LINCOLN COMMUNITY HEALTH CENTER, INC.
1301 Fayetteville Street • P.O. Box 52119
Durham, North Carolina 27717 – 2119

Continuous Quality Improvement Plan

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Continuous Quality Improvement Plan

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Continuous Quality Improvement Plan

PURPOSE

In keeping with Lincoln Community Health Center (LCHC)'s vision, mission, strategic plan, and core values, it is the intent to support a culture of quality and safety, utilizing an interdisciplinary approach to reduce the risk of harm in systems, processes, and the environment of care. Under the direction of the LCHC Board of Directors (BOD) and the Quality Improvement (QI) Policy, LCHC has developed the Continuous Quality Improvement Plan (CQI Plan). The CQI Plan provides an organizational framework that fosters intentionality in providing high quality care to our patients. This organizational framework will include periodic assessment of the appropriate utilization of the services LCHC provides, including their scope, breadth, and quality. LCHC will take a systematic approach to the quality improvement process as data is collected and evaluated on the care provided. Quality will be assessed throughout the organization through the monitoring of specific clinical quality measures, customer service, work culture, and finance. These indicators are reported out through the Quality Improvement Committee and ultimately to the LCHC BOD, as outlined within the CQI Plan. One of the cornerstones in continuous quality improvement will be having a willingness to add, change, or remove procedures, processes, and programs when necessary in order to provide higher quality care to our patients.

PRINCIPLES

The basic principles that build the foundation of the LCHC CQI Plan are the following:

- Intentionality in providing a high quality of care for our patients.
- Involvement of the entire organization, from the Board of Directors, the leadership team, and the providers, who will lead the effort, to the rest of the LCHC staff.
- Being systematic in the approach, including soliciting feedback from the entire staff, patients, and the community.
- Using objectivity as part of the process, which includes collecting data in a uniform way that adheres to the maxims of evidence-based medicine and is performed with all integrity.
- Utilizing the standard of care as a benchmark whenever possible.
- Continually monitoring, evaluating, and improving processes throughout the Center.
- Being visionary and avoiding pitfalls while maximizing quality of care.
- Constantly assessing technology and its potential use in providing higher quality and more efficient care while balancing any potential deleterious effects.
- Assuring the quality of care provided when extending the organization's reach to new communities.

SCOPE

All staff are committed to assessing and continuously improving quality and safety in everything LCHC undertakes including the provision of safe, efficient, and timely patient care. LCHC's Quality Improvement & Risk Management Director (QI Director), in collaboration with the LCHC Leadership team, will establish the priorities for performance improvement, patient safety, and quality. Priority is given to high-risk, high-volume, and problem-prone processes. Leadership communicates those priorities and establishes targets for the organization's performance utilizing various tools such as the strategic plan and balanced scorecard. In addition, quality assessment and quality improvement activities remain consistent with the ambulatory care standards of the Joint Commissions, the guidelines for the Federal Tort Claims Act (FTCA), and the definition of quality health care established by the Bureau of Primary Health Care (BPHC), and its relationship to best practices and

benchmarks. LCHC utilizes the PDSA (Plan, Do, Study, Act), Root Cause Analysis (RCA), and Failure Mode and Effects Analysis (FMEA) methodologies, as applicable, and the expertise of internal resources to investigate opportunities for improvement.

LCHC's leaders are committed to fostering an environment that encourages recognition and reporting of identified risks to patient safety and quality. Leaders demonstrate this commitment by:

- Creating an environment that promotes non-punitive reporting so that communication is fostered and encouraged among all disciplines and levels of authority.
- Continually evaluating the environment and culture of quality and safety
- Promoting an ongoing proactive program for risk identification
- Providing the support to measure, analyze, and manage discrepancies found in processes that affect patient safety
- Encouraging the involvement of patients and families as vital participants in achieving health.

Based on the QI Policy and CQI Plan, the LCHC Quality Improvement Committee (QIC) will ensure the following are monitored and reported to the Board of Directors (BOD) through QI reports, as applicable:

- Review and approval of Quality Improvement Policy
- Review and approval of administration policies
- Review and approval of clinical policies, as applicable
- Incident report summary
- Credentialing and privileging of Licensed Independent Practitioners
- Patient satisfaction survey summary
- Reports to QIC, as needed
- Clinical and Fiscal Measure Report, based on UDS data, to the BOD
- Performance Improvement Process and Evaluation for CQI Initiatives, as applicable

STRUCTURE AND FUNCTION

Continuous Quality Improvement permeates all levels of the health center. The QIC, which oversees the CQI Plan, has the specific role of monitoring overall quality of care and working on continuous improvement of that care. The QIC is responsible for overseeing all of the Quality Assessment and Quality Improvement activities for LCHC. The QIC addresses all issues that relate to quality and patient safety. Specific quality improvement projects will be assigned by the QIC to work groups referred to as Quality Support Committees. The BOD, leadership, providers, staff, patients, and community all have a role in building and maintaining a high quality of care at LCHC. Roles at each one of these levels of our CQI Plan are included below.

LCHC's BOD has an advisory fiduciary role in the continual improvement of quality and safety at LCHC, with specific tasks delegated to applicable organization leadership. The BOD reviews and approves the QI Policy at least every 3 years, receives and acts on reports, policies, and procedures presented, and ensures the availability of resources and systems to support all quality improvement activities, as applicable.

The QI Director coordinates the CQI Plan with the assistance of LCHC Senior Leadership and the QIC. The QIC reports its activities and findings to the CEO and the BOD.

ACCOUNTABILITY AND RESPONSIBILITY

As the LCHC BOD is accountable for the quality of care at LCHC, the BOD will ensure success of the CQI Plan through the maintenance of the QI Policy and the provision of resources, as needed, for the successful implementation of the CQI Plan. The BOD holds the CEO, or delegate, accountable for the efficient and effective operational functions of the CQI Plan, as outlined throughout the Plan.

The QI Director, or delegate, has operational responsibility for coordinating the activities for the CQI Plan.

The CMO, or delegate, is responsible for provider performance and improvement of the CQI Plan. The CMO, or delegate, also holds responsibility for recommending provider credentialing and re-credentialing requirements to the BOD to minimize LCHC's exposure to malpractice claims as it relates to ongoing practice.

The effectiveness of the CQI Plan is the direct responsibility of the Center's Leadership. Leadership is ultimately responsible for the selection and prioritization of measures to be included in the CQI Plan, the frequency and efficient collection of data to be monitored and evaluated, and the prioritization and actual effectiveness of improvement activity. The CQI Plan is conducted in a manner to ensure organization compliance with appropriate policies concerning confidentiality, conflict of interest, and the Health Insurance Portability and Accountability Act (HIPAA) requirements to ensure patient/staff confidentiality and privacy.

CHIEF EXECUTIVE OFFICER

The CEO, or delegate, shall select the Chairperson of the QIC. The CEO, or delegate, shall facilitate and support the QIC, and assure the adequacy of communication, accountability, training, and resources as needed for effective and continuous quality improvement.

QUALITY IMPROVEMENT COMMITTEE

Purpose:
The Quality Improvement Committee (QIC) will serve as the basic organizational framework for implementing the CQI Plan of LCHC in accordance with the QI Policy. The QIC shall have primarily a review and advisory function, with the purpose of continual quality improvement in order to augment the health of the community we serve.

Monitoring and Continuous Improvement:
The QIC reviews performance activities regularly. Reports on activities and outcomes (e.g. performance indicators and measures, risk and safety assessment results, event report summaries and trends) are presented to the BOD. Data reporting may include event trends, claim analysis, frequency and severity data, credentialing activity, relevant provider and staff education, and risk management/patient safety activities. Recommendations from the QIC are submitted as needed to the BOD.

Quality Assessment:
Leadership will select components from all organizational programs (clinical, managerial, administrative, and facility-related) that have the potential to impact the health and safety of our patients directly or indirectly. Of these components, specific indicators are developed, selected, measured, and monitored on a continuing basis. The QIC, or delegated Quality Support Committees, tracks these activities and the resulting improvement activities.

Responsibilities:

- Prioritizing current quality initiatives and activities
- Quality assessment and planning and annual program evaluation
- Subcommittee and team chartering, with accountability and reporting followed up by the Chairperson of the QIC
- The ongoing monitoring, evaluation, and improvement of processes and systems
- Leading with a patient-driven philosophy and process that focuses on preventing problems and maximizing quality of care

Method:

- The QIC shall meet at least monthly
- Each Department Leadership representative, or delegate, as applicable, shall present relevant departmental quality data, work-in-progress on current quality initiatives within their department, and new departmental quality issues to the QIC on at least a semi-annual basis. The QIC shall review these items and make necessary recommendations for action with follow-up as indicated.
- The BOD delegates creation of, modification to, and improvement of data collection forms/methods (such as patient feedback forms, quality reports, etc) to the QIC when the results of the data obtained will be presented to the BOD.
- The scope of the CQI Plan defines focus areas for the QIC.
- The QIC shall determine applicable standards of care based on industry benchmarks and communicate this information to the entire staff.
- The QIC shall assign Quality Support Committees as needed to address more complex, interdepartmental issues.
- The QIC shall draft the CQI Plan to be presented to and approved by the PCMH & QIC Committees at least annually.
- A review of pertinent QIC meeting information shall be presented to the BOD at least quarterly by the Chairperson of the QIC, or delegate.

QUALITY IMPROVEMENT & RISK MANAGEMENT DIRECTOR

The CEO has appointed the Quality Improvement & Risk Management Director as the Chairperson of the QIC. In the absence of the QI Director, the CMO or another suitably qualified health professional staff member will serve as delegate to chair the QIC. The Chairperson is responsible for overseeing the day-to-day work flow of the CQI Plan on an organizational level. The Chairperson's responsibilities will include, but are not limited to, ensuring compliance with the QI Policy and the implementation of the CQI Plan and related operating procedures, ensuring the completion of peer reviews and performance assessments as applicable for aggregate review by the QIC and/or BOD, monitoring of CQI outcomes, and updating the CQI Plan and related operating procedures as indicated. The Chairperson shall develop the agenda for and preside over QIC meetings. If the Chairperson is not the QI Director, then they shall report directly to the QI Director and/or CMO, as applicable.

QUALITY SUPPORT COMMITTEES

The QIC shall designate Quality Support Committees, as applicable, to address specific quality issues, particularly issues which are complex or span multiple departments. Depending on the issue, these committees may be ongoing/standing teams, or they may be time-limited. The time-limited quality support committees shall be designated as Ad Hoc committees that are formed as the need arises.

The membership and size of each Quality Support Committee shall be determined by its goal. The Quality Support Committees shall be empowered by the QIC with necessary resources and backing to accomplish their goal, but still remain under the authority of the QIC, QIC Chairperson, and existing supervisory structure of the organization.

Quality Support Committee responsibilities include:

- Choose a committee leader/chairperson from among members
- Analyze the component and processes and baseline performance for the selected quality issue
- Develop changes in processes, structure, staffing, policy, etc., as needed to effect performance improvement
- Identify appropriate quality standards/benchmarks, and recommend new performance targets to the QIC
- Develop a strategy, including timetables, to implement change
- Monitor and evaluate the impact of increments of change
- Adjust processes and implementation strategies as needed to achieve targets
- Continue the cycle of plan-do-study-act until desired results are achieved
- Maintain minutes of all meetings
- Report progress to the QIC, as directed by the Chairperson of the QIC

<u>Existing Quality Support Committees and Oversight:</u>

- The LCHC Board of Directors has oversight responsibility for the quality of patient care for the center in accordance with the mission and vision. The BOD holds the CEO accountable for the CQI Plan.
- LCHC's Quality Improvement Committee oversees the implementation of the CQI Plan. The QIC is directly responsible to the CEO and will submit reports at least quarterly to the LCHC BOD. The CEO, or delegate, appoints the Chairperson of the QIC.
- The QI Director, or delegate, is responsible for coordinating activities of the CQI Plan.
- The CMO, or delegate, represents LCHC clinical staff and is responsible for serving as the communication link for safety and quality priorities and goals in the clinical care environment.
- The **Primary Care Medical Home (PCMH) Committee** is tasked with oversight of continued compliance with the Joint Commission standards for PCMH accredited facilities and delegation of tasks related to maintaining current policies and procedures for the organization that meet all applicable standards and guidelines of regulatory bodies. PCMH will report to QIC monthly.
- The **Risk Management Committee** oversees all areas of potential risk for the organization. This includes the collection, review, and reporting of incidents within the organization with improvement plans as applicable. The Risk Management Committee will provide a report to the QIC at least quarterly.
- The **Environment of Care Committee** implements safety policy and staff training to ensure organized procedures for any anticipated event which could endanger the safety of the patients and staff of the Center. This includes fire, bomb threats, safety conditions, and infection control. The EOC reports to the QIC at least quarterly.
- The **Pharmacy and Therapeutics Committee** formulates policies regarding the evaluation, selection, procurement, distribution, and use of drugs, and manages a cost-effective drug formulary. This committee maintains an interdisciplinary team and reports to the QIC monthly.
- The **Early Intervention Clinic Quality Management Committee** coordinates specific approaches to addressing quality assessment and process improvement as outlined in the Early Intervention Clinic Quality Management Plan. The committee will meet according to their respective management plan and will report out to the QIC as indicated within their plan and no less than annually.

- The **Clinical Quality Measures Committee** identifies, tracks, reports, and plans improvements for clinical quality measures, specifically those identified by regulatory bodies as reportable measures. The Clinical Quality Measures Committee will report updates to the QIC at least quarterly.
- The **Lincoln Superusers Committee** is tasked with process improvement strategies involving the implementation of the electronic medical records system into the clinical flow by way of improving patient care outcomes. The Superusers Committee will report updates to the QIC as needed.
- The **Access to Care Committee** coordinates and ensures quality of care and communication between clinical services and ancillary services; analyzes and assesses performance; and coordinates appropriate recommendations for patient safety and quality improvement as they apply to patient access to services. Access to Care reports directly to the QIC at least quarterly.
    - **Telephone Access Committee** monitors patient and outside provider access to telephone lines, during and after hours. They will meet ad hoc and will submit their findings to the Access to Care Committee as needed.
- The **COVID-19 Response Team** is an ad hoc team that meets at least monthly, more frequently as needed. The team is responsible for the identification, planning, implementation, monitoring, and reporting of all organizational, local, state, and national updates as they relate to the public health crisis. This team will remain active as long as the QIC identifies a need for this specific planning and reporting. While active, the team reports to the QIC monthly.
- The **Practice Transformation Committee** is an ad hoc committee that meets as needed and is tasked with identifying areas within the organization needing process improvement, then planning, implementing, and evaluating performance improvement processes. The committee reports updates to the QIC as they become available.
- The **UDS Reporting Committee** is an ad hoc committee that meets seasonally, dependent on the reporting cycles of the HRSA UDS report. The committee is responsible for collaboration with EMR vendors for the collection and accurate reporting of all UDS data. When active, the team will report updates to the QIC as needed.
- Quality teams are responsible for implementing improvement to the patient safety and clinical quality initiatives. Process improvement teams are appointed by leadership and are charged with improving a process.
- **Each Department** will follow the Continuous Quality Improvement Plan in compliance with regulatory standards. Department performance progress will be reported to the QIC at least quarterly.

IMPROVEMENT APPROACH

Measures are selected that are meaningful to our organization and address the needs of the patients. These measures relate to processes, performance, outcomes, appropriateness of decisions, and patient/staff satisfaction.

Collected data for all measures included in the CQI Plan are displayed using the Key Performance Indicator (KPI) Dashboard, quality dashboards, charts, and graphs, as appropriate. Data are analyzed to identify trends, patterns, and performance. The results of data analysis are used to identify improvement opportunities. Analysis is based on both predetermined benchmarks and statistical quality techniques, as appropriate. Processes are continuously and systematically improved using appropriate methodologies.

Newly-designed processes or procedures, when implemented, are reassessed through measurement at predetermined intervals. The CQI Plan's improvement approach is consistent with FTCA guidelines,

specifically the reduction of malpractice exposure through a Risk Management Program that generates improvements in response to the claims data.

Improvement Process/Methodology:
When quality improvement activities are identified, the PDSA (Plan, Do, Study, Act) methodology will be used to identify recommendations and solutions for performance improvement. This model will guide the continuous quality improvement process through identifying areas that need improvement, planning an improvement process, implementing the improvement into practice, reviewing the data collected during and after the implemented improvement plan, and acting on the improvement results by either implementing permanent change, modifying the plan, or abandoning the plan in search for better alternatives.

Root Cause Analysis (RCA) is a systematic process that uses the information gathered during an investigation to determine the fundamental systemic deficiencies that led to an incident and has a broader application to the system as a whole. The organization will use RCA methodologies when reviewing incident reports and patient complaints, as applicable, as a means of identifying system deficiencies, management failures, inadequate competencies, performance errors, omissions, non-adherence to procedures, and inadequate organization communications.

The QIC will implement a Failure Mode and Effects Analysis (FMEA) as needed to address high-risk processes. When implemented, the FMEA will include an assessment of the process identified as high-risk, identification of undesirable variation/outcomes and the impact these may have on the delivery of safe patient care, a RCA to proactively determine why the undesirable outcomes may occur, a redesign of the process to minimize risk, implementation of the redesigned process, monitoring of effectiveness of this implementation, and a strategy for maintaining desirable outcomes.

PATIENTS AND CLIENTS

A patient-centered approach is the basis for all quality improvement efforts. Understanding and addressing patient needs and concerns is essential. Patient input to the QIC process will be directly incorporated at multiple levels, including:

- The BOD will receive regular reports from the QIC, including opportunities for recommendations and feedback. Feedback from the BOD will be viewed as advisory feedback, but also representative of patient feedback, as a selection of BOD representatives are also LCHC patients.
- Patient satisfaction surveys will be performed regularly and systematically, and information gleaned will be used to inform the quality process. Patient comments are available on the patient satisfaction survey.
- A Patient Feedback Procedure shall be in place.
- Patient input shall be sought as appropriate by the Quality Support Teams.

DEPARTMENT LEADERSHIP AND STAFF

The job descriptions of the CEO, CMO, QI Director, and Leadership staff shall collectively include the full scope of the CQI Plan, as described above. They shall ensure that employees understand the CQI Plan and are motivated and able to carry out the relevant parts of the CQI Plan. Leadership team shall coordinate activities in their department with those of other departments.

Leadership team, or delegates, will organize and conduct department meetings with all department staff at least monthly, as applicable. Department meetings will include a review of applicable quality data such as clinical

quality measures, resource stewardship, and patient experience reports. Reports will be based on the care provided to all patients within the organization and will be available to all staff members for review.

DECISION MAKING

On an ongoing basis, during their regularly scheduled meetings, the QIC will monitor and receive updates on the progress that the organization is making toward the standards and goals for the year as outlined in the CQI Plan. Semi-annually, the QIC will task the QI Director, or delegate, with the systematic review of the standards and goals of the year. The goal of this review is to identify and document the necessity for change in the provision of services and institute such change, whenever warranted, to the benefit of our patients.

- Decision making will be primarily directed by data systematically obtained from quality management reports through our EMR, peer review, surveys, incident reports, and other data gathering systems available to LCHC.
- A quorum of members must be present to vote on decisions within the QIC. All members have an equal vote except the Chairperson who does not vote. A simple majority decides the proposed action. In the event of a tie vote, the Chairperson will have the deciding vote.
- All decisions related to the quality of patient care should clearly identify the problem, the name of the staff person, or quality team accountable for the problem resolution, and establish a time frame for reevaluation to ensure that the problem has been resolved.
- Problems or areas of concern related to the providers will be addressed with the CMO. The CMO has ultimate oversight responsibility for all clinical areas. Problems or areas of concern related to the clinical support staff will be addressed with the Director of Nursing, or delegate. Problems or areas of concern related to other areas will be addressed with the Chief Executive Officer, or delegate, relative to the concern. Corrective action plans will be developed, implemented, and evaluated with the previously stated departments and designated staff. After al interventions have been completed, if the problem or area of concern has not been resolved, the final decision, if clinical, will be directed to the CMO, or if administrative, to the CEO, or delegate.

MEETINGS

The QIC meetings will be held monthly, unless otherwise directed by the QI Director, or delegate. In the event a QIC meeting is canceled, the QI Director, or delegate, will attempt to reschedule the meeting, as applicable, and will notify all QIC members. Meetings can be held in person or virtually, but a quorum of QIC members must be present for all meetings.

The QIC members should include interdisciplinary representation from all departments within the organization. Leadership team members will be invited to join the QIC, as applicable. Additionally, the QI Director, or delegate, will add additional members to the QIC as indicated based on their supervisory position or role. LCHC's Safety Officer will have a permanent position on the QIC.

Each meeting agenda shall include:

- Roll Call
- Review of previous meeting minutes
- Old Business and Follow-up items
- New Business
    - Clinical quality results as available

  - Patient satisfaction results as available
  - Committee reports, as applicable
  - Policy and procedure review, as applicable
- Review of audits and reports
- Review of areas of concern/problem areas

All QIC activities including any findings, recommendations, and actions are considered confidential unless otherwise noted in this CQI Plan or otherwise directed by the QIC Chairperson. Patient and employee data will be reported to the QIC in a de-identified manner and in aggregate form whenever possible.

REVIEW

Review and revision of the LCHC Continuous Quality Improvement Plan will be completed at least annually by the Quality Improvement Committee and QI Director.

REPORTING

To the CEO: The QIC Chairperson will make approved QIC meeting minutes available to the CEO upon request for review and comment.

To Organization Staff: The QIC includes leadership representation from all departments within the organization. These representatives will communicate pertinent QIC findings to their teams as applicable.

To the LCHC BOD: The BOD shall receive routine updates from the QI Director, or delegate. These updates will occur at least quarterly to a quorum of the BOD regarding key performance results and CQI Plan data. The QI Director, or delegate, will remain on the monthly BOD meeting agenda as a means of reporting updates to any CQI Plan items. The BOD can request specific QIC reports or review QIC minutes, as applicable, by way of placing a request with the QI Director, or delegate.

QUALITY INDICATORS

Indicator Selection:
The leadership of LCHC, in conjunction with the QIC, are responsible for the selection of quality and safety indicators, including external and internal sources.

External sources could include, but are not limited to:

- Uniform Data Systems (UDS) clinical quality and outcome measures
- Healthcare Effectiveness Data and Information Set (HEDIS) indicators
- Measures resulting from Health Disparities Collaborative activities
- Health care and business plan required measures
- Healthy North Carolina goals
- Other indicators that may have been developed by professional societies and/or state or local peer review organizations

Internal sources may include evidence-based, Center-specific indicators such as:

- Accuracy, legibility, and timeliness of medical records

- Performance of the medication management system
- Patient perceptions of safety and quality of care
- Patient/staff satisfaction
- Productivity
- No show rates

Areas for indicator development that are addressed over time include:

- Indicators from the Bureau of Primary Health Care (BPHC) requirements and performance improvement activities, such as:
    - Patient satisfaction, Access, Quality of clinical care, Quality of workforce, Work environment, Cost, Productivity, Health status and outcomes
- 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
- Value-Based Care Measures
- The Joint Commission's National Patient Safety Goals

Indicator Measurement:
Leadership, in conjunction with the QIC and the QI Director, will develop a plan for each indicator for how data is collected and how often the data will be reviewed by the QIC. In addition, they will set specific targets for each indicator to include a goal and a quality action point (threshold). Data are collected according to the set plan, and then summarized, displayed, and presented to the QIC on a scheduled basis.

Indicator Assessment:
The QIC analyzes data for each indicator and determines whether a quality improvement activity must take place. The data are analyzed with respect to LCHC-specific trends and external benchmark standards, as well as compared to the threshold originally determined by the indicator plan. The QIC analyzes and compares internal data over time to identify patterns utilizing quality measurement tools.

Indicator Reporting:
The results of indicator measurement activity are reported throughout the organization utilizing the KPI Dashboard, other quality reporting tools, and the QIC minutes.

Indicator Tracking:
When it has been determined that a quality improvement activity is to take place, the QIC will delegate the activity to the respective Quality Support Committee. The Quality Support Committee will select and train any applicable individuals on the activity and will ensure that the needed improvement actually occurs. The Quality Support Committee will track the progress of the improvement activity, making changes as needed, and will report outcomes back to the QIC for recording in the KPI Dashboard. Progress will continue to be tracked and added to the KPI Dashboard until actual improvement has been documented. When the improvement activity has been completed, the QIC will periodically re-analyze the ongoing data of the KPI Dashboard to ensure that the improvement activity has been successful and that the results are sustained over time.

CLINICAL QUALITY MEASURES

Standards and Goals for the year 2022 – LCHC will focus on our Clinical Performance Measures required for the Uniform Data Systems (UDS) Quality Measures, in addition to any other required quality measures as

outlined by applicable regulatory organizations. The organization has specifically chosen to add a focused emphasis on the following measures.

- Continuous Quality Improvement for Diabetes Education and Support Programs, as demonstrated by the improvement in diabetic patient A1c control and percent of the LCHC patient population with a diagnosis of diabetes.
- Continuous Quality Improvement for Hypertension Education and Support Programs, as demonstrated by the improvement in hypertensive patient blood pressure control and percent of the LCHC patient population with a diagnosis of hypertension.
- Continuous Quality Improvement for Colorectal Cancer Screening, as demonstrated by the improvement in patients, ages 50 to 75 years, who are screened for colorectal cancer using an appropriate screening method and remain up to date on required screening throughout the measurement year.

In conjunction with, but not excluding, the clinic has an ongoing quality improvement strategy and process that includes regular review of performance data and evaluation of performance against goals or benchmarks. The clinic reviews and incorporates opportunities to identify and prioritize areas for improvement, analyze potential barriers to meeting goals and plan methods for addressing barriers as needed. As applicable, each of these items will be discussed within the QIC and worked on through the Plan-Do-Study-Act (PDSA) Model.

All other clinical, fiscal, and productivity performance measures for LCHC will be monitored at least annually. Data from these items will be entered on the KPI Dashboard and presented to both the QIC and BOD, as applicable. The other items to be monitored include, but are not limited to:

- All HRSA UDS Reporting Measures
- Appointment productivity to include: no show rates, cancellation rates, and lost appointments
- Total cost per patient
- Medical cost per medical visit
- Health Center Program grant cost per patient

Goals for each of these items are maintained on the KPI Dashboard. The same decision-making process will apply to the above clinical and fiscal performance measures. Any areas of significant weakness will be moved in to the PDSA process for improvement.

ADDITIONAL QUALITY MEASURES

In addition to the above, LCHC is a Joint Commission accredited organization and deemed a Primary Care Medical Home (PCMH). Each of these designations require the tracking and reporting of specific quality, performance, and safety measures as they pertain to patient care. The QIC will track and monitor all applicable measures at least annually in compliance with these standards.

PEER REVIEW

Peer reviews are completed to examine the work of peers and determine whether the individual under review has met accepted standards of care in rendering healthcare services. Peer review applies professional control to practice and is used by the organization to hold employees, volunteers, and contractors accountable for their services to the public and the organization, as applicable. A peer review may be initiated at the request of the CEO, or delegate, a patient complaint, a physician, or an insurance carrier request. Peer Review sessions will

occur as needed or requested by the CMO, or delegate, or CEO. Additional details on peer reviews can be found in the Peer Review Protocols.

The Chief Medical Officer (CMO) ensures that Peer Review Audits and Clinical Guidelines are conducted as scheduled, and that these Audits periodically assess the appropriateness of utilization of services and the quality and safety of those services. Audits are based on systematic collection and evaluation of patient records and are conducted by licensed professionals under the supervision of the CMO. The clinical guidelines are evidence-based and include, but not limited to, health promotion, disease prevention, and clinical outcomes.

UTILIZATION REVIEW

The Utilization Review program will closely coordinate with the overall CQI Plan. The Utilization Review program provides a comprehensive process through which review of patient services is performed in accordance with both quality clinical practices and the guidelines and standards of local, state, and federal regulatory entities, as applicable. The program monitors and evaluates medical necessity and the appropriateness of care.

RISK MANAGEMENT PROGRAM

LCHC's Risk Management Program will be overseen by the Risk Management Committee and the QI & Risk Management Director and will closely coordinate with the overall CQI Plan. The 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. Minimization activities will be proactive whenever possible, incorporating safeguards against exposure to medical malpractice into LCHC policies and procedures. Improvements to related processes and policies will also results from quality activities based on malpractice claims data whenever appropriate. The Risk Management Program is further structured and guided by the Risk Management Policy and Risk Management Plan.

CREDENTIALING & PRIVILEGING PROCESS

LCHC's Credentialing & Privileging Process is closely coordinated with the overall CQI Plan and accomplishes initial credentialing, required re-credentialing, and specific privileging for all contracted and employed providers. The program ensures appropriate qualifications of health center employees, volunteers, and contractors, as applicable, to provide care and services to health center patients. For further information on the credentialing and privileging process, refer to the Credentialing Policy.

PATIENT SURVEYS

Patient satisfaction surveys will be performed regularly and systematically, and information gleaned used to inform the quality improvement process. These surveys will be administered through a system as approved by the organization's Executive Leadership team. The patient surveys will be reviewed at least semi-annually by the QIC, the results of which will be presented to the BOD. Identified areas of improvement will be moved in to the PDSA process for improvement. Additional information on patient surveys and updated versions of surveys can be found in the Patient Feedback Protocol.