Sacramento County

DHHS Primary Health Services Division

Clinic Services

Quality Improvement Plan

FY 2016-2017

Draft 8 15 16

OVERVIEW

Clinic Services demonstrates through its Quality Assurance/Quality Improvement Program a systematic approach to quality measurement. This Quality Improvement Plan (QIP) describes this process which includes methods to monitor performance and implement changes in practice when necessary, with follow up measurement to determine whether new practices positively affected performance.

Part of the ongoing Quality Improvement Program includes clinical services reviews (chart review, peer review) is conducted by physicians or by other licensed health professionals under the supervision of the Medical Director

Risk management is integral to quality management and includes annual staff safety training per state requirements, quarterly reports of grievances, complaints and service issues, medication error rates, referrals not authorized. As a public entity, a separate department oversees insurance, legal compliance etcetera, governs agency risk management.

Health Center Mission

- Improved health outcomes through high quality service with a patient centered focus.

Values

- Partnership
- Accountability
- Innovation
- Integrity

Goals

- Strong clinical outcomes
- Engaging and Effective Patient Experience
- Create ideal environment for providers, clinical learners and faculty
- Budget targets met

Guiding Principles for Service Provision

- Consistent access to care
- Respect, sensitivity, competency with /for special populations
- Safe and attractive environment for clients, visitors and staff
- Culture acknowledges that all team members provide essential high quality services
- Effective communication and information sharing
- Data informed practices
- Continuous improvement

PROGRAM STRUCTURE

Quality Improvement Committee (QIC)

1. The QIC is established to provide operational leadership and accountability for continuous quality improvement activities.
2. QIC meets at least monthly or not less than ten (10) times per year.
3. The QIC participants represent different disciplines and service areas within Health Center.
   - Medical Director – Chair of the QIC, clinical lead
   - Pharmacy Director –Leads efforts related to review of medications, protocols or formulary changes.
   - Health Center Program Manager – Leads efforts related to managed care, HRSA, fiscal and key liaison to the Co-Applicant Board.
   - Supervising Registered Nurse-Leads efforts related to nursing services, provides data and information from chart and system reviews
   - Other committee members may include program coordinators pharmacists, LCSW/MFT, etcetera as needed.
4. QIC responsibilities are:
   a. Develop and adopt the annual QI Plan that includes a specific approach to Continuous Quality Improvement (CQI).
   b. Establish measureable objectives and indicators of quality based upon identified priorities.
   c. Monitor data indicating progress toward goals on these indicators
   d. For indicators out of target range, propose actions and strategies to the Health Center Management Team.
   e. Report to the Co-Applicant Board on quality improvement activities on a regular basis.

5. HRSA Co-Applicant Board
   a. The Co-Applicant Board Authorities are outlined in Clinic Services P&P 01-02.
   b. The Co-Applicant Board delegates authority and responsibility for all matters relative to the Quality Improvement Program to the QIC.
   c. This Board reviews, evaluates and approves the Quality Improvement Plan annually and receives quarterly reports on identified quality indicators.

QUALITY IMPROVEMENT GOALS AND OBJECTIVES FY 16-17

Strong clinical outcomes

1. **Improve from 75% to 80% the percentage of patients with diabetes whose condition is under control.**
2. **Improve from 70% to 75% the percentage of patients with hypertension whose condition is under control.**

Engaging and Effective Patient Experience

1. **Access to care meets standards per policy 80% of months**
2. **Reduce No Show rate from 27% to 20%**
3. **Achieve 80% satisfaction on patient survey results**

Create ideal environment for providers, clinical learners and faculty

1. **Achieve 80% satisfaction on survey of providers clinical learners and faculty**
2. **Achieve desired targets as set by UCD schools of medicine and nursing**

Budget targets met

1. **Consistently meet productivity targets of 16 patients seen per day per FTE**

Performance Indicators are identified and measured part of the quality improvement initiatives. They:

- Have defined data elements
- Have a numerator and denominator available for measurement
- Can detect changes in performance over time and allows for a comparison over time.

Outcomes / Process Measurements are those that:

- Identify of measureable indicators to monitor the process or outcome
- Collect data for specified time period, or ongoing
- Evaluated against a threshold or target
- Evaluate the effectiveness of defined action(s)

Data Analysis is used to establish:

- Priorities for improvement
- Actions necessary for improvement
- Whether process changes resulted in improvement
- Performance of existing key processes

CQI Clinic Services utilizes a Plan–Do–Study–Act (PDSA) for focused intervention. See PDSA Work Sheet.

PLAN	Identify area target not met Identify most likely cause(s) through data review Identify potential solution(s) and data needed for evaluation
DO	Implement solution(s) and collect data needed to evaluate the solution(s)
STUDY	Analyze the data and develop conclusions
ACT	Recommendations for further study / action. This depends upon results of the analysis. If the proposed solution was effective, decisions are made regarding broader implementation including the development of a communication plan, etc. If the solution was not effective, QIC returns to planning section.

COMMUNICATION AND COORDINATION

Communication Leaders, through thoughtful inclusion and communication, ensure the staff and the Co-Applicant Board are aware and involved in QI initiatives. Leadership promotes CQI by

1. Sharing this plan including indicators and targets with staff at all levels
2. Multiple disciplines and services areas are involved in performance improvement work and reporting.
3. Information alerts or policy and procedure guidance are provided by Management Team.
4. Key priorities are imbedded in the architecture of Health Center policies, training and other core materials.

CONFIDENTIALITY AND PRIVACY OF PERSONAL HEALTH INFORMATION

All data and recommendations associated with quality management activities are solely for the improvement of client care. As such, all material is confidential and is accessible only to those parties responsible for assessing quality of care and service. All proceedings, records, data, reports, information and any other material used in the quality management process which involves peer review shall be held in strictest confidence and considered peer review protected.

The Health Center will minimize use of identifiable protected health information for quality measurement to protect it from inappropriate disclosure. Reports for committee review regarding data analysis and trending shall not disclosure a client's protected health information. Use of aggregate data or reports will be maintained in minutes.

Personal Health Information obtained as a result of a client complaint or appeal is kept in a secure area and is only made available to those who have a need to know. Computer access to personal health information about a client's complaint or appeal is limited by a pass code for only those who need access.

Clinic Services Policies and the County Office of Compliance have extensive policies and procedures related for health information management and protected health information.