## I. PURPOSE

As part of the Southern Nevada Community Health Center's (SNCHC) dedication to providing quality care, SHCHC has implemented a Quality Management Program, a systematic, organization-wide approach to provide uncompromising quality care and service to clients. Through this systematic approach, the Quality Management Program provides a mechanism to constantly survey the performance of SNCHC and provides opportunities to improve performance levels.

## II. SCOPE

SNCHC's Quality Management Program is outlined in its Quality Management Plan (QMP). The Plan's scope involves the physicians, nurses, allied health disciplines, community service agencies, administrators, managers, and staff that provide care to the uninsured or underinsured individuals of our community. The program focuses on improving key organizational functions within SNCHC, and is aligned with HRSA's BPHC Program Expectations, the NCQA Patient-Centered Medical Home (PCMH) standards, and appropriate guidelines of the Federal Tort Claims Act (FTCA). The key functions are assessed by collecting and analyzing data related to one or more dimensions of performance, which includes but may not be limited to efficacy, appropriateness (evidenced-based medical practice), availability, timeliness, effectiveness, continuity, safety, efficiency, and respect and caring. The six key functional areas within the scope of SNCHC's QMP are:

- Care Management: Biological, social, and/or quality of life consequences of patient health through clinical and social evaluation and management of care and services in areas such as preventive health, acute or chronic conditions, and behavioral health.
- Safety: Capabilities to promote a safe environment for clients by evaluation in areas such as client and provider education, continuity, and coordination of care.
- Financial and Administrative: Ability to manage the financial and administrative aspects of the organization efficiently and effectively.
- Network Quality: Periodic peer review assessments of client records by physicians or by other licensed health professionals under the supervision of physicians of the appropriateness of the utilization of services; capabilities, satisfaction, accessibility, and availability of healthcare and human services, including monitoring and evaluation of quality care/quality service complaints, credentialing/recredentialing, and adverse occurrence tracking to deliver up to date and evidence based medical care.
- Client Satisfaction: Ability to meet the needs of SNCHC patients and ultimately engaged our population base in the management of their health.
- Customer Service: Capabilities, satisfaction, accessibility of the provision of customer service. Organizational arrangements, including a focus of

responsibility, to support the quality assurance program and the provision of high-quality patient care.

## III. INTEGRATION OF QUALITY MANAGEMENT PLAN WITH GUIDING PRINCIPLES AND PRIORITIES

This plan will be aligned with SNCHC's Strategic Plan and annual work plans. The key attributes that support SNCHC's vision of a health delivery system describes a system that:

- Is centered upon treating people with dignity and improving the health of our patients.
- Provides an integrated continuum of care
- Demands excellence in service by meeting or exceeding our patient's expectations.
- Requires effective communication and information sharing.
- Continually improves its operating and clinical practices by meeting and exceeding staff expectations.
- Is best achieved by teamwork.
- Uses resources optimally.
- Is scientific and results oriented.
- Provides a safe environment for patients, visitors, and staff.
- Delivers value-based care that aligns with the best scientific evidence combined with committed and compassionate judgment of expert clinicians. Care that embodies the tenet of treating our patients holistically not as an individual/isolated organ system but as a whole – encompassing social, behavioral, and economic components.

## IV. GOALS AND OBJECTIVES

The goal of the plan is to increase the value of services by enhancing clinical quality, the patient's experience, and access to care while strengthening the ability of SNCHC to deliver sustainable cost-effective care.

**Objectives**

A. To design and implement effective processes to meet the needs of patients in a manner consistent with the health center's mission, vision, goals, and strategic plans.

B. To promote and implement evidenced based care that addresses health equity and disparities in the communities served by SNCHC.

C. To collect and use data to monitor the stability of exiting processes, identify opportunities for improvement, identify changes that will lead to improvement, and evaluate the effectiveness of programs.

D. To aggregate and analyze data on an ongoing basis and to identify changes that will lead to improved clinical effectiveness and operation efficiency.

E. and a reduction in errors.

F. To promote and foster collaboration and a culture focused on quality improvement and risk mitigation at all levels of the organization.

G. To educate leaders and staff regarding continuous quality improvement and participation in performance improvement activities.

## V. ORGANIZATION

Quality improvement and assurance activities are conducted at SNCHC by:

A. **SNCHC Board:** The SNCHC Board is the final authority and is ultimately responsible for approving the QMP as well as monitoring activities and performance. The board delegates authority and responsibility to the health center's Executive Director who in turn, may delegate authority and responsibility to the Chief Medical Officer (CMO) and/or other chosen designees.

B. **SNCHC Quality, Risk and Credentials Committee:** The Quality, Risk and Credentials Committee is a committee of the SNCHCH Governing Board. The Committee helps perform work related to the boards requirement to establish goals and activities around quality improvement and quality assurance and to monitor the health center's performance in these areas. The Committee meets at least quarterly and more frequently as needed.

   The Committee in collaboration with leadership identifies and prioritizes improvement opportunities; ensuring that adequate resources are available to accomplish performance improvement and assurance initiatives. The Committee receives, reviews, and evaluates performance improvement activities and reports regularly to the SNCHC Governing Board. The Committee is responsible for the following activities:

   1. Reviews and recommends the approval of the Quality Management (QM) Plan to the Board.
   2. Monitors patient and employee satisfaction.
   3. Monitors progress towards clinical quality performance goals and risk management mitigation activities. Performs benchmarking against relevant sources.
   4. Reviews and recommends to the Board for approval the annual Risk Management Plan.
   5. Overseeing the effectiveness of the medical staff credentialing process.
   6. Reviews and recommends to the Board for approval medical staff appointments, reappointments, and clinical privileges.

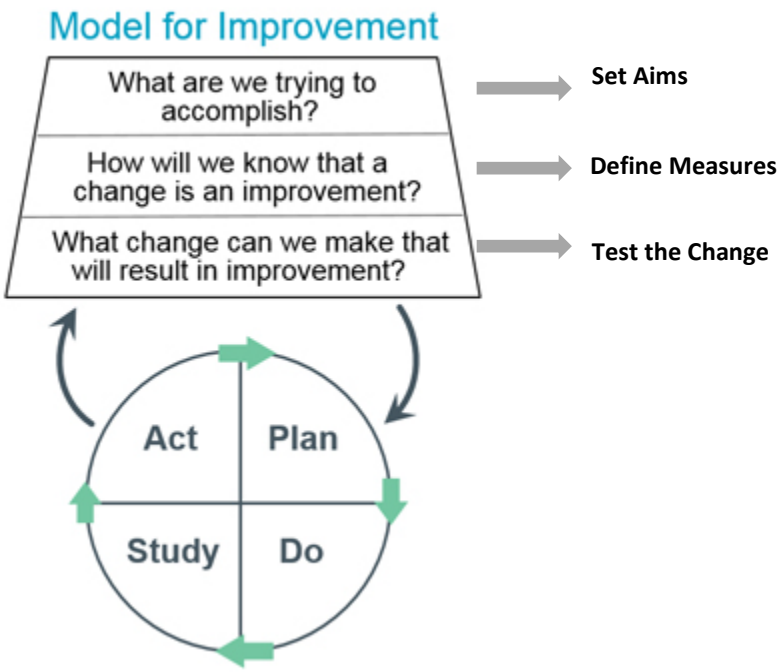
C. Quality Improvement Work Group: This group is comprised of health center leadership and staff. The purpose of the work group is to facilitate the application of health center's quality improvement and quality assurance activities. The group will provide

leadership support, prioritization of initiatives, review and analysis audits/reports and implementation of improvement activities.

## VI. PERFORMANCE IMPROVEMENT PROCESS

SNCHC will use an Improvement Model that consists of three fundamental questions and a Plan-Do-Study-Act (PDSA) cycle (Deming Cycle) to test, implement, and evaluate changes.

**Figure 1: Model for Improvement**




## VII. COLLECTION AND CONTINOUS MONITORING OF DATA

SNCHC's ongoing collection and monitoring program covers a multitude of variables including clinical, financial, operational, as well as patient and staff satisfaction.

Data collection activities will be based on priorities set by SNCHC's Strategic Plan and the Quality, Risk and Credentials Committee. In collaboration and support of staff, the Committee will consider the population served by the Health Center, as well as, high risk, high volume, and problem prone activities that occur. Requirements for data collection imposed by funding sources and legal/regulatory agencies will also be included, when appropriate. The data collected will be used to monitor the stability of existing processes, identify opportunities for improvement, identify changes that lead to improvement, and/or to demonstrate sustained improvement.

The following table is a summary of the data collection efforts that are currently underway at SNCHC along with the schedule outlining when data will be collected, analyzed, and reported.

**Table 1: Data Collection Plan**

| **Clinical Quality** | | | |
|---|---|---|---|
| **Performance Measure** | **Collected** | **Reported** | **Person Responsible** |
| Peer Reviews of Licensed Independent Practitioners (LIPs) | Quarterly | Annually | CMO/Dental Director FQHC Operations Officer, FQHC CHN Manager |
| Patient Appointment Availability, Access to Clinical Advice, No-Show Rates | Monthly | Biannually | Sr. FQHC Manager, FQHC CHN Manager |
| Review of Uniform Data System (UDS) Information | Monthly | Quarterly | FQHC Manager, Quality Management Coordinator |
| Patient Satisfaction Surveys Results | Daily | Quarterly | FQHC Manager, FQHC CHN Manager, Quality Management Coordinator |
| Patient Complaints/Grievances | Daily | Quarterly | FQHC Manager, FQHC CHN Manager, Quality Management Coordinator |
| HRSA and NCQA (PCMH) Requirements | As Per Guidelines | As Deemed Necessary | FQHC Manager, FQHC CHN Manager, Quality Management Coordinator |
| Clinical Indicators Targeted for Improvement (PDSA) | Quarterly | Quarterly | CMO, Quality Management Coordinator, Sr. Compliance Specialist |

**Table 2: Data Collection Plan for Safety and Risk Management**

| **Safety and Risk Management** (Reports to the SNCHC Board) | | | |
|---|---|---|---|
| **Performance Measure** | **Collected** | **Reported** | **Person Responsible** |
| Incident Reporting (Patient Safety, Employee Safety) | Daily | Monthly (Sentinel Events) Quarterly (All Others) | Quality Management Coordinator, Sr. Compliance Specialist |
| Health Information Technology (HIT) Security Review | Biannually | Annually | Chief Information Officer |
| HIPAA Compliance | Monthly | Annually | Sr. Compliance Specialist |

**Table 3: Data Collection Plan for Human Resources Committee**

| **Credentialing, Privileging, and Engagement** (Reports to the SNCHC Board as necessary) | | | |
|---|---|---|---|
| **Performance Measure** | **Collected** | **Reported** | **Person Responsible** |
| Competency Reviews of Staff (In Conjunction with Annual Review) | Annually | Annually | CMO/Dental Director/CAN |
| Staff Engagement | Annually | Annually | Human Resources (HR) Director |
| Staff Competency (Patterns and Trends) | Annually | Annually | FQHC Sr. Manager, FQHC CHN Manager |

**Table 4: Data Collection Plan for Fiscal Committee**

| **Revenue Cycle and Utilization:** (Reports to the SNCHC Board) | | | |
|---|---|---|---|
| **Performance Measure** | **Collected** | **Reported** | **Person Responsible** |
| Operating Revenue | Quarterly | Annually | Chief Financial Officer |
| Profit Center Report | Monthly | Annually | Chief Financial Officer |

Other information may be collected on an as needed basis and will be based upon performance improvement objectives or other rationales.

## VIII. AGGREGATION AND ANALYSIS OF DATA

Decision-making will be supported by data collection and information analysis. Data will be aggregated and analyzed by the organization in such a way that current performance levels, patterns, or trends can be identified. The organization will utilize appropriate statistical tools and techniques to analyze and display data.

When appropriate, data will be trended and compared internally over time. In addition, external sources of information will be used to benchmark SNCHC performance when it is available and appropriate to identify opportunities for improvement.

Analysis will be conducted when data indicates that levels of performance, patterns, or trends vary substantially from those expected and for those topics chosen by SHND as priorities for improvement.

At a minimum, each clinical and financial performance indicator collected for the purposes of UDS reporting will be tracked monthly. In addition, each committee will have the responsibility to establish meaningful monitoring in their area of expertise and make recommendations to the Board regarding the level of information to be shared regularly.

Each PDSA activity will establish quantitative tracking methodology and a corresponding performance goal as part of its process. More intensive aggregations and analysis of data may be required in an active PDSA activity above and beyond general monitoring.

## IX. QUALITY ASSURANCE ACTIVITIES

### A. Credentialing and Privileging

All SNCHC Licensed Independent Practitioners (LIPs), Other Licensed and Certified Practitioners (OLCPs), and Other Clinical Staff (OCS) are credentialed and privileged at the time of hire and are re-credentialed and privileged every two years. Modifications and/or the removal or reinstatement of privileges can occur at any time because of ongoing professional evaluation.

### B. Clinical Practice Guidelines

SNCHC's clinicians and staff will provide health care services with utmost accuracy, efficiency, confidentiality, and precision. All applications of health care or health care related services will be guided by appropriate governing entities. SNCHC adheres to current evidence-based clinical guidelines, standards of care, and standards of practice in the provision of medical, dental, and behavioral health services. (See Protocols and Medical Orders, and Confidentiality Privacy of PHI Policy).

### C. Risk Management

All employees will be informed of the principles of risk management at the start of employment, annually, and as deemed necessary. Risk management is defined by the Joint Commission as "clinical and administrative activities undertaken to identify, evaluate, and reduce the risk of injury to patients, staff, and visitors, and the risk of loss to the organization itself." SNCHC supports the establishment of a culture that emphasizes implementing evidence-base best practices, learning from error analysis, and providing constructive feedback rather than blame and punishment. Employees are encouraged to bring their risk management concerns to the Safety Officer, Compliance Officer, their supervisor, the FQHC Operations Officer or a member of the Safety and Risk Management Committee at any time.

### D. Incident Reporting

All employees are oriented to the Incident Reporting Policy and Procedure that provides guidance for reporting 1) Incidents affecting patients or visitors, 2) Injury, illness or near-miss events affecting employees, and 3) non-safety related incidents affecting patients. A summary of incidents is reported quarterly to the Quality, Risk and Credentials Committee. Incidents will be assigned a "category of harm" and those incidents that have a category of harm of E-I will be reported to the Board (See Patient Safety Policy). A summary of all incidents is reported the board quarterly.

### E. Patient Satisfaction

All SNCHC locations and service lines participate in patient satisfaction surveys. SNCHC surveys patients routinely in the two most prevalent languages of the patient population, in either English, or Spanish. Aggerate and service line survey results are share with the health center's leadership weekly and with all staff monthly. Additionally, survey results are reviewed and tabulated quarterly by staff and reported to the Quality, Risk and Credentials Committee. Improvements are

recommended based on the survey results. A summary is provided annually to the Board.

### F. Patient Grievance

SHND has a patient grievance and complaint process that ensures patients can freely voice complaints/grievances and recommend changes without being subject to discrimination, retaliation or unreasonable interruption of care, treatment, or service (See Client Complaints/Grievance Policy). The health center's leadership team attempts to resolve grievances informally at first. The FQHC Operations Officer will support the resolution of formal grievances. The Quality, Risk and Credentials Committee is given a report on the number and type of grievances on a quarterly basis and is responsible for ensuring the resolution of grievances and collaborates with leadership to ensure resolution of grievance and the implementation of improvements to mitigate future grievances.

### G. Clinical Audits

Quality is monitored through audits, data review, and analysis to assure problems are identified (i.e., peer reviews, front desk/billing/health information technology audits, personnel files, UDS data, program audits etc.) and reported to the appropriate manager and the management team All audits are reviewed by the Quality Improvement Work Group. This group will provide direction and resources to respond to audit findings as well as quality improvement and quality assurance activities.

### H. Policies and Procedures

Policies and procedures related to quality improvement and assurance are initiated by health center leadership, reviewed, and recommended by the Quality, Risk and Credentials Committee to the SNCHC Governing Board for final review and approval. Policies are reviewed on a three-year schedule or earlier as needed by the Quality Improvement Work Group. Policies with substantial changes are sent to the Governing Board for approval. Upon hire, staff members are assigned job-relevant policies and procedures through an online policy management system. Each time a policy is updated, all staff members who are assigned that document are required to read and acknowledge it.

Protocols, standing orders, and procedures are developed and approved by the FQHC Operations Officer or their designee and are reviewed annually. These documents are also kept in the online document management software system.

### I. Patient Safety Program

SNCHC is committed to improving safety for its patients at all its locations. This continuous quality improvement plan has incorporated the activities and functions necessary to establish and maintain a comprehensive program for patient safety and will be implemented at all levels of the organization.

Activities and functions that have been incorporated to address patient safety include:

- All patients will be given a copy of the Patient Rights and Responsibilities along

with the Notice of Privacy Practices at their first visit. These documents are available upon request after their initial visit. Patients will sign a form verifying that they have read/acknowledged the Patient Rights and Responsibilities and Notice of Privacy Practices.

- Annual HIPPA trainings for staff.
- Communication with patients about patient safety including patient education and informing patients about their care.
- Staff education including related orientation and training and expectations for Incident Reporting.
- Safety improvement activities included in Section VII of this plan under "Collection and Continuous Monitoring of Data."
- Annual Infection Control trainings for staff.
- Reporting of results to staff, committees, executive leadership, and governance.
- Process for proactive risk reduction and analysis of sentinel events.

## X. PERFORMANCE IMPROVEMENT INITIATIVES

Performance improvement initiatives will be facilitated through the Quality Improvement Work Group based on the data identified and reviewed in Section VII. A key part of this data is the UDS data which will be reviewed in February or March. After analyzing the UDS data and comparing it to the clinic's internal goals, state and national counterparts, and Healthy People 2030 goals for clinical quality, initiatives will be reassessed and determined. Initiatives will be aligned with SNCHC's Strategic Plan. As other opportunities or challenges arise, SNCHC may add or delete goals using the Plan-Do-Study Act (PDSA) process.

## XI. DOCUMENTATION OF QUALITY IMPROVEMENT ACTIVITIES

Quality improvement activities will be documented utilizing a variety of tools and forms. The Governing Board and its Committees will document their activities in a minutes' format. The Quality Improvement Work Group PDSA cycles will be documented on a cycle of change form or on PDSA worksheets. Other forms and tools that may be used to document activities include narrative reports and trend sheets.

## XII. EDUCATION and TRAINING

Educational and training needs for quality improvement and quality assurance activities will be identified by Quality Improvement Work Group and/or the FQHC Operations Officer and will be provided in the appropriate setting. To ensure training occurs, a training plan for new employee orientation and ongoing training has been developed for each position type and is followed. Providers are required to have continuing medical education through lectures and seminars and their involvement in such activities are monitored annually. This will provide them with the opportunity to keep up with current trends and

evidenced based medical care.

## XIII. ANNUAL PLAN EVALUATION

The Quality Improvement Work Group is responsible for performing an annual evaluation of the appropriateness and effectiveness of the Quality Management Plan. The result of the annual evaluation is reviewed with the Quality, Risk and Credentials Committee. The Quality Management Plan is approved by the Governing Board annually.

## XIV. CONFIDENTIALITY

SHND will maintain the confidentiality of patient records, including all information as to personal facts and circumstances obtained by SHND staff about recipients of services. Specifically, SNCHC will not divulge such information without the individual's consent except as may be required by law or as may be necessary to provide service to the individual or to provide for medical audits by the Secretary of HHS or his/her designee with appropriate safeguards for confidentiality of patient records.

Confidentiality statements are signed by all SNCHC employees, contracted providers, SNCHC Board, and guests. Information including, but not limited to, minutes, reports, medical records, or other documents used will be maintained to insure confidentiality for patients and providers. Access to these records will be restricted to the administrative personnel as deemed necessary and will be kept in a locked file.

All information generated from the Quality Management Plan is considered confidential and will be exempt from subpoena or discovery. This is in accordance with Laws 2005, LB 361, Sections 71-8701 to 71-8721, which is known as the Patient Safety Act. Discussions in the context of peer reviews and medical record reviews are completely confidential.

## XV. RESPONSIBILITIES

A. **SNCHC Board:** The SNCHC Board is ultimately accountable for the quality of care and services provided by SNCHC through the development of a comprehensive performance program. The Board delegates responsibility for implementation and evaluation of this program through the Quality, Risk and Credentials Committee and the Executive Director.

B. **Executive Director:** The Executive Director is responsible for implementation and evaluation of the CMP Plan as outlined in the above plan. In collaboration with the SNCHC Board, the Executive Director will work with the health center's management team to align the performance improvement activities with the strategic plan and prioritize improvement efforts.

C. **Quality Improvement Work Group:** A group of leadership and staff of SNCHC who operationalize the Quality Management Plan

D. **FQHC Operations Officer/Chief Medical Officer/Medical Director/Dental**

**Director/Behavioral Health Director:** These positions are responsible for providing leadership support of the quality improvement/assurance program and to ensure the provision of high-quality care.

E. **Managers/Supervisors:** Directors, managers, and supervisors are responsible for the implementation of the QM program for their respective units/clinics/programs. In addition, these managers may serve as chairs, team leaders or as members of committees, subcommittees, teams, and/or task forces.

F. **Clinical Staff:** Clinical staff members should be familiar with the performance measures and QM initiatives of SNCHC and their respective unit/program/clinic. Clinical staff will be active participants in the performance improvement activities through participation on committees, subcommittees, teams, and task forces as appointed as well as through the implementation of improvement activities. The purpose of this participation is to bring the care provider's perspective to the performance improvement opportunities and initiatives of SNCHC as well as resolution of problems.

G. **Other Professional and Classified Staff:** Staff members should be familiar with performance measures and Quality Improvement Work Group initiatives underway for SNCHC and their specific unit/program/clinic. Staff members will be asked to participate in these activities as well as participate on committees, subcommittees, teams, and task forces as appointed. The purpose of this participation is to provide a broader perspective of performance improvement opportunities and initiatives at SNCHC as well as resolution of problems.

**Effective (Original) Date**: 01/08/2020
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**Review & Update**: Annually
**Revision Date(s)**: 01/01/2022, 05/10/2023
**Responsible for Review & Update**: FQHC Operations Officer
**Distribution**: All FQHC Division Staff
**Rescinded Date**: N/A
**Related Policies/Reference**: Quality Management Policy, Credentialing and Privileging Policy and Procedure, Protocol Development and Use Policy and Procedure, Risk Management Policy and Plan, Incident Reporting Policy and Procedure, Patient Grievance and Complaint Policy and Procedure