

A large, stylized graphic of the letters 'QM' in a light green color. The 'Q' is on the left and the 'M' is on the right, both rendered in a thick, sans-serif font. The 'Q' has a white circular cutout in the center. The 'M' is composed of two vertical bars connected at the top.

Your Health Center

**QM**

Quality Management Plan

**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 safe, effective, efficient and of the highest possible quality. To carry out these responsibilities, **Your Health Center's** Governing Board and staff are actively committed to assessing and continuously improving quality and safety in everything the Center undertakes. This Quality Management (QM) Plan presents methodologies that will help achieve the Center's vision of quality and safety 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 the following three inter-related sections:

- Section I describes how the organization structures its Quality Management activities, reflecting performance improvement guidelines mandated by The Joint Commission, the requirements of the Federal Tort Claims Act, and the Program Requirement of the Bureau of Primary Health Care.
- Section II describes the three components of Quality Management.
- Section III 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 Health Center** believes that the health status of patients is positively impacted by the quality and safety of care delivered at the Center. We believe that quality and safety include all facets of our organization—clinical, managerial, administrative and facility related. All organizational improvement activities center on improving quality and safety, 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 vision, our strategic plan 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, CPE, FACPE

(NOTE: 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.)

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 the ambulatory care standards of The Joint Commission, the appropriate guidelines of the Federal Tort Claims ACT (FTCA), and the definition of quality health care as set forth by the Bureau of Primary Health Care (BPHC) as “the provision of appropriate services to individual

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and populations that are consistent with current professional knowledge in a technically competent manner, with good communication, shared decision making and cultural sensitivity. Quality health care is evidence-based, increases the likelihood of desired health outcomes, and addresses six aims—safe, effective, patient-centered, timely, efficient, and equitable—using a systems approach to continuously improve clinical, operational and financial domains.”

### **B. Purpose**

The purpose of **Your Health Center’s** Quality Management (QM) Program is to enhance patients’ health and safety, continuously improve patient perceptions of care, enhance staff morale, and improve organizational efficiency and effectiveness. Our QM Program will 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 QM Program is comprehensive and includes all clinical and administrative departments and activities that have a direct or indirect influence on the quality, safety and outcome of care delivered to all **Your Health Center** patients. This scope includes primary care, dental, family planning (Insert all provider disciplines and patient care programs that are to be included.).

All services (and sites, as appropriate) will be approved by BPHC to ensure compatibility with scope 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. 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 or safety 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 QM Program.

#### **2. Responsible Individuals**

a. The Director of Quality has overall operational responsibility for the QM Program. This position reports to the Chief Executive Officer.

(Organizations should seriously consider hiring a full-time Director of Quality. A common mistake is for the Director of Quality to report to the Medical Director. Remember that quality involves the entire organization.)

b. The Chief Medical Officer is specifically responsible for the provider performance assessment and improvement component of the QM Program. This position also reports to the Chief Executive Officer. The Chief Medical Officer is also responsible for recommending provider credentialing and recredentialing requirements to the Board in accordance with BPHC Program Information Notice (PIN) 2002-22, to minimize the Center’s exposure to malpractice claims. These recommendations 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 and safety at **Your Health Center**. The Board reviews and approves the overall QM 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 (QM) Committee**

The Board Quality Management (QM) Committee is a standing committee that monitors the ongoing effectiveness of **Your Health Center's** QM Program and ensures that the Board fully understands and is actively involved in it. The QM Committee is staffed by the Center's Director of Quality and/or the Chief Medical Officer and meets at the discretion of the chair at least every other month.

### **3. Corporate Quality Committee (CQC)**

The Corporate Quality Committee (CQC) 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 and patient safety. The CQC reports its activities and findings to the Board QM Committee.

**Your Health Center** recognizes the important role of leadership in its QM Program, as well as the need for broad-based representation from all Center stakeholder groups. Accordingly, the CQC includes the members of the Executive Staff, the Chief Medical Officer, representative providers, representatives of other major job categories, and representatives of Health Center programs such as dental and behavioral health. The CQC meets monthly, and the chair is appointed by the Chief Executive Officer.

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

## **F. Integration and Coordination**

**Your Health Center's** QM 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 and credentialing programs are closely coordinated with the overall QM Program.

The Director of Quality coordinates the QM Program with active assistance from the Chief Executive Officer, the Chief Medical Officer, the CQC and the Board QM 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 systematic improvement approach described by The Joint Commission in the "Improving Organization Performance" chapter of 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** QM Program.

- **Select Measures:** Measures are selected that are meaningful to our organization and that address the needs of the patients we serve. Measures to be included reflect all essential components of **Your Health Center's** total program. These measures relate to processes, performance, outcomes, appropriateness of decisions, and patient/staff satisfaction.

- **Collect Data:** Data are collected for all measures included in the program. Data are displayed using charts and graphs as appropriate.

- **Analyze Data:** Data are analyzed to identify trends, patterns, and performance levels that suggest opportunities for improvement. Analysis is based upon both predetermined benchmarks (internal and external) and statistical quality control techniques as appropriate.

- **Take Action to Improve:** Processes are continuously and systematically improved using appropriate methodologies.

- **Monitor Changes:** Newly designed processes or procedures, when implemented, are then reassessed (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 that generates improvements in response to claims data (see III. C., page 9). (Confirms that The Joint Commission’s methodology for organizational improvement has been built into the QM Program).

#### **H. The Role of Leadership and Management in the QM Program**

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

The philosophy of **Your Health Center** is that the QM 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. The effectiveness of this program is the direct responsibility of Center leadership.

Leadership and management are ultimately responsible for the selection and prioritization of measures to be included in the program, the frequency and efficient collection of data to be monitored and evaluated, and the prioritization and actual effectiveness of improvement activity.

An “Internal Roles” chart defining the role of leadership and management within the QM Program can be found on page 11.

#### **I. Confidentiality and Conflict of Interest**

The QM 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 Health Insurance Portability and Accountability Act (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.)

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

### **OVERVIEW**

Your Health Center’s QM Program has three fundamental components—Quality Assessment (through measurement and evaluation), Quality Improvement (both clinical and organizational), and provider-specific quality activities. The CQC 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** select important components of our total program (clinical, managerial, administrative and

facility related) that have the potential to impact the health and safety of our patients, directly or indirectly. For each of these components, specific indicators are developed or selected, measured and monitored on a continuing basis. The CQC 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 CQC.)

### 1. Indicator Selection

The management of the Health Center, in conjunction with the CQC, is responsible for the selection of quality and safety indicators to be included in Quality Assessment activity. The Center will begin with a few basic indicators and then add more indicators over time as the Quality Assessment phase matures and becomes more comprehensive. Management will select indicators to be included from both external and internal sources.

External sources could include, but not necessarily be limited to, Uniform Data System (UDS) clinical outcome and quality measures; relevant *Healthcare Effectiveness Data and Information Set* (HEDIS) indicators; measures resulting from Health Disparities Collaborative activities; health care and business plan required measures; and other currently available indicators that may have been developed by professional societies and/or state or local peer review organizations.

Internal sources could include evidence-based, Center-specific indicators that represent important aspects of care as delivered by **Your Health Center**, including things such as the accuracy, legibility and timeliness of medical records; the performance of the medication management system; and patient perceptions of safety and quality of care.

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

- a. Indicators flowing from BPHC requirements and performance improvement activities, including patient satisfaction, access, quality of clinical care, quality of the workforce, work environment, cost, productivity, health status and outcomes
- b. Indicators resulting from the Institute of Medicine's six Aims for Improvement, including safe care, effective care, patient-centered care, timely care, efficient care and equitable care
- c. Pay for Performance Measures
- d. The Joint Commission's National Patient Safety Goals

### 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 at which formal quality improvement activity should be seriously considered). Data are then collected according to the plan, summarized, displayed in user-friendly format and presented to the CQC on a scheduled basis.

### 3. Indicator Assessment

The CQC will analyze the data for each indicator and determine whether 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. The Committee also analyzes and compares internal data over time to identify patterns.

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

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#### 4. Indicator Reporting

The results of indicator measurement activity are reported throughout the organization via the minutes of the CQC.

#### 5. Indicator Tracking

When the CQC 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 CQC 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 and that organization leadership assume responsibility for prioritization. The Quality Assessment process will help with this activity. Further discussion regarding prioritization by the CQC should address the identification of high-risk, high-volume, problem-prone and high-profile issues.)

Your Health Center has identified four primary methods (including improvement teams and reengineering teams) for resolving problems identified in the Assessment phase and for improving organizational performance. The CQC 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 CQC 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 four primary methods for resolving problems or responding to opportunities for improvement are as follows:

#### 1. Process Improvement Teams

(Based on the Nolan Accelerated Model for Improvement, developed by Thomas W. Nolan, PhD, Senior Fellow at the Institute for Health Care Improvement)

Process Improvement Teams are appointed by management and are charged with improving a process by developing responses to the following fundamental questions:

- a. What are we trying to accomplish? (setting aims)
- b. How will we know that a change is actually an improvement? (establishing measures)
- c. What changes can we make that will result in improvement? (selecting changes)

The team then designs and implements (with the support of management) the Plan/Do/Study/Act (PDSA) cycle to test improvement ideas.

The improvement plan must include both a baseline measurement and a built-in mechanism to determine the effectiveness (and, when appropriate, the replicability) of the improvement. The CQC monitors progress of the improvement activity. If the PDSA cycle is successful, the resulting change is then implemented.

(NOTE: Other effective process improvement methods, such as the 10-Step Method and FOCUS-PDSA, also exist, of course. The model used here is only one example of a formal improvement methodology.)

## 2. Root Cause Analysis

Root cause analysis is required by The Joint Commission as an in-depth methodology for reaching an understanding of what went wrong in the event of significant adverse incidents or sentinel events. These could include things such as medication errors and adverse drug reactions.

A root cause analysis team is appointed by management. The team follows pre-established protocol to carry out its analysis.

## 3. Proactive Risk Assessment

Proactive risk assessment is also a requirement of The Joint Commission. As opposed to root cause analysis, a proactive risk assessment is about reaching an understanding of what could go wrong before it actually does go wrong. It involves fixing a process before an untoward event occurs. At least annually, management appoints a Proactive Risk Analysis Team. The team is charged with conducting an in-depth analysis of a high-risk, high-volume or problem-prone process, and then, based on the analysis, recommending a process improvement plan.

## 4. 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 CQC 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 QM, 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 Program. Most of these activities are now required components of the FTCA-deeming process.)

(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 in order to design or improve processes that evaluate and treat specific diagnoses, conditions, or symptoms. These guidelines are grounded in national standards. The provider staff monitors for guideline effectiveness. In addition, the provider staff has developed—and the Chief Medical Officer 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 Chief Medical Officer is responsible for ensuring that Peer Review Audits and Clinical Guidelines Audits are conducted as scheduled and designed to provide periodic assessment of the appropriateness of utilization of services and the quality of services. These audits are based upon a systematic collection and evaluation of patient records and are conducted by our physicians or other licensed health care professionals under the supervision of our physicians. 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 the necessity for Quality Improvement activity is identified and documented as the result of Peer Review and Clinical Guidelines Audits, the Chief Medical Officer appoints provider representatives to a process improvement or reengineering team as appropriate. Necessary changes (improvements) will be instituted when indicated.

### 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 Chief Medical Officer 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 CQC.

## 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 Program. 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 with both quality clinical practices and 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 health care 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, Recredentialing and Privileging

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

In addition, provider credentialing requirements (per BPHC PIN 2002-22) will be specifically detailed in writing by the Governing Board, based on recommendations from Center management (especially the Chief Medical Officer).

(Monitors the effectiveness of the credentialing, recredentialing 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 Program.

(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.)

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## INTERNAL ROLES IN QUALITY MANAGEMENT (QM)

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



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