Quality: The New Paradigm

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GAPHC

“Quality is never an accident; It is always the result of high intention, sincere effort, intelligent direction, and skillful execution. It represents the wise choice of many alternatives.”

William A. Foster

Session Objectives:

Participants will be able to:

✓ Summarize FTCA & HRSA requirements of an FQHC Quality Program
✓ Explain the key components needed for a resilient quality program
✓ Outline critical components for a Quality Plan
✓ Employ the GAPHC Quality Assessment Tool to evaluate their current program
National Programs’ Focus On Quality

FTCA & HRSA Requirements: Quality Program

Know the Regs

FTCA
- PIN 2011-05 FTCA Coverage FQHCs
- PIN 2011-01 FTCA Policy Manual
- PAL 2010-06 Year 2011 FTCA Requirements for Coverage
- FIN 2005-07 FTCA & Volunteers
- FIN 2007-13 FTCA & Emergency
- PIN 2001-21 Deeming Requirements Clarification
- PIN 2001-11 Deeming Requirements Clarification
- PAL 2005-01 Deeming Requirements Clarification
- PAL 1999-11 Section 210 Deemed Entities
- FIN 1995-23 Policies & Procedures FTCA Coverage

FQHC Program Requirements
- PIN 98-23
- Section 330(k)(3)(c) of PHS Act, 42 CFR 51c.303(c)(1-2), 42 CFR Part 74.25(c)(2) 42 CFR Part 51c and 42 CFR Parts 56.201-56.604
- Ongoing QI/QA Plan encompassing management and clinical services, maintaining confidentiality of patient records
- Focused responsibility for QI
Expectations of Quality - HRSA

HRSA/BPHC PIN 98-23

FQHC Quality Programs should:

- Have the capacity to examine topics-
  - patient satisfaction, Access, quality of clinical care, quality of the work force and work environment, cost and productivity, & health status outcomes
- Have the capacity to measure performance using standard performance measures and accepted scientific approaches.
- In analyzing performance data, health centers should compare their results with other comparable providers at the state and national level [BENCHMARK], and set realistic goals for improvement.
- Periodic reassessment

HRSA Ongoing Goal

100% of Health Centers’ Quality Programs (Plans) will be evaluated & approved by outside reviewer

- How?
  - Accreditation
  - Patient Centered Medical Home Recognition
- Strategy:
  - Providing programs that support accreditation and/or recognition

Expectations of Quality - FTCA

- “focus of responsibility” to support the QI Program
- The provision of high quality patient care
- Periodic assessment of:
  - Appropriateness of the utilization of services
  - Quality of services provided
(42 CFR 51c.303(c)(1-2)
Quality Program Summary

- Written, approved PLAN
- Information Management
  - Medical Record/EMR
  - Data Management
- Assessment of Data:
  - Appropriate use of services
  - Quality of services provided
  - Identification of future services
- Use data to identify system changes and sustaining improvements

Quality Program Summary

- "Systematic Collection"
  - Written process
  - Scheduled
  - Methodology
- Communication and training plan
- Peer Review
- Credentialing
- Privileging
- Documentation – "proof-of-life"

Key Characteristics of a Quality Program

**PATIENT-CENTEREDNESS**

Is a fundamental focus of quality care and undergirds the 5 characteristics that follow.

1. A systematic process with identified leadership, accountability, and dedicated resources available to the program
2. Use data and measurable outcomes to determine progress toward relevant, evidenced-based benchmarks
3. Focus on linkages, efficiencies and provider, and client expectation in addressing outcome improvement
Key Characteristics of a Quality Program (cont.)

4. A continuous process that is adaptive to change and that fits within the framework of other programmatic quality assurance and quality improvement activities.

5. Ensure that data collected are fed back into the quality improvement process to assure that goals are accomplished and that they are concurrent with improved outcomes.

Other Expectations for Quality

- Accreditation programs
- PCMH Recognition
- Certification programs
- Meaningful Use standards

Never forget the patients’ “definition” of quality!

Key Components Of A Quality Program
Quality Program Infrastructure

- Defines the structure and design of the quality program in the FQHC
- Includes:
  - Authority & responsibilities (for quality) for Board, CEO, Medical Director, Quality Committee, Quality staff, all providers, staff and sites
  - Policies that define and instruct the process for quality activities
  - Defines the committee structure, reporting and communication flow
  - Resources allocated for the quality program
  - Performance measures and strategic quality initiatives supported by the quality program

Quality Authority & Responsibility

- Responsibility for Quality begins and ends with the Board
- Board authorizes CEO to provide resources to support quality program
- Board assigns responsibility for quality program to Medical Director & Quality Committee
- Day-to-day activities usually assigned to Quality Coordinator

The Board’s Role

Six Key Functions
1) Establish the Mission, Vision, and Strategy
2) Build the Foundation for an Effective Leadership System
3) Build Will
4) Ensure Access to Ideas
5) Attend Relentlessly to Execution,

- Define and preserve the health center’s mission;
- Establish and monitor the health center’s policies and procedures;
- Safeguard the health center’s assets;
- Select, evaluate and support the health center’s Chief Executive Officer (“CEO”);
- Monitor and Evaluate Performance, its own as well as that of the health center; and
- Plan for the health center’s long-range future.

http://www.ith.org/
The Quality Plan:

- **Defines** the health center’s quality program
- **Summarizes** the quality infrastructure
- **Indicates** the line of authority/responsibility and how quality is communicated in the health center
- **Identifies** needed policies and procedures for the quality program and health center

“Follow the yellow brick road!
F-O-L-L-O-W
the yellow brick road!”

**HRSA PAL 2011-05 FTCA Application**

1. Minutes from the last six QI/QA committee meetings (please provide explanation if less than 6);
2. Minutes from the last six Board meetings evidencing oversight of QI/QA activities (please provide explanation if less than 6);
3. Credentialing and privileging policies; and
4. Clinical policies and procedures in the following areas: referral tracking, hospitalization tracking, x-ray tracking, and lab results tracking.
Your Quality Plan is

Your navigational compass

IT MUST BE

accurate

calibrated

reflect the health center accurately

manageable

Note: This is a legally binding document when submitted for FTCA, grant, etc

Quality Plan Purpose

A quality plan is a written document that outlines:

♦ the organization-wide quality program,
♦ including a clear indication of responsibilities and accountability,
♦ performance measurement strategies and
♦ Goals, and elaboration of processes for ongoing evaluation and assessment of the program.
Disclaimer

× This is ONE WAY to develop a Quality Program & Plan – there are other viable ways not discussed here
× The Table of Contents includes all expected (HRSA, FTCA and accreditation) elements of a robust quality program/plan
× The only absolutes are the HRSA & FTCA program expectations for FQHCs…and accreditation standards for those accredited.

Quality Plan Development

| Quality Program Description | This defines the organization, scope of project, authority and responsibility. Usually doesn’t change unless significant changes occur in the FQHC. |

Attachments

1. Measures – defined with numerator/denominator, exclusions, data collection plan and frequency
2. Work Plan and Calendar – defines and schedules the quality work for the year, including when each measure is audited and reported to the Quality Committee.
3. Quality Committee organisational structure, names and positions of the quality committee and a schedule of all committee meetings.
4. Other items referenced in the Quality program Description – but NOT policies and procedures. There should be a separate Quality Policy binder.

Quality Plan Development

♦ Divided into 4 sections
  ♦ Review & Approvals Page
  ♦ Table of Contents (TOC) – includes all topics and attachments/appendices
  ♦ Program description – main body of the document
  ♦ Attachments/appendices
Quality Plan Development

- Rationale for doing it this way:
  - First page is the Review & Approvals Page so it is obvious and requires no searching
  - TOC – developed as a Word field assures everything is included and makes it easy to locate within the document
  - Program description contains the summary of the quality program – these pages rarely change, so an annual review keeps it current
  - These documents are referred to in the Program Description and may change multiple times during the year – requiring review and approval with changes.
  - Rather than taking the entire document back for review, it is permissible to take the revised attachments (stand alone documents) through the review and approval process.

Quality Plan TOC

- Review & Approval
  - Introduction
  - Purpose
  - Guiding Statement(s)
  - Definition for Quality
  - Quality Goals & Objectives
- Overview & Planning
  - Identified customers
  - Program Scope (Scope of Project)
  - Organization-wide functions
  - Pt. Centered Functions
  - Dimensions of Performance
  - Prioritization for Performance Improvement
- Quality Program Infrastructure (structure & design)
  - Authority & Responsibility
  - Committee(s)
  - Integration of Utilization and Risk Management
  - Resource Allocation
  - Reporting & Communication
  - External Accountability
  - Strategic Quality Initiatives
  - Performance Measurement
  - Methodology for Improvement
  - Education & Training
  - Documentation & Communication
  - Reporting
  - Documentation
  - Confidentiality
- Annual Program Evaluation
- Appendices

Review & Approval

- Annual Review & Approval
- Who Reviews & Approves?
  - CEO
  - Board Chair
  - Medical Director
  - Quality Committee Chair (if that isn’t the Medical Director)
Introduction

- **Purpose**
  - Usually a statement that sums up the WHYS for organizational quality for THIS organization

- **Guiding Statement(s)**
  - Mission Statement, and/or organizational values statement, core values and/or guiding principles DEFINITION OF QUALITY - from HRSA program requirements and accreditation/recognition standards

- **Goals & Objectives**
  - Must be linked to the organization’s strategic goals – to be effective
  - K-I-S-S – limit to 2-5 significant goals and make them S.M.A.R.T.

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Purpose Statement

- **Example:**
  - ABC Health Center’s quality management strategy is a focused, comprehensive, and never-ending effort to monitor and improve patient safety and performance of all care and services provided. Its key aim is to strive, within existing resources, for optimal outcomes in a patient-centered medical home, that minimizes risks for patients and the organization, assures appropriate utilization of services and are cost-effective.

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Definition of Quality

- CQI is generally used to describe the ongoing
  - monitoring,
  - evaluation, and
  - improvement processes.

- It is a patient-driven philosophy and process that focuses on preventing problems and maximizing quality of care.
Quality Goals & Objectives

Examples:

- To align all of the FQHC’s improvement activities with the strategic goals
- To link quality initiatives with the organization’s strategic goals
- To develop an organizational culture of quality that empowers providers and staff to integrate quality improvement in their activities of daily work
- To integrate quality into staff/ provider job expectations by including performance improvement criteria in annual performance appraisals and provider contracts

Overview & Planning

- Identified customers
- Program Scope (Scope of Project)
- Organization-wide Functions
- Pt. Centered Functions
- Dimensions of Performance
- Prioritization for Performance Improvement

Program Scope

- Your Grant defines the organization’s program scope (Scope of Project BPHC PIN 2002-07)
- Defines the range of services provided within the organization. Example:
  - Pediatrics, Adult Medicine, Quality Plan Elements, OB/GYN, Primary Care, Preventive Care, Dental
- Quality Program goals and measures are set within the range of services or Program Scope
- Organization-wide Functions
- Pt. Centered Functions
Institute of Medicine: Crossing the Quality Chasm

- IOM Committee reported to Congress Committee On Quality Of Health Care In America
- "...a national statement of purpose..." for all healthcare providers
- Information technology – meaningful use of data, health information exchange
- "clinicians should be adequately compensated for taking good care of all types of patients"
- ...reinvent the nation’s health care delivery system
- Don Berwick, MD, then CEO of Institute for Healthcare Improvement, now Director of CMS was part of the COMMITTEE
- Six specific aims (dimensions of performance) care needs for healthcare TO BE


Six Aims -Dimensions of Performance

- SAFE – avoiding injury to patients from care
- TIMELY – reducing waits and harmful delays for both those who give and receive care
- EFFECTIVE – providing evidence-based services and avoiding under/overuse when it is not likely to benefit
- EFFICIENT – avoiding waste – of equipment, supplies, ideas, energy and staff
- EQUITABLE – no variance in quality because of personal characteristics such as gender, ethnicity, geographic location, or socioeconomic status
- PATIENT-CENTERED – providing care that is respectful of and responsive to individuals preferences, needs and values, and ensuring patient values guide all clinical decisions

IOM – “Healthcare Should Be STEEP”

Prioritization for Performance Improvement

- Requirement of HRSA FQHC program
- Accreditation/recognition standards
- Linked to strategic plan
- High volume
- High risk
- Problem-prone

- Impact on Safety of Pt/Staff
- Reduce waits/delays
- EBG
- Reduces waste of resources
- Culturally appropriate
- PCMH focused
### Example - Decision Matrix

<table>
<thead>
<tr>
<th>Criteria</th>
<th>Total Score</th>
</tr>
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<tr>
<td>Require</td>
<td>5</td>
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<tr>
<td>Skills</td>
<td>4</td>
</tr>
<tr>
<td>Staff</td>
<td>3</td>
</tr>
<tr>
<td>N/P</td>
<td>2</td>
</tr>
<tr>
<td>Risk</td>
<td>2</td>
</tr>
<tr>
<td>Phone</td>
<td>2</td>
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<tr>
<td>Safe</td>
<td>2</td>
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<tr>
<td>Wait</td>
<td>2</td>
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<td>EBG</td>
<td>2</td>
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<tr>
<td>Waste</td>
<td>2</td>
</tr>
<tr>
<td>Culture</td>
<td>2</td>
</tr>
<tr>
<td>Overall</td>
<td>3</td>
</tr>
</tbody>
</table>

### Quality Program Infrastructure

- **Authority & Responsibility**
- **Committee(s)**
- **Integrated Quality – Utilization & Risk**
- **Resource Allocation**
- **Reporting & Communication**
- **Strategic Quality Initiatives**
- **Performance Measurement**
- **External Accountability**

### Authority & Responsibility

- **Board** – full board: oversight authority & responsibilities
  - Designated Committees: quality, risk, credentialing
  - Description of their participation (in quality)
- **CEO**
  - Authority & responsibilities
  - Participation in quality planning
  - Role in Quality Committee/Teams: ex officio
  - To provide resources and remove barriers
**Authority & Responsibility**

✍ **Medical / Clinical Director**

- Authority & responsibilities
  - Day-to-day oversight of quality program
  - Oversight Clinical Policies & Protocols development and revisions
  - Peer Review
  - Privileging/ Credentialing
  - Utilization Assessment
  - Risk Assessment
- Linkage to medical staff committee

✍ **Quality Committee**

- Representative – all sites, all departments
- Meeting requirements – monthly, minutes & data
- Reporting mechanism – including to the Board, up & down
- Authority & responsibilities
  - Is THE oversight body for ALL quality initiatives/activities in the FQHC
  - Direct report to the Board – through the Medical Director/ QC Chair
- Sub-committees/ Teams
  - List
  - Chartered by the Quality Committee
  - Reports to the Quality Committee

✍ **Quality Coordinator**

- Authority & Responsibility
  - Facilitator of Quality Committee and subcommittees
  - Responsible for assembling agendas and minutes of committees
  - Usually compliance and accreditation/ recognition responsibilities
  - Usually risk and utilization management in smaller FQHCs
  - HIPAA privacy audits
  - Data integrity and authenticity
- Part of the senior leadership team
- MUST have dedicated time for quality activities
- Oversight of quality audits
- Oversight of annual policy review – org-wide
- Quality Reports and information/data management
- NOTE: the demands for quality, data and transparency are increasing
  - It is unrealistic to expect less than a 0.5 FTE for this position.
Quality Committee

MEMBERSHIP
- Chair – Provider
- QI Coordinator (facilitator)
- Risk/Compliance-Safety Coordinator
- All sub-committee chairs
- Medical Staff
- Clinical Staff
- Finance
- Front Office
- Medical Records
- In-house Lab Staff
- All departments/services represented
- All sites represented

SHOULD THE CEO BE PART OF THE QUALITY COMMITTEE??

POTENTIAL SUB-COMMITTEES
- Medical Staff Committee
- Risk Management
- Utilization
- Compliance & Accreditation
- Safety & Infection Control
- Clinical Services
- Finance & Admin Committee
- Ad Hoc Committees/Teams
  - HDC TEAM
  - PCMH Standard 1-6 Teams

Note: Names, roles and responsibilities will be based on the FQHC’s desired structure BUT all should report to & through the Quality Committee

Committee Structure

XZY FQHC Board

CEO  Medical Director
  QI Coordinator  Quality Committee

Risk Management
Compliance & Safety
Clinical Services
Finance & Admin
Ad Hoc Committees
Medical Staff

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In smaller organizations it is acceptable and most efficient that quality, risk and utilization management functions and measures are incorporated into the quality program. Otherwise many of the leadership and staff would be attending multiple meetings with little time to DO any improvement work!
Utilization  
Quality  
Control  
Risk  
Quality Improvement  
Utilization

Resources Allocation

<table>
<thead>
<tr>
<th>Staff Position</th>
<th>FTE Dedicated to QI</th>
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<tbody>
<tr>
<td>QI Coordinator</td>
<td>1.0</td>
</tr>
<tr>
<td>Medical Director</td>
<td>0.3</td>
</tr>
<tr>
<td>QI Team Mbrs.</td>
<td>0.1 x 10 team members = 10</td>
</tr>
<tr>
<td>TOTAL</td>
<td>2.3 FTE</td>
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</tbody>
</table>

Strategic Quality Initiatives

- Focus on strategic plan goals — executive level priorities  
- Based on needs assessments/ data  
- May be long term initiatives that carry through multiple years before completed  
- Has organization-wide impact  
- Involves new systems, process design and/or significant redesign  
- May be clinical, operational, or developmental  
- Involves multiple disciples, overtime, clinical & nonclinical and my involve the community (especially for FQHCs!)
Strategic Quality Initiatives Example

Marketing Quality Initiative:
- **AIM:** To expand the awareness and availability of services for underserved populations in counties served by ABC Health Center
- **Dimension of Performance:** Timely, Effective, Efficient, Equitable, Patient-Centered
- **Measures:** Increase in new patients; increase in applications for sliding scale
- **Process:** ** defined as part of the Team Charter and Work Plan

**All Quality Teams will have a completed Team Charter that defines all of these including measures and the process**

PCMH Quality Initiative:
- **AIM:** To redesign the healthcare system to align with NCQA PCMH standards and implement all “must pass” functions of these standards in preparation for NCQA PCMH Recognition
- **Dimension of Performance:** Safe, Timely, Effective, Efficient, Equitable, Patient-Centered
- **Measures:** **Each standards’ functions will have specific measures and deliverables and ongoing use of the PCMH Assessment Tool
- **Process:** ** defined as part of the Team Charter and Work Plan

**All Quality Teams will have a completed Team Charter that defines all of these including measures and the process**

Closing The Measure Loop

- Feedback on Design
  - Satisfaction Survey
  - Comparison of Goals
  - Pre-Design
  - Post-Design
  - Defining Goals

- Sustained Improvement
  - Improvement Measures
  - Post-Design
  - Pre-Design

- Closing the Gap
  - Pre-Design
  - Sustained Improvement

- Defining Goals
  - Feedback on Design
  - Post-Design
  - Pre-Design

- Improvement Measures
  - Feedback on Design
  - Pre-Design
  - Post-Design

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Performance Measurement

Included here is:
- Indicates who is accountable for data collection, data integrity, and scheduling of audits
- Indicates who is responsible for data analysis, review, and communicating findings (report development)
- Includes strategies on how to report and disseminate results and findings; communicate information about quality improvement activities
- Describe the process to use data to develop new QI activities and address identified gaps
- This section will stimulate several Quality Policies

Performance Measurement

Indicators/Measures, For a balanced 'report card' include:
- process,
- outcome,
- satisfaction measures

Use nationally developed measures whenever possible, rather than developing your own. Sites to access:
- HRSA Clinical Quality Performance Measures
  http://www.hrsa.gov/quality/coremeasures.htm
- Healthy People (2010 & 2020)
  http://www.healthypeople.gov/About/
- National Forum
  http://www.qualityforum.org/
- Agency for Healthcare Quality & Research
  http://www.ahrq.gov/
- NCQA HEDIS® Measures

Performance Measurement

Steps To Measure Performance:
1. Identify the critical aspects of the care and services provided
2. Identify indicators to measure these important aspects of care and service
3. Prioritize care and services that are:
   - High Risk, High Volume, Problem Prone
4. Identify benchmarks for the measures
5. Set goals
6. Identify or develop data collection tool – test new/revised tools before use
7. Establish baseline
8. Schedule periodic assessments as part of PDSA cycles
9. Develop reporting tool for measures
“Data is a lot like garbage. You have to know WHAT you are going to do with the stuff BEFORE you start collecting it.”

Mark Twain

External Accountability

- Defines the internal and external accountabilities set up for the organization.
- For all health center’s HRSA’s FQHC program requirements included here
- For those who are accredited or recognized (PCMH) should be included here

Quality Methodology
Quality Methodology

- Models of Quality
  - The Improvement Model – PDSA
  - The Expanded Care Model
- Provider & Staff Development
  - Orientation – both models
  - Team training – both models and process
  - Ongoing training as part of staff and provider meetings
  - Communication includes a summary of PDSA cycles, as well as data on specified measures

Model for Improvement

- What are we trying to accomplish?
- How will we know that a change is an improvement?
- What change can we make that will result in improvement?

Based on the sequential building of knowledge and is centered on three questions that are fundamental to all improvement activities and the Plan-Do-Study-Act (PDSA) cycle.

- The questions and the PDSA cycle allow for application to be as simple or as sophisticated as needed, depending on the situation and the people involved.
- Multiple PDSA cycles that can adapt changes to local settings allow for knowledge to be built while changes are being tested, thus reducing risk.

The Expanded Chronic Care Model

- Create supportive environments
- Strengthen community action
- Build healthy public policy
- Self-Management Support/Develop personal skills
- Delivery System Design/Improve health services
- Decision Support

Activated Community

Informed Activated Patient

Productive Interactions & Relationships

Prepared Proactive Practice Team

Prepared Proactive Community Partners

Population Health Outcomes / Functional & Clinical Outcomes

From Associates in Process Improvement: http://www.apiweb.org/API_home_page.htm
**Documentation & Communication**

- Reporting
- Documentation
  - Agendas & Minutes
  - Quality Binders
    - Quality Committee Binder
    - Team binders
    - Quality Initiative Binders
  - Credentialing, Privileging and Peer Review files
  - Document Retention
- Confidentiality

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**Quality Communication**

- Stakeholders
- Board
- All Sites of FQHC
- Staff Performance Feedback

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**Confidentiality**

- Protected & Privileged
  - The Health Care Quality Improvement Act of 1986, as amended 42 USC Sec. 11101 01/26/98. Note each state has legislation defining confidentiality and protection for individuals carrying out quality improvement activities
  - Specific requirements for maintaining confidentiality in the organization
  - Signed Attestation = Policy
  - Excellent way to remind everyone of the importance of protecting Confidentiality
  - Some accreditation agencies require it
  - At minimum, Board, QI staff and Quality Committee members, place in HR file
Evaluate the Quality Program Annually

Quality Program Evaluation
Annual Program Evaluation: Assessing Performance

- Quality Plan defines:
  - When and who is performing the evaluation
  - Written evaluation
  - Submitted to the Board
- Evaluation assesses three main areas:
  - Infrastructure Effectiveness
  - Quality Improvement Activities
  - Performance Measures

Quality Program Evaluation

- Annually evaluate the quality program:
  - Find out what is effective
  - Use concrete measures
  - What is not effective? –not working?
  - Lessons Learned?
  - What should be included going forward?
- Communicate the results
Appendices to the Quality Plan

- Work Plan – standardized and defined numerator/denominator and the universe for current year
- Health Care Plan & Business Plan
- Calendar - schedule of audits, training, ALL quality activities, etc. for the current year
- Diagram of Committee Structure
- List of Current Committee members - names and titles
- Committee(s) meeting schedules
- Information – Communication Flowchart
- List of Quality Policies
- Any other document referenced in the Program Description – in the order mentioned in the document

Measures Defined

- Measure Name
- Numerator
- Denominator
- Universe & Exceptions
- Data Source
- Benchmark/ Source
- Baseline/Our Goal
- Rational for measure & FREQUENCY of audit
- Includes ALL measures
- ANYONE should be able to complete your quality measures audits by using this tool!

Quality Work Plan

| Measure Name | Numerator | Denominator | Data Source | Baseline/Our Goal | Rational for measure & FREQUENCY of audit
|--------------|-----------|-------------|--------------|-------------------|------------------------------------------
| Diabetes Measures | HbA1c levels | All FOUR Diabetes measures will be audited quarterly for improvement | Number of adult patients age 18 to 75 years with a diagnosis of Type 1 or Type 2 diabetes whose most recent HbA1c level during the measurement year is <7% of patients in the denominator | Number of adult patients age 18 to 75 years as of December 31 of the measurement year with a diagnosis of Type 1 or Type 2 diabetes, who have had at least two visits during the reporting year and do not meet any of the exclusion criteria | Are you still using CDEMS? If so say that if not specify EMR or MR review
| Diabetes Measures | HbA1c levels | All FOUR Diabetes measures will be audited quarterly for improvement | Number of adult patients age 18 to 75 years with a diagnosis of Type 1 or Type 2 diabetes whose most recent HbA1c level during the measurement year is <7% of patients in the denominator | Number of adult patients age 18 to 75 years as of December 31 of the measurement year with a diagnosis of Type 1 or Type 2 diabetes, who have had at least two visits during the reporting year and do not meet any of the exclusion criteria | Not applicable |
**Quality Initiatives**

**Business Plan**

**Health Care Plan**

**Clinical Measures**

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**Calendar**

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<th>Jun</th>
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<td>X</td>
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<tr>
<td>2. Birth weight &lt; 1500 grams/ 1501- 2499 grams/&gt; 2500 grams</td>
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<tr>
<td>6. Mammograms</td>
<td>X</td>
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<tr>
<td>7. Blood Pressure</td>
<td>X</td>
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<tr>
<td>8. Diabetes. HbA1c &lt;7%/ &gt;7%/ equal to or less than 9%/ &gt;9%</td>
<td>X</td>
<td>X</td>
<td>X</td>
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<tr>
<td>9. Behavioral Health Measure</td>
<td>X</td>
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<tr>
<td>10. Regulatory Compliance - Infection Control</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
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<tr>
<td>11. Regulatory Compliance - HIPAA</td>
<td>X</td>
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<tr>
<td>12. Regulatory Compliance - OSHA</td>
<td>X</td>
<td>X</td>
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<td>X</td>
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<tr>
<td>13. Safety - Fire Drill/ CPR/ Disaster Drill/</td>
<td>X</td>
<td>X</td>
<td>X</td>
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<td>X</td>
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<td>14. Peer Review</td>
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<td>X</td>
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<td>X</td>
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<tr>
<td>15. Credentialing &amp; Privileging</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
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<td>17. Patient Satisfaction Survey</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
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<td>X</td>
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<tr>
<td>18. UDS Measures are collected annually</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
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</table>

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**Quality Policies examples:**

<table>
<thead>
<tr>
<th>Policy Number</th>
<th>Policy Name</th>
</tr>
</thead>
<tbody>
<tr>
<td>QM-101</td>
<td>QM Program</td>
</tr>
<tr>
<td>QM-102</td>
<td>Quality Committee</td>
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<tr>
<td>QM-103</td>
<td>Quality Minutes</td>
</tr>
<tr>
<td>QM-104</td>
<td>Conflict of Interest</td>
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<tr>
<td>QM-105</td>
<td>Confidentiality</td>
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<tr>
<td>QM-106</td>
<td>Chartering Sub-Committees</td>
</tr>
<tr>
<td>QM-107</td>
<td>QM Plan (Program Description)</td>
</tr>
<tr>
<td>QM-108</td>
<td>QM Program Workflow</td>
</tr>
<tr>
<td>QM-109</td>
<td>QM Work Plan Development</td>
</tr>
<tr>
<td>QM-110</td>
<td>Quality Methodology</td>
</tr>
<tr>
<td>QM-111</td>
<td>System Improvement: Care Model</td>
</tr>
<tr>
<td>QM-112</td>
<td>QM Program Evaluation</td>
</tr>
<tr>
<td>QM-113</td>
<td>Policy Development, Review &amp; Approval</td>
</tr>
<tr>
<td>QM-114</td>
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</tbody>
</table>
GAPHC Quality Assessment Tool

**REQUIRED COMPONENTS OF THE QI PLAN**

<table>
<thead>
<tr>
<th>REQUIRED</th>
<th>DISCUSSION POINTS/ RATIONAL</th>
<th>COMMENTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. REVIEW &amp; APPROVALS PAGE</td>
<td>Annual review and approval is required. Approval must be signed by Medical Director/Chair of QI Committee, CEO, and Board Chair. FTCA requires Board approval of current QI Plan, with this signature the Board assigns responsibilities and expectations for the organization’s quality program. This is a legal document and is binding – which is why the organization should always review carefully and assure the document reflects current practices or “how quality is done” in the organization.</td>
<td></td>
</tr>
<tr>
<td>2. INTRODUCTION</td>
<td>Provide a basic “picture” of your organization – IN ONE SHORT PARAGRAPH! Who you are, who you serve and clinic sites/ counties. Then briefly explain how QI is integrated within the system/ organization.</td>
<td></td>
</tr>
</tbody>
</table>

---

**Develop the Quality Plan:** development/revisions are based on:
- Organizational changes
- Population & services (scope of project) provided
- External requirements (HRSA, accreditation)

**Implement the Quality Plan**
- Use the QI Plan as the roadmap for implementing an integrated quality program system-wide

**Evaluate the Quality Plan**
- Did you do what you said you were going to do?
- Why? Why not?
- What were the results?
- How can next year be better?

**Act on the lessons learned to revise the Quality Plan for the next year**

---

**Resources:**

- Institute for Healthcare Improvement - [www.ihi.org](http://www.ihi.org)
- Goal/QPC - [http://www.goalqpc.com/resources_tqm_wheel.cfm](http://www.goalqpc.com/resources_tqm_wheel.cfm)
- AHRQ - [http://www.ahrq.gov/clinic/epcix.htm](http://www.ahrq.gov/clinic/epcix.htm)
- Institute for Clinical Systems Improvement - [http://www.icsi.org/](http://www.icsi.org/)
- Expanded Care Model – [www.improvingchronicillnesscare.org](http://www.improvingchronicillnesscare.org)

**The Plan-Do-Study-Act (PDSA) cycle was originally developed by Walter A. Shewhart as the Plan-Do-Check-Act (PDCA) cycle. W. Edwards Deming modified Shewhart's cycle as PDCA, replacing “Check” with “Study.”**

HRSA Resources

- HRSA PINs & PALs: http://bphc.hrsa.gov/policiesregulations/policies/index.html
- FTCA Helpline
  General Inquiries Related to Operations
  866-FTCA-HELP (866-382-2435)
- HRSA or the Office of Quality and Data: OQDcomments@hrsa.gov or (301) 594-0818
- HRSA FTCA Program
  Policy and Coverage Inquiries
  (301) 594-0818

Resources

- Institute for Healthcare Improvement: http://www.ihi.org/IHI
- Quality & Risk: http://www.hrsa.gov/qualityimprovement/
- CDN Learning Opportunities
  http://www.cdnetwork.org/NewCDN/index.aspx
- NACHC free downloads quality, risk & clinical publications
  http://iweb.nachc.com/Purchase/SearchCatalog.aspx
- National Quality Center: excellent resource
  http://nationalqualitycenter.org/index.cfm/22

Resources

- Quality Manuals & Templates: Georgia Association for Primary Health Care
  www.gaphc.org
- Jan Wilkerson, RN, CPHQ, 404-270-2172, jwilkerson@gaphc.org