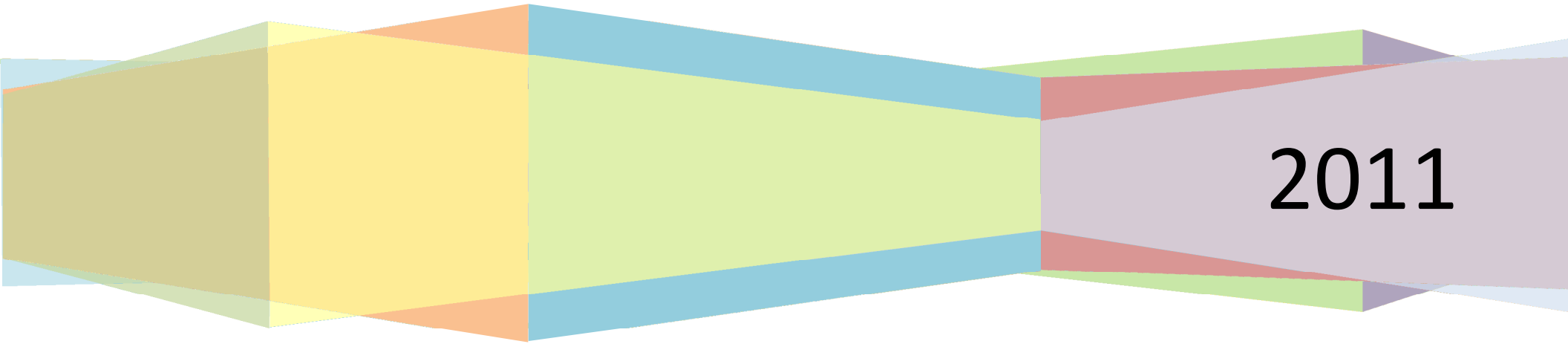
The Georgia Association For Primary Health Care

Quality Plan Assessment Tool

Jan Wilkerson, RN, CPHQ



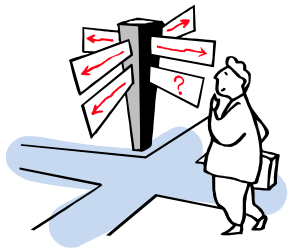
Disclaimer

This document is provided as guidance for assisting community health centers in developing a Quality Plan that will meet external requirements, like FTCA and accreditation. It is not intended to be the final word or 'authority' on developing and implementing a Quality Improvement Plan in community health centers. There are multiple ways to develop a Quality Improvement Plan in an FQHC, and what is presented here is but one way – certainly not the ***only*** way.

The format of this assessment tool is designed to guide you through your current Quality Plan to identify content that is missing and needs to be included and content that is already there but may need strengthening. Column one contains the specific header within the Quality Plan; column two provides the rationale for inclusion as well as direction for strengthening your document.

A word of caution, a template is only as good as the customization and adaptation that takes place. This is not intended to be a "canned-one-size-fits-all" template that an organization just **[insert organization's name here]** and magically have a Quality Plan. It **IS** a tool to assess the **current** Plan and offer rationale on why something should be included, or not and to assist quality staff in developing a practical, "DO-ABLE" ROAD MAP for achieving quality excellence in your organization. Achieving quality excellence in a journey, **not a destination**, and I want to share the journey with you, and maybe lighten your load.

The suggestions here come from many resources, with some of the most notable included in the Resources page, feedback from health centers and more than twenty-five years of work in the field of quality management. It is a work in progress and your comments/ suggestions can only improve the **tool**, so your input would be welcome.



Happy Journey, Jan

Jan Wilkerson, RN, CPHQ ***jwilkerson@gaphc.org*** *May 2011*

Objectives for This Tool:

- Provide a tool health centers can use to assess the organization's current Quality Improvement (QI) Plan;
- Equip health center staff to develop/ revise the Quality Plan with a format and content that will meet HRSA and accreditation expectations;
- Offer practical advice on developing and implementing a Quality Plan that meets organizational needs and supports the organization rather than being an encumbrance; and
- Inform health center staff of other resources available to assist in their quality improvement efforts

Quality Assessment

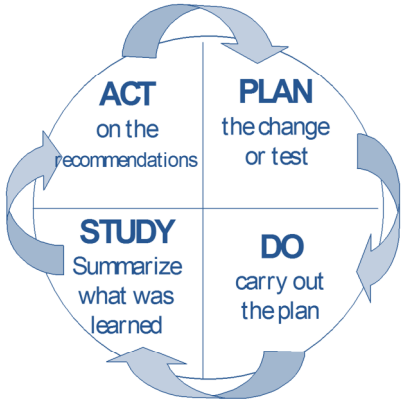
Quality assessment is a component of continuous quality improvement. Quality assessment is a systematic, ongoing cycle of collecting and analyzing evidence of a program's effectiveness. The information collected is used to evaluate how well the program's goal is being achieved, and decide what may be done to better achieve the goal.

The Quality Plan provides the "road map" for moving the organization toward quality and describes the infrastructure to support the quality program. The importance of a well-designed, functional Quality Plan cannot be stressed enough. Therefore, it is reasonable to assess the design and functionality of the health center's Quality Plan and annual Quality Program evaluation.

Development, implementation and evaluation of the Quality Plan, hence the Quality Program, is cyclic and not unlike the P-D-S-A Cycles, we have used in our HRSA Health Disparities Collaborative Teams. The Quality Program is defined by the Quality Plan and supported by the policies, committees and activities that compose the quality infrastructure. The timeline for Quality Plan development/ revision, implementation and evaluation should be an annual process because things change and as a living document, the Quality Plan and Quality Program should change with the FQHC. *(Note: current FTCA requirements are that the Quality Plan is revised and approved every 3-year by the FQHC Board)*

Jan Wilkerson, RN, CPHQ ***jwilkerson@gaphc.org*** *May 2011*

Timeline for Quality Plan revision, implementation and evaluation:



Step 1:	**Develop the Quality Plan;** development/revisions are based on: ▪ Organizational changes ▪ Population & services (scope of project) provided ▪ External requirements (HRSA, accreditation)
Step 2:	**Implement the Quality Plan** ▪ Use the QI Plan as the roadmap for implementing an integrated quality program system-wide
Step 3:	**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?
Step 4:	Act on the lessons learned to **revise the Quality Plan** for the next year

The Quality Improvement Plan is a living document – meaning it should be well worn by the end of the year, not on a shelf and "dusted-off" occasionally. All providers and staff should know where to locate the Quality Plan and each site should have a copy of the current Quality Plan and work plan measures.

Jan Wilkerson, RN, CPHQ ***jwilkerson@gaphc.org*** *May 2011*

Structure of the Quality Plan

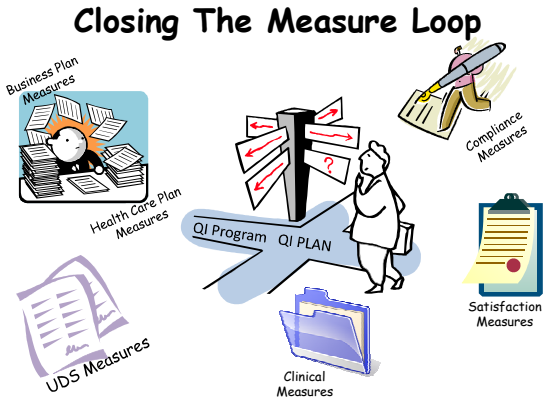
There are multiple methods of structuring a Quality Plan, but the one I am discussing here is a document with supporting attachments. That is the body of the document summarizes the quality program of the organization. Within the summary references to specific policies and/ or attachments at the back of the document will occur. The reason for this is very practical – when making changes to something within the body of the Quality Plan the full document must go back to the Board for review and approval. However, if it is an attachment then only the attachment has to go back for approval. Since the Quality Plan is a living document, – you would expect changes and tweaks during the year – but it is usually in the area of policies or attachments. (This also makes yearly review/ revision easier to accomplish!) This is an organizational decision and for future continuity, it should be well defined in a Quality Plan Development policy.

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	Some of these attachments may change during a year and the ***attachment*** would need to go back through the review process, but not the entire Quality Plan. Attachments include: 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 organizational 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. Remember this entire document is provided to multiple agencies as a snapshot of your quality program – keep it clear and as concise as possible.

A Word About Measures

First, a few words of caution: There are MANY worthwhile measures available and appropriate to health centers, do not get bogged down. #1- Chose from available measures, rather than developing your own. #2- More is NOT better, measures are only part of the quality program. #3-Select measures that is meaningful to your organization.



Focusing on evidence-based measures helps the organization focus on evidence-based guidelines. It also helps the organization to benchmark and understand where they are in relation to national/ state goals.

There are a multitude of worthwhile measures that are evidence-based to select from, and numerous areas your Quality Committee will want to improve. The temptation is to let your enthusiasm lead to too many measures at one time which often lead to frustration and failure. It is important for the Quality Committee to prioritize improvement work on what is **high volume, high risk and problem prone** within your organization plus required measures (HRSA and those required for accreditation, if applicable). By considering the resources (time, energy and staff) available and determining what can realistically be done in the next twelve-months, then developing the work plan around those measures, the Quality Committee develops a practical approach to quality improvement AND have a list of future items they will want to pursue. Besides, if you spend all your time measuring, you will limit the time you have to make the improvements!

Meaningful improvement IS the objective of the Quality Program. Linking the improvement efforts back to your mission (WHY you are there in the first place), helping all stakeholders – board members, clinicians, staff and patients to have that quality vision is the responsibility of the Quality Committee. When the quality 'vision' is viewed by all, woven into the fabric of the organization, it becomes the culture or way of life rather than an add-on annoyance the "*they*" require. Selecting measures that are relevant (*high volume, high risk and problem prone*) to your organization makes it easy for the Quality Committee to engage stakeholders in improvement activities.

Jan Wilkerson, RN, CPHQ ***jwilkerson@gaphc.org*** *May 2011*

An integrated quality program requires both process and outcome measures and measures that relate directly and indirectly to clinical services. The scope of this document is to help health centers ASSESS the QI Plan; we are limiting the measure discussion here to the 8 HRSA required UDS measures for health centers. In the resource section, there are references for other evidence-based measures for discussion in your Quality Committee. We learned in the Health Disparities Collaboratives that measures can be a powerful tool for system and policy change, but too many measures can lead us into the "more data" sink-hole and that **does not** lead to improvement. The most practical advice on measurement identification continues to be what is high volume, high risk and problem prone **for the organization.**

Once the QI Plan (road map) is completed, there are policies to develop and put into place with the implementation of the QI Program!

Let's get started…

This document is divided into two sections: the program description (infrastructure components) and the supporting attachments. This design provides ease of revision for specific attachments, rather than revising the whole document. The entire document – program description **and** ALL attachments complete the QI Plan – neither stands alone. It is entirely a preference, your plan can include all items as they appear in the document or you can refer to them as attachments. *(The important thing is that all elements are contained and that your organization can USE it.)*

Jan Wilkerson, RN, CPHQ ***jwilkerson@gaphc.org*** *May 2011*

ORGANIZATIONAL QUALITY ASSESSMENT TO SUPPORT QUALITY PLAN

ASSESSMENT COMPONENTS	DISCUSSION POINTS	✔ C COMMENTS/ ACTIONS
1. When was the last revision of the QI Plan?	The document should have a revised date, preferably in the footer, so everyone knows it is the current plan.	
2. Besides the QI Coordinator, who knows where to locate a hard copy of the QI Plan?	At least, the Medical Director and CEO, needs to know, in case the QI Coordinator leaves. Ideally, it is kept in a binder, on a shelf where staff can access/ refer to as needed.	
3. Is there a written process for revision, approval and evaluation of the QI Plan?	This should be the first of several quality policies that should be in place in the organization.	
4. Are there <u>current</u> written quality policies that define how quality improvement is performed in your organization?	Quality policies are intended to describe the processes staff will use to measure and improve the quality in the organization. From these policies, any individual should be able to complete quality audits and develop a quality report. Policies also describe the ongoing roles and responsibilities of staff and the QI Committee. This assures consistency and helps with staff and committee orientation. *(Current means within the past 12-months, the policy has been reviewed and approved by the Board.)*	
5. Do the measures specified in your current Health Care Plan match those in your QI Plan?	In the new design and HRSA expectations, these measures should mirror each other. (You may have more in your Quality Plan, but the ones listed in your Health Care Plan should be included in the QI Plan.)	

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ASSESSMENT COMPONENTS	DISCUSSION POINTS	✔ C COMMENTS/ ACTIONS
6. Does staff, not on the quality committee, know what quality measures the organization is working to improve?	It is important to engage the stakeholders and give them the quality visions, so they can help with improvement efforts!	
7. Are quality improvement activities shared in staff meetings?	Same as above. Also, if quality is to be organizational culture, it needs to be included in staff meetings.	
8. Has the Quality Improvement Committee meet (separate from staff meetings) a minimum of 6 times in the past twelve-months?	To be effective, the Quality Committee must meet and make decisions on how improvement efforts are going and what needs to happen next. Again to be effective, they should meet once a month.	
9. Are there written minutes and reports of the Quality Committee for each meeting?	Organizations must demonstrate that quality improvement activities impact organizational change. Committee minutes are an excellent way to document system/ policy changes and reflect the work of the quality committee.	
10. Does the Quality Committee provide the Board with a written report for each Board meeting on the quality activities of the organization?	While the Board delegates responsibility of day-to-day quality activities to the Medical Director, QI Coordinator and Quality Committee, the Board cannot and must not delegate oversight of the quality program. There should be an expectation at each Board meeting there will be a written Quality report and Board minutes should reflect this.	

Quality Plan Assessment Tool

REQUIRED COMPONENTS OF THE QI PLAN	DISCUSSION POINTS	✓ COMMENTS
1. **REVIEW & APPROVALS PAGE**	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.***	
2. **INTRODUCTION**	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.	
3. **PURPOSE**	WHY the QI Program Exists: The purpose of the Quality Improvement (QI) Program is for Org Name to continuously monitor, analyze, and improve our performance. This QI Program Description & Work Plan is to define the QI program and outline specific activities to be conducted during the year to promote continuous quality improvement within the organization, and support the objectives and scope of the QI Program. The ultimate objective is to continually strive to fulfill the mission of Org Name.	
4. **ORG MISSION STATEMENT**	As with everything in the organization, the quality program should support the mission of the organization. The mission statement should provide guidance on all quality activities.	
5. **PROGRAM SCOPE**	Specifies all areas/ departments/ services that the quality program encompasses. An integrated quality program includes the total operation of the organization – so there will be financial measures as well as clinical measures. *(Refer to measures.)* Health Centers, as part of their grant, are expected to file a SCOPE OF PROJECT *(BPHC PIN 2002-07)*. The Scope of Project would define the Program Scope and may list as: Specifically, the QI Program includes, but is not limited to:	

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	Monitor and evaluation of: ▪ Primary Care Delivery, ▪ Preventive health services, ▪ Management chronic disease, ▪ Acute Care provided in clinic, ▪ Specialty Services- Dental, OB/GYN, Pediatrics, and ▪ All high volume, high risk services, and problem prone issues.	
QUALITY INFRASTRUCTURE (COMPONENTS 6-9)	The Quality infrastructure includes the following components: ▪ Leadership-identifies who is responsible for quality management activities of the organization, ▪ Quality Committee structure- documents who is the chair of the quality committee, membership, who coordinates quality activities and other committees' relationship to the quality committee, ▪ Roles & responsibility- defines all key positions, departments/ services, internal and external stakeholders and expectations for the quality program, ▪ Resources- identified and provides authority for allocation of resources for the quality program.	
6. **AUTHORITY & RESPONSIBILITY**	Quality leadership would include: the Board, CEO, Medical Director, QI Coordinator, the Quality Committee and other sub-committees. Their roles and responsibilities would be described here. ▪ Board→Medical Director→QI Coordinator ▪ Quality Committee→ subcommittees like Medical Staff (Peer Review), Risk (Safety & Compliance), HDC Teams and other Quality Teams as defined by the Quality Committee. The Board has legal responsibility for the quality of services provided to the community. The Board retains oversight of the QI Program while delegating day-to-day activities to the Medical Director and/ or designee*. The Board also authorizes the CEO to provide resources (staff, time, etc.) to accomplish this approved QI Plan. The Board assigns responsibility to an established Quality Improvement Committee as defined in this document. *Designee→ Rarely will any clinician have time to attend to the daily activities of QI, so	

<table>
<tr><th>REQUIRED COMPONENTS OF THE QI PLAN</th><th>DISCUSSION POINTS</th><th>✔ COMMENTS</th></tr>
<tr><td></td><td>it is usually delegated to a QI Coordinator –by FTCA requirements is to be a licensed health professional –RN, LPN, RT, etc. because in order to assess medical record clinical judgment is required. (There are some who argue this, but for FTCA* states it in this way..)
* FTCA specifics this designee (or QI Coordinator) to be a <u>licensed health professional.</u>
<u>(42 CFR 51c.303(c)(1-2)</u></td><td></td></tr>
<tr><td>7. RESOURCES ALLOCATED TO QUALITY</td><td>This is to define how much and what resources are allocated to the Quality Program. I usually use a simple table to depict it:
<table><tr><th>Staff Position</th><th>FTE Dedicated to QI</th></tr><tr><td>QI Coordinator</td><td>1.0</td></tr><tr><td>Medical Director</td><td>0.2</td></tr><tr><td>QI Team Mbrs.</td><td>0.1 x 6 team members</td></tr></table>I also just put the position that way if the individual changes but the position remains the same, it eliminates the need for revision. The individual will be named in the attachment QI Committee members.</td><td></td></tr>
<tr><td>8. COMMITTEE(S)</td><td>The roles and responsibilities of the Quality Improvement Committee (QIC) are defined here. The important aspect here is to demonstrate that the QIC is a multi-disciplinary group, that it is balanced and representative of all departments in the organization (integrated) and empowered to carry out improvement activities in the organization. It is also important that the committee members be representative of the various positions in the organization. For ease of getting things done, organizations will assign all department heads to be on the QIC – so they can have department head meetings AND QIC meetings at the same time –NOT! Not only is this counterproductive, it will not meet expectations for a QIC and business (AND MINUTES) / quality activities get blurred. To be effective, the QIC needs to be multi-disciplinary and multi-functional – the improvement insights gained with this type of group is phenomenal! Also, I suggest a method of annually rotating staff onto the QIC – so everyone gets an opportunity to participate.

<u>Written Quality Plan example</u>:</td><td></td></tr>
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REQUIRED COMPONENTS OF THE QI PLAN	DISCUSSION POINTS	✔ COMMENTS
	The Medical Director has delegated the day-to-day responsibilities of the QI Program to the QI Coordinator, who works closely with the Medical Director. The QI Coordinator in conjunction with the Medical Director will act in a facilitative and consultative manner to assist the Quality Improvement Committee (QIC) in the implementation of policies, plans and projects aimed at improving performance, achieving/maintaining compliance and accreditation or external (HRSA) Performance Review. Membership of the QIC is a multidisciplinary group representative of the organization to include the different facilities operated and services provided by the organization. The QIC is composed of the following members: (Refer to attachment C for list of current QIC membership and diagram of QIC.) ▪ *Medical Director →CHAIR* ▪ *QI Coordinator→facilitates meeting* ▪ *CEO →supports & removes roadblocks* ▪ *Compliance, Safety & Risk Coordinator* ▪ *Medical Staff* ▪ *Clinical Services* ▪ *Finance & Front Office* ▪ *Medical Records* *The QIC can create permanent sub-committees (i.e. Medical Staff, and Safety) and ad hoc sub-committees (i.e. Medical Records Committee, and Human Resource Committee). The role of these committees will be defined in their charter and they will submit their findings and recommendations to the QIC. Permanent Sub-Committees are Medical Staff, and the Safety-Risk Committee. Each meets monthly and provide a report of activities to the QIC before the next scheduled meeting of the QIC.* *The main responsibility of the Medical Staff Committee is to conduct Peer Review, privileging and re-credentialing recommendations. [This information is protected and confidential, so the only report back to the QIC or Board would be Peer Review, privileging and re-credentialing was completed and recommendations will be taken to the Board by the Medical Director]. All documentation and data collected by this committee are protected and privileged under Georgia Code #3910 (GA. L. 1975) when maintained in a secured and confidential manner. Refer to organizational policies for*	

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	Credentialing, Privileging and Peer Review. *The scope and length of project for an Ad Hoc committee and work groups will be defined by the QIC prior to chartering the ad hoc committee. The Charter will include their charge, a timeframe for completion and suggested dissolution dates. Ad Hoc committees can become permanent sub-committees when approved by the QIC. Currently, there are no Ad Hoc committees of the QIC.* *The QIC submits a report to the Board at each regular meeting.* **Policies needed to define procedures and processes for completing QIC responsibilities.** ***Note each state has a Code defining Peer Review protection for the provider and is covered by the federal** The Health Care Quality Improvement Act of 1986, as amended 42 USC Sec. 11101 01/26/98.*	
9. **ACCOUNTABILITY**	Defines the internal and external accountabilities set up for the organization. For all health center's it is their HRSA grant responsibilities, but those who are accredited will address that as well. Also, if there are special partnerships that require quality improvement reporting/ accountability you would include them here – like the participation in the Health Disparities Collaborative – Diabetes (for example).	
10. **CONFIDENTIALITY**	Defines the protected and privileged nature of quality activities and how the organization will protect confidentiality in compliance with state and federal laws. It is important to be knowledgeable of the rights and responsibilities of the Ga. Code #3910 (GA. L. 1975), HIPAA and The Health Care Quality Improvement Act of 1986, as amended 42 USC Sec. 11101 01/26/98 and have policies in place to assure these are followed. I recommend a Confidential Attestation for each QIC member and Board member – to be resigned annually. This builds in annually training and reminder of confidentiality and underscores the importance for all individuals participating in quality activities to be discrete.	

REQUIRED COMPONENTS OF THE QI PLAN	DISCUSSION POINTS	✔ COMMENTS
	Policies needed to define procedures and processes for Confidentiality Attestation and expectations – Board, staff and QIC members. Written Quality Plan example: *Records and information generated in the performance of the medical staff and other allied professional staff and the CQI program activities are confidential and protected as privileged information under Ga. Code #3910 (GA. L. 1975). Health care providers duly appointed and acting within the scope and functions of the program are protected under Georgia Law from liability and damages.* ***All copies of minutes, reports, worksheets and other data will be maintained in a manner assuring strict confidentiality. A written confidentiality policy detailing procedures for maintenance and release of data and other Quality Improvement information will be utilized to assure compliance with the confidentiality policy. Annually each QIC member and Board members participating in quality improvement activities are required to sign the Confidentiality Policy.***	
PERFORMANCE MEASUREMENT **(COMPONENTS 11-13)**	This section defines the technique (process of HOW) the organization improves quality. In order to be effective, the process must be systematic with continuous activities that lead to measureable improvement. Included here is: ▪ Indicates who will collect and analyze data ▪ Indicates who is accountable for collecting, analyzing and reviewing performance data results and communicating findings ▪ 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	

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	identified gaps ***This section will stimulate several Quality Policies to be developed to support this document.***	
11. **METHODOLOGY FOR IMPROVEMENT**	This is the section where you describe what process or method the organization will use to go about improving quality. There are several models out there like FOCUS PDCA, PDCA, FADE, IMPROVE, etc. it is up to the organization to identify and adopt ONLY one as the QI process. It will be used throughout the organization and all improvements will be documented in this format. I value the Improvement Model as taught during the Health Disparities Collaborative (HDC) because when employed correctly it has demonstrated that it will keep the QI Committee, team or individual on track and focused on what needs to be accomplished. The key focus here is there is a **formalized, consistent** process for improving quality, used by the entire organization. FTCA*(42 CFR 51c.303(c)(1-2)* specifies: ▪ Assessments shall be: • Based on the systematic collection and evaluation of patient records • Identify and document the necessity for change in the provision of services, and • Result in the institution of such change, whenever warranted ***Policies needed to define procedures and processes***	

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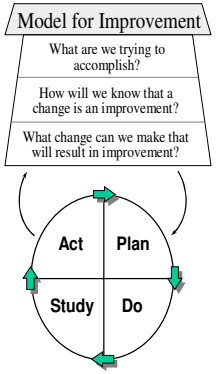	▪ What are we trying to accomplish? ▪ How will we know that a change is an improvement? ▪ What changes can we make that will result in improvement? Employing the PDSA Worksheet as a documentation tool is part of this written process. ***Policies needed to define procedures and processes***	
12. **SYSTEM DEVELOPMENT: CARE MODEL**	This is NOT a requirement, but for health centers that have/ are continuing to implement system changes this is an excellent strategy to use. It incorporates the evidence-based guidelines, population focus and embeds them into organization SYSTEM change for improvement. The Care Model consists of six components for clinical delivery system changes, when paired with the Improvement Model improvements are identified, implemented and sustained. It is important to note that all staff is trained on how to use the Improvement Model, PDSA cycles, and the Care Model. ***Policies needed to define procedures and processes***	
13. **DATA MANAGEMENT & COMMUNICATION**	This section defines the system of data collection – electronic, medical record review or both, indicates accountability for data collection and analysis. Describes how the aggregate data is provided to the appropriate committee for review and determination and how those finding and recommendations are distributed within the organization. Communication is on two levels: first is the quality work that must be done – with tools	

REQUIRED COMPONENTS OF THE QI PLAN	DISCUSSION POINTS	✔ COMMENTS
	and data, needs assessment, trend identification etc. communicated to get the job done. The second level is about stakeholder engagement. This is to communicate and connect improvement-activities so internal and external stakeholders can "see" quality improvement in the organization. Similar to how HDC teams communicated their improvements in the organization – storyboards, newsletters and posters. *Note: data collection tools are part of the policies developed rather than part of this document. Those tools may be revised multiple times by the teams employing them and do not have to be included here. This also prevents the Quality Plan from being too cumbersome. The purpose here is to summarize the process.*	

GOALS & MEASURES	▪ Quality Goals are targeted conditions toward which the quality program will direct efforts and resources
	▪ Top priorities for the Quality Program
	▪ Limit to no more than 5 goals with broad range
	▪ Established numeric value based on national/ state benchmarks
	▪ Goals should be SMART
	  ▪ Specific
	  ▪ Measurable
	  ▪ Achievable
	  ▪ Realistic
	  ▪ Time specific
	▪ Critical aspects of care and services provided in the organization (from the Program Scope) are identified and quantified; ensure integration of all required measures (HRSA, Medicaid/ Medicare, Health Care Plan, etc)
	▪ Determine indicators (measures) that disclose the progress of the Quality Program	

14. **QUALITY GOALS**	These 5 (or less) are the priority of the quality program. *EXAMPLES OF GOALS:* ▪ To measure, monitor, and improve performance in key aspects of clinical	

REQUIRED COMPONENTS OF THE QI PLAN	DISCUSSION POINTS	COMMENTS
	and health services delivery for our patients, providers, and employees for the coming year ▪ To provide a foundation for complying with regulatory and accrediting agencies, such as, the HRSA Performance Evaluation and Joint Commission accreditation in 2009 ▪ To redesign guidelines, protocols and procedural operations with the objective of producing a medical home health care delivery system that improves clinical and functional outcomes for patients served at this facility These are the **priorities** of the organization because they are part of their strategic plan, business plan and health care plan, therefore they can become a priority for quality improvement activities in the organization. To be consistent, the measures below should support these priorities and goals in some fashion.	
15. **QUALITY MEASURES**	Here I LIST only required measures and describe that other measures are identified as critical aspects of care and services by being high volume, high risk and /or problem prone. Then I refer to the Quality Work Plan for a complete list and definitions of all measures for the Quality Program.	
16. **ANNUAL EVALUATION**	This section describes the purpose and summarizes the Quality Program Evaluation process. Includes: ▪ Evaluation of the effectiveness of the Quality Infrastructure to identify needs to improve HOW quality work gets done ▪ Evaluation of quality activities to determine if the goals of the Quality Program were met – why/ why not? ▪ Reviews the performance measures to document whether the measures are appropriate to ASSESS the clinical and non-clinical care provided- why/ why not? ▪ Makes recommendations for the development of the next year's Quality Plan, including goals & measures, infrastructure redesign and improved communication of quality activities/ results	

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	▪ Annual Revision→ This implies and needs to state how the Quality Plan will be revised – annually, by whom and go through the approval process. Specifies who will initiate the process, what the sign-offs are and when it is to be taken for review/ approval. Again this is a summary, with Quality Policies defining the entire process. ▪ Annual evaluation is a separate document that provides a summary of activities and findings and is submitted to the Board for review at the end of each calendar year. *(January 2010 for year ending 2009)*	
IMPLIED COMPONENTS OF THE QUALITY PLAN	These must either be addressed in the Quality Plan or as Quality Policies. In an effort to keep the Quality Plan basic and not cumbersome, I prefer to address these in Quality Policies and will be addressed in the Quality Manual. However, I list them here so they are not forgotten: ▪ Participation of stakeholders – internal & external ▪ Quality training for staff – to engage them and make it an organizational culture ▪ Spreading quality improvements and lessons learned – from site to site, organization to organization ▪ Develop feedback loops – satisfaction from internal and external customers and how data is used to improve processes in the organization ▪ IMPLEMENTATION of the Quality Plan – it is great to have a plan…only if it is implemented! Quality work with the Quality Committee should begin at the beginning of each calendar year.	
ATTACHMENTS TO THE QI PLAN	Documents that Support the Quality Plan or are referred to within the document. Again, it is advisable to limit these and not include Quality Policies, to keep the documents manageable. ***Policies needed to define procedures and processes see below***	

REQUIRED COMPONENTS OF THE QI PLAN	DISCUSSION POINTS	✔ COMMENTS
17. **MEASURES:** **WORK PLAN & CALENDAR**	**Work Plan:** Each measure is defined numerator/ denominator, data collection method, benchmark and performance goal. Reliable, valid measures must be established so key elements of organizational function can be monitored. Measures of healthcare performance can be process or outcome measures. Process measures answer the question, "Are we doing the right things?" Outcomes measures answer the question, "Are we doing the right things well?" Other measures include adverse sentinel events defined as "an unexpected occurrence-involving death or serious physical or psychological injury, or the risk there of" (Joint Commission, 2008). Such events typically are rare occurrences with grave consequences. They require immediate investigation and development of root cause analysis. **Calendar:** is a simple spread sheet checklist that depicts what measure is being assessed for each month of the year. The frequency of the measurement depends on how often the process or activity repeats itself. Assessing a measure once a year is NOT advantageous to improvement. The expectation is there is a calendar demonstrating a planned approach to quality activities with a subsequent report to the QIC.	
18. **COMMITTEE MEMBERS**	▪ Each Committee/ quality team provides the names and titles of their current membership ▪ Updates whenever membership changes ▪ Include: • QIC Diagram & Member List • Medical Staff Member List • Risk Management Committee Member List • Any other Committee performing quality functions • Ad Hoc/ QI Team – include their team charter form to define who and why they	

REQUIRED COMPONENTS OF THE QI PLAN	DISCUSSION POINTS	✔ COMMENTS
	exist	
19. **Annual Confidentiality Attestation**	***Can be listed as separate policy but needs to be done for everyone participating in quality activities.*** ***Policies needed to define procedures and processes***	
20. **Annual Conflict of Interest Statement**	***Can be listed as separate policy but needs to be done for everyone participating in quality activities.*** ***Policies needed to define procedures and processes***	
21. **PDSA WORK SHEETS OR ANY OTHER DOCUMENTS REFERRED TO IN THE QUALITY PLAN**	If it was referred to and is NOT a written Quality or organizational policy include it as an attachment. If it is a policy – quality or other organizational- be sure it has been revised, approved and is current. ***These should be kept in a separate binder as completed.***	

Resources:

- **FTCA http://bphc.hrsa.gov/ftca/**
- **Federal Law FQHCs http://www.access.gpo.gov/nara/cfr/waisidx_08/42cfr51c_08.html**
- **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**
- **Joint Commission http://www.jointcommission.org/**
- **National Association for Healthcare Quality http://www.ncqa.org/tabid/661/Default.aspx**
- **Institute for Healthcare Improvement http://www.ihi.org/IHI/**
- **Quality Indicators http://www.qualityindicators.ahrq.gov/general_faq.htm**
- **National Quality Center is a HRSA website for HIV Quality Improvement and has excellent tools and tutorials to help staff understand quality management – just insert "primary care" for HIV in most places and they are applicable. Main difference will be measures (see below) http://nationalqualitycenter.org/**
- **Evidence-based Measures and quality tool kits: http://www.innovations.ahrq.gov/qualitytools/**

For more about Quality Plan templates and Quality Policies templates please see our website www.gaphc.org or contact Jan Wilkerson at 404-270-2172 jwilkerson@gaphc.org

Jan Wilkerson, RN, CPHQ ***jwilkerson@gaphc.org*** *May 2011*