I. PURPOSE

As part of the Southern Nevada Community Health Center's (SNCHC) dedication to providing quality care, SHCHC has implemented a Quality Management Program, a systematic, organization-wide approach to provide uncompromising quality care and service to clients. Through this systematic approach, the Quality Management Program provides a mechanism to constantly survey the performance of SNCHC and provides opportunities to improve performance levels.

II. SCOPE

SNCHC's Quality Management Program is outlined in its Quality Management Plan (QMP). The Plan's scope involves the physicians, nurses, allied health disciplines, community service agencies, administrators, managers, and staff that provide care to the uninsured or underinsured individuals of our community. The program focuses on improving key client and organizational functions within SNCHC, and will at all times, remain consistent with HRSA's BPHC Program Expectations, the NCQA Patient-Centered Medical Home standards, and appropriate guidelines of the Federal Tort Claims Act (FTCA). The key functions are assessed by collecting and analyzing data related to one or more dimensions of performance, which includes but may not be limited to efficacy, appropriateness, availability, timeliness, effectiveness, continuity, safety, efficiency, and respect and caring. The six key functional areas within the scope of SNCHC Quality Management Program are:

- Care Management- biological, social, and/or quality of life consequences of clinical and social evaluation and management of care and services in areas such as preventive health, acute or chronic conditions, behavioral health.
- Safety- capabilities to promote a safe environment for clients by evaluation in areas such as client and provider education, continuity and coordination of care
- Financial and Administrative- ability to efficiently and effectively manage the financial and administrative aspects of the organization
- Network quality- periodic peer review assessments of client records by physicians or by other licensed health professionals under the supervision of physicians of the appropriateness of the utilization of services; capabilities, satisfaction, accessibility, and availability of healthcare and human services, including monitoring and evaluation of quality care/quality service complaints, credentialing/recredentialing, and adverse occurrence tracking.
- Client Satisfaction- ability to meet the needs of SNCHC customers.
- Customer Service- capabilities, satisfaction, accessibility of the provision of customer service. Organizational arrangements, including a focus of responsibility, to support the quality assurance program and the provision of high-quality patient care

III. INTEGRATION OF QUALITY MANAGEMENT PLAN WITH GUIDING PRINCIPLES AND PRIORITIES

This plan will be aligned with SNCHC's Strategic Plan and annual work plans. The key attributes that support our vision of a health delivery system describes a system that:

- Is centered upon treating people with dignity and improving the health of our patients.
- Provides an integrated continuum of care

- Demands excellence in service by meeting or exceeding our customer's expectations.
- Requires effective communication and information sharing.
- Continually improves its operating and clinical practices by meeting and exceeding staff expectations.
- Is best achieved by teamwork.
- Uses resources optimally.
- Is scientific and results oriented.
- Provides a safe environment for clients, visitors, and staff.
- Delivers care based on the best scientific evidence combined with judgment of expert clinicians.

IV. GOALS AND OBJECTIVES

The goal of the plan is to increase the value of services by enhancing quality and strengthening the ability to deliver cost-effective care.

Objectives

A. To design effective processes to meet the needs of patients which are consistent with the health center's mission, vision, goals, and plans.
B. To collect data to monitor the stability of exiting processes, identify opportunities for improvement, identify changes that will lead to improvement, and sustain improvement.
C. To aggregate and analyze data on an ongoing basis and to identify changes that will lead to improved performance and a reduction in errors.
D. To achieve improved performance and sustain the improvement throughout the organization.
E. To promote collaboration at all levels of the organization enabling the creation of a culture focused on performance.
F. To educate leaders and staff regarding responsibilities and effective participation in performance improvement activities.

V. ORGANIZATION

Quality improvement and assurance activities are conducted at SNCHC by:

A. **SNCHC Board:** The SNCHC Board is the final authority and is ultimately responsible for the QMP. It delegates authority and responsibility to the Executive Director who in turn, may delegate authority and responsibility to the Chief Medical Officer (CMO) and/or other Chosen designees.

B. **Quality Management Committee (QMC):** The QMC is accountable to the SNCHC Board for the quality of care and services provided by the health center. The QMC will strive to meet monthly but no less than six times per year.

The QMC identifies and prioritizes improvement opportunities and ensures that adequate resources are available to accomplish performance improvement and assurance initiatives. The Committee receives, reviews, and evaluates performance improvement activities and reports regularly to the SNCHC Board. The Committee is responsible for the following activities:

- Ensuring SNCHC adheres to clinical guidelines, standards of care, and/or standards of practice;
- Reviewing the QMP on an annual basis;

- Reviewing summary reports of incidents and patients' complaints/grievances and ensuring follow-up actions occur;
- Reviewing the results of patient satisfaction activities;
- Reviewing the results of QI/QA assessments on at least quarterly basis to identify modifications in the provision of SNCHC services, and reporting to the SNCHC Board bi-annually
- Reviewing clinical policies and procedures at least every three years.

The Quality Management Coordinator is the Chairperson for the QMC. QMC members are to include the following: one representative from the SNCHC Board, the Executive Director, the CMO, the Chief Administrative Nurse (CAN), the FQHC Operations Officer, HIT specialist and the Dental Director. The CMO may ask other staff members to participate on the committee based on their role regarding care and process improvement to enhance or continuously improve the care of patients and/or the efficiency and solvency of SNCHC.

The following positions may be invited to attend the QMC on an as needed basis: Clinic Manager, LPN/Medical Assistant, and Front Office Representation.

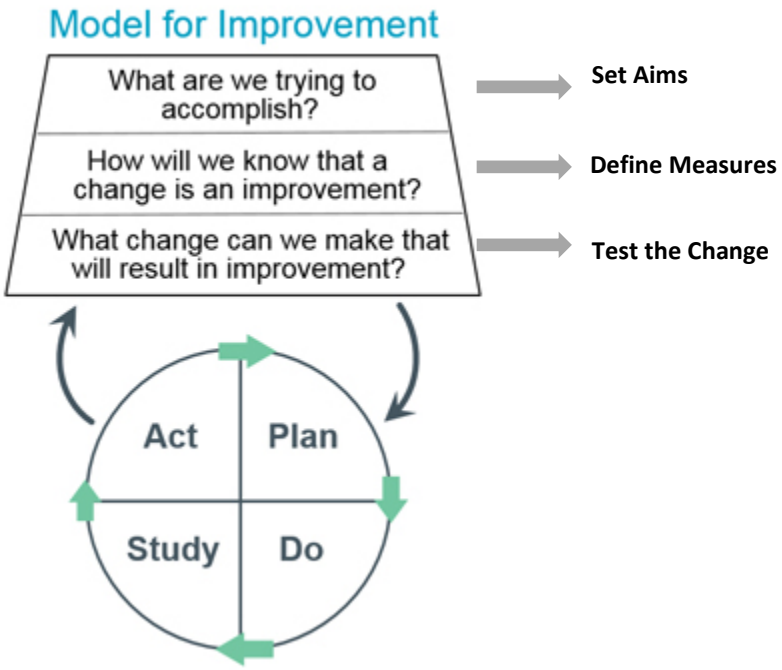
C. **Human Resources Committee:** The Human Resources Committee reports directly to the SNCHC Board and is responsible for the establishment, implementation, and rigorous review of the process to measure competencies of SNCHC staff members. Members will include a minimum of two Board members, the Human Resources Director, and other members based on their expertise and experience.

D. **Fiscal Committee:** The Fiscal Committee reports directly to the SNCHC Board and is responsible for monitoring the overall financial welfare of the clinic and assuring its financial stability. Members include the two Board members, the CMO, the Chief Financial Officer, the FQHC Operations Officer and other members based on their expertise and experience.

VI. PERFORMANCE IMPROVEMENT PROCESS

SNCHC will use the Improvement Model that consists of three fundamental questions and a Plan-Do-Study-Act (PDSA) cycle (Deming Cycle) to test and implement changes.

Figure 1: Model for Improvement



VII. COLLECTION AND CONTINOUS MONITORING OF DATA

Southern Nevada Health District's ongoing collection and monitoring program covers a multitude of variables including clinical, financial, operational, as well as patient and staff satisfaction.

Data collection activities will be based on priorities set by SNCHC's QMC Committee. The QMC Committee will consider the population served by the Center as well as high risk, high volume, and problem prone activities that occur. Requirements for data collection imposed by funding sources and legal/regulatory agencies will also be included, when appropriate. The data collected will be used to monitor the stability of existing processes, identify opportunities for improvement, identify changes that lead to improvement, and/or to demonstrate sustained improvement.

The following table is a summary of the data collection efforts that are currently underway at SNCHC as well as a schedule outlining how data will be collected, analyzed, and reported. This data will be collected within the organization's limited resources.

Table 1: Data Collection Plan

Clinical Quality			
Performance Measure	**Collected**	**Reported**	**Person Responsible**
Peer Reviews of Licensed Independent Practitioners (LIPs)	At least quarterly	At least annually	CMO/Dental Director
Audits for compliance in all areas	At least annually	At least annually	Systems Auditor
Patient appointment availability, access to clinical advice, no-show rates	Monthly	Bi-annually	CMO
Review of Uniform Data System Information	Monthly	Quarterly (Feb/May/Aug/Nov)	CMO
Patient satisfaction Surveys Results Focus groups	 Daily At least Annually	 Quarterly (Feb/May/Aug/Nov) In conjunction with strategic planning	CMO
Patient complaints	Daily	Quarterly (Feb/May/Aug/Nov)	CMO
HRSA and PCMH Requirements	As determined by guidelines	As appropriate	CMO
Clinical indicators targeted for improvement (PDSAs) and QMC programs	Quarterly	Quarterly Feb/May/Aug/Nov	CMO, CAN, Quality Management Coordinator, Sr. Compliance Specialist

Table 2: Data Collection Plan for Safety and Risk Management Subcommittee

Safety and Risk Management Subcommittee: (Reports to QMC Committee)			
Performance Measure	**Collected**	**Reported**	**Person Responsible**
Safety and Risk Management Measures			
Incident reporting (patient safety, employee safety)	Daily	Monthly (Sentinel Events only) Quarterly for all others (Feb/May/Aug/Nov)	Quality Management Coordinator, Sr. Compliance Specialist, CAN
Safety surveillance tours (care of environment)	Quarterly	Quarterly (Mar/June/Sept/Dec)	Facility Services Manager
Nosocomial infections	Daily	Quarterly (Feb, May, Aug, Nov)	CMO/CAN
Communicable disease reportable to state	Monthly	Quarterly (Feb, May, Aug, Nov)	CMO
Health Information Technology (HIT) Security	Bi-annually	Annually (Sept)	Chief Information Officer

Safety and Risk Management Subcommittee: (Reports to QMC Committee)			
Performance Measure	**Collected**	**Reported**	**Person Responsible**
Review			
HIPAA Compliance	Monthly	Annually (March)	Sr. Compliance Specialist

Table 3: Data Collection Plan for Human Resources Committee

Human Resources Committee: (Reports to the SNCHC Board as necessary)			
Performance Measure	***Collected***	***Reported***	***Person Responsible***
Competency reviews of all staff in conjunction with their annual review	Annually	Annually	CMO/Dental Director/CAN
Staff satisfaction	Annually (Survey in Oct)	Annually (Nov)	Roundtable Committee, Human Resources (HR) Director
Staff turnover	Annually	Annually (Feb)	HR Director
Staff competency patterns and trends	Annually	Annually (Feb)	HR Director

Table 4: Data Collection Plan for Fiscal Committee

Fiscal Committee: (Reports to the SNCHC Board)			
Performance Measure	***Collected***	***Reported***	***Person Responsible***
Assets/Liabilities	Quarterly	Annually (Feb)	Chief Financial Officer
Operating Revenue	Quarterly	Annually (Feb)	Chief Financial Officer
Days in Net Patient Receivables	Quarterly	Annually (Feb)	Chief Financial Officer
Days in Accounts Payable	Quarterly		Chief Financial Officer
Cost per patient	Quarterly	Annually (Feb)	Chief Financial Officer
Cost per encounter	Quarterly	Annually (Feb)	Chief Financial Officer
Payer type comparing billed/collected/budgeted	Monthly	Annually (Feb)	Chief Financial Officer
Medical user growth (Encounters/provider FTE)	Semiannually	Annually (Feb)	Chief Financial Officer
Age receivables	Monthly	Annually (Feb)	Chief Financial Officer
Profit Center Report	Monthly	Annually (Feb)	Chief Financial Officer

Other information may be collected on an as needed basis and will be based upon performance improvement objectives or other rationales.

VIII. AGGREGATION AND ANALYSIS OF DATA

Decision-making will be based upon data collected. Data will be aggregated and

analyzed by the organization in such a way that current performance levels, patterns, or trends can be identified. The organization will utilize appropriate statistical tools and techniques to analyze and display data.

When appropriate, data will be trended and compared internally over time. In addition, external sources of information will be used to benchmark SNCHC performance when it is available and appropriate to identify opportunities for improvement.

Analysis will be conducted when data indicates that levels of performance, patterns, or trends vary substantially from those expected and for those topics chosen by SHND as priorities for improvement.

At a minimum, each clinical and financial performance indicators collected for the purposes of UDS reporting will be tracked monthly. In addition, each committee will have the responsibility to establish meaningful monitoring in their area of expertise and make recommendations to the Board regarding the level of information to be shared regularly.

Each PDSA activity will establish quantitative tracking methodology and a corresponding performance goal as part of its process. More intensive aggregations and analysis of data may be required in an active PDSA activity above and beyond general monitoring.

IX. QUALITY ASSURANCE ACTIVITIES

A. Credentialing

All SNCHC Licensed Independent Practitioners, other Licensed and Certified Healthcare Practitioners, and other clinical staff are credentialed at the time of hire and are re-credentialed when their license is up for renewal (See Credentialing and Privileging Policy and Procedure).

B. Clinical Practice Guidelines

SNCHC's clinicians and staff will provide health care services with utmost accuracy, efficiency, confidentiality, and precision. All applications of health care or health care related services will be guided by appropriate governing entities. SNCHC adheres to current evidence-based clinical guidelines, standards of care, and standards of practice in the provision of medical, dental, and behavioral health services. (See Protocol Development and Use Policy and Procedure).

C. Risk Management

All employees will be informed of the principles of risk management at the start of employment, annually, and as deemed necessary. Risk management is defined by the Joint Commission as "clinical and administrative activities undertaken to identify, evaluate, and reduce the risk of injury to patients, staff, and visitors, and the risk of loss to the organization itself." SNCHC supports the establishment of a culture that emphasizes implementing evidence-base best practices, learning from error analysis, and providing constructive feedback rather than blame and punishment. Employees will be encouraged to bring their risk management concerns to the Safety Officer, their supervisor, or a member of the Safety (Risk Management) Committee at any time.

D. Incident Reporting

All employees will be oriented to the Incident Reporting Policy and Procedure that provides guidance for reporting 1) Incidents affecting patients or visitors, 2) Injury, illness or near-miss events affecting employees, and 3) Non-safety related incidents affecting patients. A summary of incidents is reported quarterly to the QMC Committee. A Board member who serves on the QMC provides a summary annually to the Board. Incidents will be assigned a "category of harm" and those incidents that have a category of harm of E-I will be reported to the Board (see Incident Reporting Policy and Procedure).

E. Patient Satisfaction

All SNCHC locations participate in patient satisfaction surveys. SNCHC distributes survey invites to patients routinely in the two most prevalent languages of the patient population, in either English, or Spanish. Survey results are reviewed and tabulated quarterly by staff and reported to the QMC. Improvements are recommended based on the survey results. A Board member who serves on the QMC provides a summary annually to the Board.

F. Patient Grievance

SHND has a patient grievance and complaint process that ensures patients can freely voice complaints/grievances and recommend changes without being subject to discrimination, retaliation or unreasonable interruption of care, treatment or service (See Patient Grievance and Complaint Policy and Procedure). The QMC is given a report on a quarterly basis and is responsible for ensuring the resolution of grievances.

G. Clinical Audits

Quality is monitored through audits, data review, and analysis to assure problems are identified (i.e. peer reviews, front desk/billing/health information technology audits, personnel files, UDS data, etc.) and reported to the appropriate manager and the management team.

H. Policies and Procedures

Policies and procedures related to quality improvement and assurance are initially approved by the Quality Management and the SNCHC Board. They are reviewed on a three-year schedule. Upon hire, staff members are assigned job-relevant policies and procedures through an online policy management system. Each time a policy is updated, all staff members who are assigned that document are required to read and acknowledge it.

Protocols, standing orders, and procedures are developed and approved by the appropriate medical/dental/behavioral health officer and are reviewed annually. These documents are also kept in the online document management software system.

I. Patient Safety Program

SNCHC is committed to improving safety for its patients at all its locations. This continuous quality improvement plan has incorporated the activities and functions necessary to establish and maintain a comprehensive program for patient safety and will be implemented at all levels of the organization.

Activities and functions that have been incorporated to address patient safety include:

- All patients will be given a copy of the Patient Rights and Responsibilities

along with the Notice of Privacy Practices at their first visit. These documents are available upon request after their initial visit. Patients will sign a form verifying that they have read/acknowledged the Patient Rights and Responsibilities and Notice of Privacy Practices.

- Communication with patients about patient safety including patient education and informing patients about their care.
- Staff education including related orientation and training and expectations for reporting.
- Safety improvement activities included in Section VII of this plan under "Collection and Continuous Monitoring of Data."
- Reporting of results to staff, committees, executive leadership, and governance.
- Process for proactive risk reduction and analysis of sentinel events.

X. PERFORMANCE IMPROVEMENT INITIATIVES

Performance improvement initiatives will be facilitated through the Quality Management Committee based on the data identified and reviewed in Section VII. A key part of this data is the UDS data which will be reviewed in February or March. After analyzing the UDS data and comparing it to the clinic's internal goals, state and national counterparts, and Healthy People 2020 goals for clinical quality, initiatives will be reassessed and determined. Initiatives will be aligned with SNCHC's Strategic Plan. As other opportunities or challenges arise, SNCHC may add or delete goals using the Plan-Do-Study Act (PDSA) process.

XI. DOCUMENTATION OF QUALITY IMPROVEMENT ACTIVITIES

Quality improvement activities will be documented utilizing a variety of tools and forms. The QMC (and its subcommittees and teams), the Fiscal Committee, and the Human Resources Committee will document their activities in a minutes' format. In addition, PDSA cycles will be documented on a cycle of change form or on PDSA worksheets. Other forms and tools that may be used to document activities include narrative reports and trend sheets.

XII. EDUCATION

Educational needs for quality improvement will be identified by the QMC and/or the CEO and will be provided in the appropriate setting. To ensure training occurs, a training plan for new employee orientation and ongoing training has been developed and is followed.

XIII. ANNUAL EVALUATION

The QMC is responsible for the annual evaluation of the appropriateness and effectiveness of the Quality Management Plan. This annual evaluation is accomplished through the efforts of the QMC. Primarily, the review will focus on the UDS data since this is the most comprehensive tool.

XIV. CONFIDENTIALITY

SHND will maintain the confidentiality of patient records, including all information as to personal facts and circumstances obtained by SHND staff about recipients of services. Specifically, SNCHC will not divulge such information without the individual's consent except as may be required by law or as may be necessary to provide service to the individual or to provide for medical audits by the Secretary of HHS or his/her designee with appropriate safeguards for confidentiality of patient records.

Confidentiality statements are signed by all SNCHC employees, contracted providers, SNCHC Board, and guests. Information including, but not limited to, minutes, reports, medical records, or other documents used will be maintained to insure confidentiality for patients and providers. Access to these records will be restricted to the administrative personnel as deemed necessary and will be kept in a locked file.

All information generated from the Quality Management Plan is considered confidential and will be exempt from subpoena or discovery. This is in accordance with Laws 2005, LB 361, Sections 71-8701 to 71-8721, which is known as the Patient Safety Act. Discussions in the context of peer reviews and medical record reviews are completely confidential.

XV. RESPONSIBILITIES

A. **SNCHC Board:** The SNCHC Board is ultimately accountable for the quality of care and services provided by SNCHC through the development of a comprehensive performance program. The Board delegates responsibility for implementation and evaluation of this program through the QMC and the Executive Director.
B. **Executive Director:** The Executive Director is responsible for implementation and evaluation of the CMP Plan as outlined in the above plan. In collaboration with the SNCHC Board, the Executive Director will work with the management team to align the performance improvement activities with the strategic plan and prioritize improvement efforts.
C. **Chief Medical Officer/ Dental Director/Chief Behavioral Health Officer/Chief Administrative Nurse:** These officers are responsible for the support of the quality improvement/assurance program and to ensure the provision of high-quality care.
D. **Managers/Supervisors:** Directors, managers, and supervisors are responsible for the implementation of the QM program for their respective units/clinics/programs. In addition, these managers may serve as chairs, team leaders or as members of committees, subcommittees, teams, and/or task forces.
E. **Clinical Staff:** Clinical staff members should be familiar with the performance measures and QM initiatives of SNCHC and their respective unit/program/clinic. Clinical staff will be active participants in the performance improvement activities through participation on committees, subcommittees, teams, and task forces as appointed. The purpose of this participation is to bring the care provider's perspective to the performance improvement opportunities and initiatives of SNCHC as well as resolution of problems.
F. **Other Professional and Classified Staff:** Staff members should be familiar with performance measures and QMC initiatives underway for SNCHC and their specific unit/program/clinic. Staff members will be asked to participate in these activities as well as on other committees, subcommittees, teams, and task forces as appointed. The purpose of this participation is to bring the perspective to the performance improvement opportunities and initiatives of SNCHC as well as resolution of problems.

EFFECTIVE (ORIGINAL) DATE: 1/8/2020
APPROVAL DATE:
REVISION DATE(S):
PRIOR POLICY: N/A

DISTRIBUTION: All FQHC Division Staff
SCHEDULE FOR REVIEW & UPDATE: Annually or as needed for modification
RESPONSIBLE FOR REVIEW & UPDATE: Executive Director
DATE(S) REVIEWED: N/A
RESCINDED DATE: N/A
REFERENCE(S): N/A
RELATED POLICIES/REFERENCE: Quality Management Policy, Credentialing and Privileging Policy and Procedure, Protocol Development and Use Policy and Procedure, Risk Management Policy and Plan, Incident Reporting Policy and Procedure, Patient Grievance and Complaint Policy and Procedure