Continuous Quality Improvement Process

It is the policy of the Larry Combest Community Health and Wellness Center (LCCHWC) Governing Board to establish a PDCA (Plan, Do, Check, Act) and maintain a Continuous Quality Improvement (CQI) Process to ensure compliance with applicable laws, regulations, policies, procedures, effective delivery systems, accepted professional and accreditation standards and to promote a culture of safety. The CQI process is established as a Performance Improvement (PI) Committee and a Peer Review Committee with the benefits of confidentiality by the Texas Medical Practice Act and under the federal Patient Safety and Quality improvement Act of 2005 and of immunity by the Texas Nurse Practice Act and Health Care Quality Improvement Act.

The CQI process includes performance improvement functions assigned by the Executive Director that relate to the adoption of and adherence to center policies and procedures, to create a system for health services for optimized comprehensive clinical care and a culture of safety throughout the center. These functions are related to the implementation of compliance, privacy, safety and risk management plans and initiatives; promoting patient access to optimized care when needed, where needed, as well as monitoring of policies, procedures and practices related to management and operations, information management and human resources.

The CQI process is established to provide a framework to coordinate review of indicators and measures, to confirm compliance with applicable laws and regulations, patient and staff safety and risk management, patient satisfaction and outcomes, and ethical and professional standards. The CQI process promotes safety management based on rules and regulations; establishes outstanding safety performance as an organizational goal and views safety performance as dynamic and continuously improving. The CQI process is designed to be consistent with:

1) Applicable federal and state laws and regulations;
2) Compliance and performance improvement standards and requirements of HRSA
3) Federal Tort Claims Act (FTCA) and Texas Tort
4) Federally Qualified Health Center (FQHC) program regulations, including grant funding requirements.
5) Health Insurance Portability and Accountability Act (HIPAA)

MISSION & PURPOSE

A. The Combest Center’s Mission Statement

To provide access to comprehensive health services to those in need;
To reduce or eliminate health disparities among high risk populations; and
To integrate student clinical experiences and faculty practice in effective delivery of health care services.
B. CQI Process Purpose

The purposes of the CQI process are to promote optimized, safe, efficient, effective, appropriate and quality health care services. Other purposes are to reduce fraud, waste, abuse and other illegal and/or unethical conduct, to identify opportunities for improving services, to empower staff to take corrective measures to ensure safety, compliance and continuing performance improvement, and to take corrective or disciplinary action as necessary to protect the patients, staff and center. The program is established to:

- Fulfill legal, licensing, certifying and funding requirements;
- Document compliance with laws, regulations, and professional standards, including those related to patient privacy;
- Document practices consistent with the TTUHSC OP 52.06 Standards of Conduct and Ethics Guide;
- Promote the concept of continually improving the system for the delivery of health care services and monitoring progress toward organizational goals;
- Provide a mechanism for review of quality of services; CQI process activities are carried out in good faith and without malice;
- Provide data upon which to base performance improvement decisions;
- Promote appropriate cost-effective and quality health services, generating a commitment and interest in what is possible;
- Promote staff involvement and team efforts to make improvements, promote compliance, and enhance the work environment and job satisfaction—staff is expected to cooperate fully with recommendations resulting from the PI program, including the evaluation of actions and resolutions.
- Receive and act upon comments, complaints, and feedback from patients, visitors and staff;
- Minimize the risk of injury to patients, visitors, and staff through monitoring and appropriate intervention regarding safety in the environment of care; and
- Minimize financial losses due to malpractice liability costs through preventative and responsive measures.

CQI Process

A. Authority

The CQI process is implemented pursuant to the LCCHWC Governing Board bylaws that require the evaluation of the quality of health care services provided at the Combest Center. The CQI process includes all employees of the Combest Center and the results are reported to the LCCHWC Governing Board. The LCCHWC Governing Board is responsible for the oversight of the Combest Center CQI process and for making recommendations to the LCCHWC Governing Board regarding the CQI process operations.

The CQI process is authorized to evaluate health care services through the Medical Peer Review process and through the Performance Improvement Process, including patient care rendered by the health care
practitioners. The process includes data collection, analysis, outcome investigation, review and recommendations for action by PI Committee. The functions include the evaluation of: (1) accuracy of diagnoses; (2) quality of care rendered by health care practitioners; (3) compliance with medical indicators (4) evaluation of the health care plan and (5) merits of any complaints relating to health care practitioners and determinations or recommendations regarding those complaints. The CQI process includes oversight of the evaluation of the qualifications of health care practitioners and certain oversight functions associated with the PDCA, the Privacy/Security Plan and the Risk Management Plan. The CQI Process information are the property of the health center alone is not available to any outside organization for any purpose unless published. In addition, certain immunities may be available to participants in the CQI process for good faith actions.

B. Accountability
The LCCHWC Governing Board is responsible for creating a culture of safety by establishing and providing for the CQI process. The LCCHWC Governing Board is also responsible for appointing the Executive Director. The Executive Director is responsible for operations and management of the center and for the assignment of various functions to staff. Further, the Executive Director must enact the necessary measures to ensure that the staff understands and adheres to the center policies. Additionally, the Executive Director must ensure that a CQI process is fully operational and effective in providing assurance of compliance to the LCCHWC Governing Board. The Governing Board receives reports to verify center compliance and performance improvement.

The Combest Center is accountable to the Governing Board to monitor the quality, effectiveness and safety of its services. The funding sources for the Combest Center hold the Governing Board accountable to assure that the quality of services is monitored to document the acceptable quality of the services, their accessibility to the patients served, and their provision in compliance with various laws and regulations. The Health Insurance Portability and Accountability Act (HIPAA) mandate assurances regarding patient privacy rights and proper procedures for billing transactions and coding. The Combest Center must maintain effective performance improvement and risk management activities to reduce the likelihood of claims by controlling risk factors, appropriately responding to incidents or adverse events that might result in a claim and maintaining a credentialing program for licensed and certified CQI. Towards these ends, the Combest Center must establish and maintain a program to promote a safe and caring environment for delivery of quality services including compliance, privacy, performance improvement and risk management.

It is the intent of the Combest Center to implement the CQI process as based on PDCA models to assist the health center staff to promote continually improved performance in the quality of care provided at all levels and to reduce risks to patients, visitors, and staff. The CQI process also provides information to guide individual and health center CQI development.
The Governing Board approves the TTUHSC Code of Conduct. The Standards of Conduct and Ethics Guide is based on the center’s mission, vision and values, and established the following accepted standards of ethical conduct.

1. Be honest;
2. Follow center policies and procedures;
3. Keep accurate and timely records;
4. Protect center assets;
5. Respect patient and CQI rights;
6. Do not accept gifts or gratuities;
7. Do not offer, solicit or accept bribes or kickbacks;
8. Avoid conflicts of interest;
9. Report violations without fear of retaliation;
10. Maintain the ethical conduct of "Do the Right Thing Now"; and

The Governing Board, Executive Director, and Leadership staff, as well as all employees, independent contractors and vendors are required to adopt the Standards of Conduct and Ethics Guide and to conduct themselves accordingly. The Standards of Conduct and Ethics Guide promotes open, nonhierarchical communications to create a culture where staff is empowered to raise concerns about patient and staff safety without fear of retaliation. Communications include guidelines concerning the zero tolerance policy for harassment or criminal or fraudulent activity and the seriousness of any violation of the code of conduct or professional standards, as well as the potential penalties and disciplinary action necessary to ensure a safe environment.

C. Performance Improvement Committee

The CQI process and the PI Committee are coordinated by the PI Committee Coordinator. The Executive Director designates the PI Committee Coordinator and members, including the functions of compliance, privacy and safety. Oversight, safety provisions and monitoring reports are made to the PI Committee, The Executive Director and the Governing Board, as appropriate. Measures for safety and performance improvement as well as corrective and disciplinary action are taken, as needed to promote safety and compliance, to improve systems and individual performance. Corrective measures to improve systems and disciplinary action may be taken as necessary to prevent and detect illegal conduct.

The Executive Director shall designate a staff member or members to oversee the CQI process and to authorize such persons to investigate any and all matters concerning compliance, privacy, safety, and performance improvement. Such investigations are conducted by, or at the direction of the PI Committee in its function as an Executive Director, and Governing Board as appropriate. Certain information is confidential and protected from discovery by medical peer review privileges (under federal and state law regulations): Attorney-Client Privilege; Attorney-Work Product Privilege; and/or HIPAA privacy provisions; therefore, it is
necessary to determine what information is and what information is not appropriate to share among center staff. Corrective actions, disciplinary measures, or performance improvement measures are taken by the Executive Director, as appropriate. The CQI process and the CQI review plan are evaluated annually by the Governing Board and PI Committee.

The PI Committee will meet monthly and will consist of administrators, representatives from the different programs at the Center, the Medical Director, and representatives from all services. The PI Committee will gather, review, synthesize, and summarize information to be shared and reported back to the Governing Board. Minutes will be kept in a concise, action oriented format with supporting materials to be shared at PI meetings and to Governing Board.

Information gathered through the CQI process will be utilized to set and track clinical and procedural outcomes as well as to evaluate and develop strategic planning processes to maintain/improve clinic operations. The information gathered and reported by this committee will contribute to short and long term goal setting, needs assessments, health care plan and program development. It will be utilized to identify the CQI training opportunities and the development of improved clinic procedures.

**Performance Improvement Implementation**

**A. CQI Program Organization**

The Executive Director is responsible for oversight of CQI process and for the operation of the PI Committee. The Executive Director is responsible for appointing a health center employee to serve as PI Committee Coordinator and a physician to serve as Medical Director. The Executive Director must provide for CQI time and resources for meetings, data collection, and other tasks in order to allow the PI Committee Coordinator, the Medical Director, and team to carry out their functions.

The Executive Director keeps the Governing Board advised through a summary of the activity of the PI program, reporting on matters under development or resolved by the CQI process and on those deemed appropriate for Governing Board information or action. Communication between the CQI process and the Governing Board are consistent with privacy laws and standards.

The CQI process is evaluated for its effectiveness in promoting performance improvement, quality of services, and patient outcomes and for its internal functioning. The evaluation is conducted annually and the Executive Director reports the results to the Governing Board with recommendations. The success of the program is evaluated through annual staff surveys, attainment of the health care plan goals, discussions at the program level and discussion with the LCCHWC Governing Board.

**B. Governing Board**

The Governing Board is responsible for determining the quality of services and the safety of the facility are monitored and that problems are appropriately addressed. The Governing Board delegates to the Executive
Director the responsibility for implementing a CQI process. The Governing Board is responsible for acting on recommendations originating in the CQI process as appropriate and for evaluating the effectiveness of the CQI process.

C. Program Directors

Program Directors, in addition to administrative and service functions are accountable to the Executive Director for monitoring the quality and safety of services and the functions of their respective areas of responsibility and for taking appropriate actions. To fulfill these responsibilities, as sharing and cooperative effort in problem solving is essential. The Combest Center-wide PI Committee provides a means to problem solve appropriate issues within the Combest Center. Certain administrative and personnel matters are the primary responsibility of the Executive Director or Program Managers and are not appropriate for action or recommendation by the CQI process.

D. Medical Director/Clinical Director

The Medical Director/Clinical Director is responsible for overseeing the CQI process and with the Executive Director, is responsible for determining that the quality of services meets the accepted standard of care and is appropriate to the scope of services of the Combest Center and assures that appropriate reviews and monitors are conducted to promote performance improvement.

The Medical Director participates in the credentialing process concerning credentials and privileges for the scope of practice of clinical staff and serves as an adhoc member of the Peer Review Committee designated to make recommendations regarding privileges of licensed and certified health care professionals at the Combest Center.

E. PI Committee Coordinator

The PI Committee Coordinator is designated by the Executive Director to coordinate the CQI process and activities of the PI Committee. The PI Committee Coordinator is responsible for coordinating meetings, making assignments for completion of tasks and assignments, maintaining the records, minutes and documents of the CQI process, overseeing the review schedule and coordinating the activities, and preparing reports of the review for the CQI process.

F. Compliance Officer and Privacy Officer

The Executive Director will make referral to the appropriate TTUHSC department and are consistent with the Texas Tech University Health Sciences Center Compliance Plan and the Health Sciences Center Privacy/Security Plan. Many of these functions are coordinated with the monitoring of the CQI process.

G. Independent Health Care Practitioners

The Governing Board and the Executive Director make decisions regarding the privileges of nurse practitioners, physicians and other licensed and certified health care professionals to practice at the Combest
Center, based upon peer advice, the credentialing and competency processes, and recommendations of the CQI process. The Combest Center’s bylaws, rules, and contracts provide direction for health care practitioners to monitor the quality of health care services, including record screening and review through the CQI process. The process and procedures relating to authority to practice at the Combest Center shall be consistent with the Governing Board Bylaws.

**Performance Improvement Monitoring Information**

The CQI process works with five types of information:

- Health Care Plan measures
- Medical Peer Review
- Clinical reviews conducted by Medical Director
- Incidents, accidents and grievances; and
- Patient, Community and Board input.

A schedule for gathering the five types of information is set at the beginning of each grant year. Monitoring and reporting are summarized utilizing the PLAN-DO-CHECK-ACT process to ensure effectiveness. Performance Improvement Projects are developed and undertaken based on this process. The CQI process documents activity reports to the LCCHWC Governing Board at least quarterly. The CQI process reports include a system for tracking each issue under review, to document progress, data collection, assessment, and findings, and indicate recommended actions, as well as resolutions and follow up monitors as needed.

Guidelines for development and design of a quality improvement initiative are as follows:

**PLAN**

a. Define the problem or opportunity for improvement.
   - Consider areas that are problem-prone, high risk and/or high volume.
   - Identify the rationale for this quality improvement initiative.
   - Data sources for problem identification include patient satisfaction surveys, patient complaints, staff complaints or concerns, trends identified by faculty or staff, infection control monitoring, risk management issues, and other internal or external audits or surveys.

b. Identify the dimensions of quality related to the issue including application of known best practices and evidence-based practice.

c. Identify the stakeholders and other individuals and departments involved or affected by the process.

d. Answer the following three questions:
   - What are we trying to accomplish?
   - How will we know that a change is an improvement (i.e., what can we measure?)?
   - What changes can we make that will result in improvement?

e. Determine how performance can be measured. Aggregate and analyze data related to the problem and establish baseline measures.

f. Identify a threshold or benchmark against which to measure.
g. Outline data collection processes including who is responsible; how, where and when data will be collected; and reporting procedures.

h. Determine the sample size when indicated. Sample size should reflect the number of cases involved: If the average number of cases per quarter is more than 600, at least 5% are reviewed; if fewer than 600, at least 30 cases are reviewed; if fewer than 30, review 100%.

i. Determine what processes may be altered, developed and implemented to affect change.

**DO**
Implement the change; consider implementing change on a small-scale to test effectiveness prior to implementing throughout the organization.

**CHECK**

a. Collect data to determine effectiveness of change as outlined in the planning stage.

b. Compare to established threshold, benchmarks, or previously collected data.

c. Revise the process if goals are not met.

d. Ask the following questions:
   - Can more be done?
   - Are there stakeholders we have not considered that should be involved in the process?
   - Do we have the power to affect this change long-term? (If NO—discontinue collection of data and generate a report for the quality improvement files).

**ACT**

a. Institute change (if determined to be effective).

b. Formalize the process (consider need for policy revisions, new policy development, employee education, and other actions).

c. Incorporate the change into the culture.

**Statistics and Outcome Data**
Health Center performance is monitored against the measures noted in the Health Care Plan, which are based on Healthy People 2020, Health Disparities Collaborative targets, local experience of health disparities, FQHC requirements, HRSA requirements and other specific indicators specific to chronic diseases. The Health Care and Business Plans constitute the strategic plans of the Health Center and are reviewed on an annual basis to determine whether the goals need revision. Monitoring is completed utilizing the EMR system for chart reviews, as well as analyzing outreach records, productivity reports, satisfaction survey data, infection control reports, and patient concern reports.

**Clinical Reviews**
In chart reviews, the Medical Director examines charts of recently seen and/or first time patients to determine the extent to which the clinical services provided are in compliance with health center protocols. These reviews are documented on chart review forms and provide information for aggregation, as well as direction to health center providers. Review form information is summarized for use in the CQI process and then are
returned to the practitioner for correction. These reviews also meet collaborating physician requirements regarding nurse-practitioners’ practice.

Peer Reviews
Pursuant to the Federal Tort Claims Act which provides liability coverage for the Federally Qualified Health Centers, all licensed and certified professional staff must be subject to review to evaluate quality of services, provide feedback and be given the opportunity for improvement or corrective action as may be indicated. The Texas Medicaid Managed Care program requires that all provider staff be subject to peer review and that quality improvement and corrective actions be taken and monitored as appropriate. All persons must adhere to the confidentiality provisions including peer review information concerning patients and providers.

Functions of Medical Peer Review:

A. Evaluate and monitor quality of services
   1. Accuracy of diagnoses
   2. Quality and appropriateness of services provided
   3. Compliance with standard of care and legal requirements
   4. Areas for potential improvement in quality, utilization or economy
B. Evaluate qualifications and credentials of licensed and certified staff and make recommendations regarding clinical privileges
C. Investigate complaints and make recommendations
D. Implement and monitor quality improvement and risk management measures.

(2007 TACHC Compliance and Performance Improvement Manual)

Process:
1. Peer Review will be performed quarterly.
2. Quarterly charts will be randomly selected by the PI Committee Coordinator. Then charts will be assigned to each reviewer. Each reviewer will receive a printed list of charts to review and the review tools needed to complete the peer review.
3. Each provider will be given 5 charts to review.
4. Providers will be given 12-15 days to review charts and submit reviews to PI Committee Coordinator.
5. Once reviews are complete the individual results will be sent to treating providers to determine if they would like to make any comments on the findings. They will have 10 days for the process and then will return reviews to PI Committee Coordinator. PI Committee Coordinator will summarize findings and report to Executive Director, PI Committee, & BOD.

Incidents, Accidents, and Grievances
Staff must be alert for incidents or complaints that may lead to a liability claim. Occurrence reports are to be completed for any unusual event that has potentially or actually resulted in a threat to safety or adverse outcome. Analysis of occurrence, accidents, and grievances gives the Health Center two kinds of information:
The study of the occurrence, accidents, and grievances gives the health center information to use for risk management, in that a pattern of occurrences may alert to a hazardous condition that should be corrected or a pattern of occurrences, incidents or grievances could signal that a problem is occurring that could result in liability. The occurrences and grievances can also give the health center information about the quality of services being provided. A pattern of occurrences may indicate that a problem has arisen or that there is a gap in services available to the persons served. Occurrence reports themselves are confidential and used by the Executive Director to ensure that appropriate immediate action is taken to assure positive outcomes and recue further threat to safety. Aggregated information format the occurrence report is presented to the PI Committee for study and action.

**Patient, Community, and Board Input**
The PI Committee considers ways that input regarding positive experiences and suggestions for service improvements may be obtained from patients, the community, and members of the LCCHWC Governing Board. Patients are surveyed quarterly to determine their level of satisfaction with services and such non-clinical factors as their wait time. This input is used by each program and the PI Committee to review quality and effectiveness of services.