decisions, and human interactions in all components of the organization having the potential to impact patient health.)

(Mandates continual improvement of processes, performance, decisions, and human interactions in all components of the organization having the potential to impact patient health.)

OVERVIEW: Your Health Center's Quality Management program has three fundamental phases: Quality Assessment (through measurement and evaluation), Quality Improvement (both clinical and organizational), and provider-specific quality activities. The Corporate Quality Committee meetings (and any departmental quality meetings) focus on monitoring and encouraging these three activities throughout the organization.

A. Quality Assessment

In the Quality Assessment phase of the Center's QM program, the leadership and management of **Your Health Center** selects important components of our total program (clinical, managerial, administrative, and facility-related) that have the potential to impact the health of our patients, directly or indirectly. For each of these components, specific indicators are developed, measured, and monitored on a continuing basis. The Corporate Quality Committee tracks these activities, as well as all resulting improvement activities.

(As noted previously, larger organizations may have department-specific quality committees. In this case, evaluation and tracking would be done first at the department level, then results would be passed up to the Corporate Quality Committee.)

1. Indicator Selection

The management of **the Health Center**, in conjunction with the Corporate Quality Committee, is responsible for the selection of quality indicators to be included in Quality Assessment activity. The Center will begin with a few indicators, then add more indicators over time as the Quality Assessment

phase becomes more comprehensive.

Your Health Center will choose from HEDIS and other currently available indicators. In addition, management will develop evidence-based, Center-specific indicators that represent important aspects of care as delivered by **Your Health Center**.

Other areas for indicator development that **Your Health Center** will address over time include:

- a. Clinical and management indicators resulting from the ongoing work of the BPHC Health Disparities Collaboratives.
- b. Indicators relating to the Center's long-term quality vision.
- c. Indicators flowing from BPHC Program Expectations: patient satisfaction, access, quality of clinical care, quality of the workforce, work environment, cost, productivity, health status, and outcomes.
- d. Indicators resulting from the Institute of Medicine's six Aims for Improvement: safe care, effective care, patient-centered care, timely care, efficient care, and equitable care.

2. Indicator Measurement

For each indicator, management develops a plan for how data will be collected and how often the data will be reviewed by the CQC. In addition, management sets specific targets for each indicator, to include a **goal** and a **quality action point** (threshold for improvement). Data are then collected, according to the plan; summarized; and presented to the Corporate Quality Committee on a scheduled basis.

3. Indicator Assessment

The Corporate Quality Committee will analyze the data for each indicator and determine whether or not Quality Improvement activity must take place. The Committee will analyze the data with respect to both Center-specific trends and external benchmarking standards, as well as in relation to the "threshold" (quality action point) originally determined by management.

(Describes how measurement data are evaluated and how a decision is made to initiate Quality Improvement activity.)

4. Indicator Reporting

The results of indicator measurement activity are reported throughout the organization through the Minutes of the Corporate Quality Committee.

5. Indicator Tracking

When the Corporate Quality Committee directs that Quality Improvement activity must take place, management then has responsibility for selecting and training an improvement team and ensuring that needed improvement actually occurs. The CQC will track the progress of the improvement activity at each of its subsequent meetings until actual improvement has been documented. When the improvement activity has been completed, the Corporate Quality Committee will then periodically re-analyze the ongoing data to ensure that the improvement activity has been successful and that the results are sustained over time.

(Describes the procedure for tracking the results of indicator improvement activity, and for ensuring that identified problems are actually resolved and long-term improvements are realized.)

B. Quality Improvement

(The Joint Commission requires that the organization have a method to prioritize improvement activity. The Quality Assessment process will identify and help prioritize this activity. Further discussion regarding prioritization by the Corporate Quality Committee should address the identification of high risk, high volume, problem-prone, and high profile issues.)

Your Health Center has identified three primary methods (as described below) for resolving problems identified in the Assessment phase and for improving organizational performance. The Corporate Quality Committee will support and monitor teams involved in Quality Improvement activity and will ensure that all replicable results of the Health Disparities Collaboratives and other appropriate internal and external entities are available to Your Health Center improvement teams. In addition, the Corporate Quality Committee will ensure that the teams are appropriately trained and adequately supported by management. Once a team completes its improvement activity, the CQC will periodically reassess the issue addressed to ensure

that improvement is effective and ongoing.

The three primary methods for resolving problems or taking advantage of opportunities for improvement are as follows:

1. “Pilot Method” (based in the Plan-Do-Study-Act Cycle)

(“Pilots” empower all staff and providers to try any improvement ideas. When a pilot is established, the documentation should answer three questions: 1) What are we trying to accomplish? 2) What changes can we make that will result in improvement? 3) How will we know that a change is actually an improvement?)

All Center departments and employees are encouraged to pilot improvement opportunities using the Plan-Do-Study-Act (PDSA) Cycle. The CQC may also determine that the pilot method should be used to generate improvement in the performance of specific indicators.

Pilots must include both a baseline measurement and a built-in plan to determine the effectiveness (and, when appropriate, the replicability) of the improvement. A target date for conclusion of the pilot must also be pre-established. Management is responsible for tracking and supporting all pilots. The Corporate Quality Committee monitors progress of the pilots; if a pilot is successful, the resulting improvement is then incorporated into the Health Center’s policies and procedures.

2. “10-Step Improvement Method”

The Center uses the “10-Step Improvement Method” (see Appendix) for formalized improvement activity; all problems and opportunities for improvement requiring comprehensive evaluation and identification of a related improvement will be addressed through the 10-Step Method. Health Center teams work through this methodology one step at a time to improve issues identified in the Quality Assessment phase; these “10-Step teams” are appointed by appropriate departmental or corporate leadership. The Corporate Quality Committee is responsible for supporting and monitoring the 10-Step process.

(NACHC’s “Quality Management for Health Centers” seminar teaches the 10-Step Method. Other effective methods also exist, of course; this model is used here primarily as one example of a formal improvement methodology.)

3. “Reengineering”

When it is determined that major process improvement must take place or that certain processes are so dysfunctional that they must be completely redesigned, **Your Health Center** will initiate reengineering activity. The Chief Executive Officer will appoint a reengineering team. This team will be fully trained in reengineering techniques, and every team will be assigned a facilitator skilled in reengineering. The Corporate Quality Committee will monitor all reengineering activity.

(Reengineering is a dramatic, frequently necessary, and effective improvement methodology.)

C. Provider Performance Assessment and Improvement

(Although provider patient care activity is included as an integral part of Quality Management, provider activities relating to quality — and nearly all such activities do — are so important and often so problematic that specific emphasis must be placed on this functional area in the QM Plan.)

(The specific activities noted below generally apply to “licensed independent practitioners” as defined by the Joint Commission.)

1. Clinical Guidelines

The provider staff has identified/developed **Your Health Center's** specific evidence-based clinical guidelines, as grounded in national standards, the ongoing work of the BPHC Health Disparities Collaboratives, and JCAHO's four criteria for guideline development (Select, Implement, Evaluate, and Refine). In addition, the provider staff has developed — and the

Medical Director is responsible for—health assessment/maintenance plans and clinical outcome indicators. Specialty practitioners are consulted as needed in the ongoing development of these items.

2. Peer Review and Clinical Guidelines Audits

The Medical Director is responsible for ensuring that Peer Review Audits and Clinical Guidelines Audits are conducted as scheduled. Each question on these Audits becomes an indicator in the Quality Assessment phase, with a predetermined target, a plan for data collection, and a schedule for frequency of review.

3. Provider Performance Improvement Activity

When Quality Improvement activity becomes necessary as the result of Peer Review and Clinical Guidelines Audits, the Medical Director appoints provider representatives to a team commissioned to complete either a pilot, the 10-step method, or reengineering (whichever is most appropriate).

4. Integration with Organization-wide QM Program

(This section recognizes that provider-specific assessment/improvement activities must be integrated into the overall QM program.)

The Medical Director is responsible for the resolution of any clinical problems identified, as well as for ongoing Quality Improvement activity in the clinical area. Provider Quality Improvement activities are continuously monitored by the Corporate Quality Committee.

... all problems and opportunities for improvement requiring comprehensive evaluation and identification of a related improvement will be addressed through the 10-Step Method.

III. ADDITIONAL COMPONENTS OF THE QM PROGRAM

(These important activities are often specifically required by health plans as part of a Health Center's QM Plan. They are definitely appropriate for a quality program and should be built into Quality Assessment and Quality Improvement activities.)

A. Utilization Management

Your Health Center's Utilization Management program provides a comprehensive process through which review of inpatient and outpatient services is performed in accordance both with quality clinical practices and with the guidelines and standards of local, state, and Federal regulatory entities.

The Utilization Management program is designed to monitor, evaluate, and manage the quality and timeliness of healthcare services delivered to all Your Health Center patients. The program provides fair and consistent evaluation of the medical necessity and appropriateness of care, through use of nationally recognized standards of practice and internally developed clinical practice guidelines.

(Monitors the appropriateness of care.)

B. Credentialing, Re-credentialing, and Privileging

The Center's credentialing and privileging processes accomplish initial credentialing, required re-credentialing, and specific privileging for all contracted and employed providers. This ensures appropriate qualifications to provide care and services, and it verifies the absence of any State and CMS-imposed sanctions. Specific quality indicators addressing the credentialing and privileging processes are part of the Center's QM program.

(Monitors the effectiveness of the credentialing, re-credentialing, and privileging process.)

C. Risk Management

Your Health Center's Risk Management program monitors the presence and effectiveness of patient risk minimization activity, including incident reports, sentinel events, infection control, lab quality control, and patient safety. These risk minimization activities will be **proactive** whenever possible, incorporating safeguards against exposure to medical malpractice into Center policies and procedures. Improvements to related processes and policies will also result from QM activities, based on malpractice claims data whenever appropriate.

The Corporate Compliance program is also a part of Risk Management. The total Risk Management program is closely integrated with Your Health Center's Quality Management Plan.

(Monitors the organization's patient risk minimization activity, including incident reports, sentinel events, and Corporate Compliance.)

D. Health Records

Your Health Center will achieve continued excellence with respect to its health records. These records will be maintained in a manner that is current, detailed, secure, and enabling of effective, confidential patient care and quality review. Health records will reflect all aspects of care and will be complete, accurate, systematically organized, legible, authenticated, and readily available to all appropriate health care practitioners and other necessary parties, in strict accordance with HIPAA guidelines.

(Monitors the accuracy, timeliness, completeness, privacy, and security of the Center's health records.)

The Corporate Compliance program is also a part of Risk Management.

The total Risk Management program is closely integrated with Your Health Center's Quality Management Plan.

Acknowledgements:

Publication of this generic Quality Management Plan was supported by the Bureau of Primary Health Care, Health Resources and Services Administration, U.S. Department of Health and Human Services.

The National Association of Community Health Centers (NACHC) also wishes to thank the following for their contributions to this document:

- ◆ **Dale S. Benson, MD, CPE, FACPE (Primary Author)** – Vice President of the Medical Division and Medical Management for AltaMed Health Services, Inc. in Los Angeles (CA). Dr. Benson is a nationally known author and speaker on quality and is Past President of the American College of Physician Executives (ACPE).
- ◆ **Ambulatory Innovations, Inc. (Contractor)** – The ambulatory health care resources, training, and consulting company that developed this Plan under contract to NACHC and the Bureau of Primary Health Care.
- ◆ **Peyton G. Townes, Jr. (Primary Editor)** – President of Ambulatory Innovations, Inc. Mr. Townes has many years' experience as a manager, program developer, fundraiser, author, speaker, and consultant within ambulatory and indigent care.
- ◆ **AltaMed Health Services, Inc.** – A Community Health Center providing comprehensive health care services to indigent and minority populations in the Los Angeles (CA) area. Many elements of this Plan came from the Quality Management program of this organization.
- ◆ **Interviewees** – Persons providing invaluable input and feedback as the Plan was being developed:
 - **Lon Berkeley**, Accreditation Initiative Coordinator, Joint Commission on Accreditation of Healthcare Organizations
 - **Martin J. Bree**, Director, Center for Risk Management, Health Resources and Services Administration
 - **Thomas Curtin, MD**, Vice President and Director for Clinical Affairs, NACHC
 - **Kathy McNamara**, Assistant Director for Clinical Affairs, NACHC
 - **Freda Mitchem**, Director for Systems Development and Policy, NACHC
 - **Stephen R. Smith**, Senior Advisor to the Administrator, Health Resources and Services Administration
 - **David Stevens, MD**, Acting Chief of Clinical Quality Improvement Branch, Division of Clinical Quality
- ◆ **Reviewers** – The other health professionals who made this Plan better through their solicited feedback.

Internal Roles in Quality Management (QM)

CQC and Related Quality Committees	ABC Health Center Management
1. Assist management in identification of key processes and related indicators (structure, process, outcome).	1. Delineate organizational scope of care; identify key processes and related indicators (structure, process, outcome).
2. Annually evaluate overall QM Program.	2. Appoint appropriate committees.
3. Quality Assessment phase: <ul style="list-style-type: none"> ◆ Ensure that appropriate indicators are being actively monitored. ◆ Assess indicator measurement data. ◆ Initiate Quality Improvement plans as needed. 	3. Manage data collection: <ul style="list-style-type: none"> ◆ Provide data to QM Committees as scheduled ◆ Establish thresholds (Quality Action Point levels).
4. Quality Improvement phase: <ul style="list-style-type: none"> ◆ Support and monitor all Quality Improvement activities: Pilots, 10-Step Method, and Re-engineering. ◆ Evaluate effectiveness of QI activities, and document improvements. 	4. Manage Quality Improvement activities: <ul style="list-style-type: none"> ◆ Solve problems. ◆ Develop policies & procedures development as needed. ◆ Manage Pilots, 10-Step Method projects, and Re-engineering projects. ◆ Assign responsibility for improvements.
5. Report up through Quality Management channels.	5. Report to CEO through Corporate Quality Committee.

Your Health Center

10 - S T E P I M P R O V E M E N T M E T H O D

1. Identify the problem or opportunity to improve.
2. Identify the related process.
3. Measure the problem or opportunity.
4. Identify the customer(s) of the process.
5. Determine customer requirements.
6. Determine possible causes of the problem/opportunity.
7. Determine possible improvements.
8. Prioritize and choose one possible improvement.
9. Test and measure the possible improvement.
10. If the possible improvement is not successful, select/test/measure another. If the possible improvement is successful, continue to monitor the new process and its results.

This publication was supported by Grant/Cooperative Agreement Number U30CS00209 from the Health Resources and Services Administration, Bureau of Primary Health Care (HRSA/BPHC). Its contents are solely the responsibility of the authors and do not necessarily represent the official views of HRSA/BPHC.



National Association of Community Health Centers, Inc.®

7200 Wisconsin Avenue

Suite 210

Bethesda, MD 20814

Phone (301) 347-0400

Fax (301) 347-0459

Web site www.nachc.com