Sacramento County Health Center

Quality Improvement Plan

2019

Department of Health Services
Primary Health Division
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OVERVIEW

Sacramento County Health Center has a systematic approach to quality measurement and quality improvement. The Quality Improvement (QI) Plan outlines the 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.

Review of data is essential to the QI process. Data can include but is not limited to: performance indicators, satisfaction surveys, member concerns (complaints, grievances), service utilization, medication errors, chart review, etc. Compliance and risk management are also integral to quality management. The Health Center is a public entity and has separate units or departments for Compliance (HIPAA), risk management, contracts, fiscal, safety, information management, and counsel.

Health Center Mission

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

Values

- Partnership
- Accountability
- Innovation
- Integrity

Goals

- Effective clinical outcomes.
- Engaging and effective patient experience.
- Create an ideal environment for providers, clinical learners, faculty, and staff.
- Develop indicators for tracking QI projects.
- Operates within fiscal parameters.

Guiding Principles for Service Provision

There is:

- Access to care for routine, same day, and new members.
- Respect, sensitivity, and competency for populations served.
- A safe and attractive environment for clients, visitors and staff.
- A work culture that acknowledges 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. This includes: the Medical Director, Pharmacy Director, Project Director, Program Planner, designated Administrative Services Officer (Reports), and various representatives for Clinics, physicians, and nursing.
4. QIC responsibilities include:
    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, develop actions and strategies for Health Center Management Team implementation.
    e. Report to the Co-Applicant Board on quality improvement activities on a regular basis.
5. Management Team responsibilities include:
    a. Implement strategies and provide education to staff.
    b. Report back to the QIC.
6. Health Center Co-Applicant Board:
    a. Authorities are outlined in Clinic Services P&P 01-02.
    b. Delegates authority and responsibility for the QI Program to the QIC.
    c. Reviews, evaluates, and approves the Quality Improvement Plan annually and receives quarterly reports on identified quality indicators.

PERFORMANCE INDICATORS & ANALYSIS

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 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

Problems may be identified from data, staff, managers, concerns, audits, or agency feedback. Managers are responsible to:

1. Share the plan including indicators and targets with staff at all levels.
2. Include multidisciplinary staff from all areas of operations in problem identification, developing strategies, implementing interventions, and review of data analysis.
3. Provide information alerts or policy and procedure guidance.
4. Imbed key priorities into 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 & Procedures Manual and the County Office of Compliance have extensive policies and procedures for health information management and protected health information.

2019 QUALITY IMPROVEMENT GOALS AND OBJECTIVES

Care Coordination

- Goal: Improve care coordination of members with high service utilization, or who require services across systems.
- Objective 1: Implement a care management policy & procedure.
- Objective 2: Designate care management team.
- Objective 2: Develop care management plans for 30 patients who have been identified as meeting high utilization and complex conditions based on policy & procedure criteria.

Clinical Performance Measures

- Goal: Improve performance on UDS and HEDIS quality measures.
- Objective 1: Train providers on OCHIN documentation work flows to capture data.
- Objective 2: Select Measure(s), use 2018 base, and review progress quarterly. Measures to consider based on 2018:
    - Children and adolescents (ages 3 – 17) who had height, weight, and body mass index percentile recorded show documentation of counseling for nutrition and counseling for physical activity.
    - Two year olds fully immunized.
    - Adults (18 years and older) who had a follow-up plan when BMI is outside of normal parameters.
    - Adults (ages 18 – 85) who had a diagnosis of hypertension and whose blood pressure was adequately controlled.

Patient Access

- Goal: Consistently review availability of major appointment types (urgent care, new patients, follow-up) to meet the needs of patients and adjust availability as needed.
- Objective 1: Routinely follow managed care timely access requirements for appointment wait times:
    - 48 hours for urgent care with no prior authorization;
    - 10 business days from request for non-urgent primary care;
    - 15 business days from request for specialist;
    - 10 business days for first prenatal visit;
- Objective 2: Reduce No Show rate incrementally.
- Objective 3: Increase patient utilization of CareMessage text messaging from ___% to ____%.

Patient Experience

- Goal: Promote a positive and effective patient experience.
- Objective 1: Minimally achieve 80% satisfaction on identified key elements of patient survey.
- Objective 2: Decrease inbound contact wait times from ___ minutes to ___minutes.