

POLICIES AND PROCEDURES

POLICY TITLE: QUALITY IMPROVEMENT POLICY

POLICY NUMBER:

APPROVALS AND REVIEWS:

I. Purpose/Goal

The purpose of the QI program is to evaluate, maintain and improve the quality of patient care support functions conducted throughout the organization. The QI program will strive to ensure that patient care is optimal within the New River Health Association's resources.

The QI program is intended to monitor critical aspects of the health center's operation, provide feedback on performance against standards, and continually improve the operation of the center so that it better serves its community and uses its resources more efficiently.

II. Components of Quality

There are five components of quality to be evaluated and toward which corrective action will be targeted. These are:

1. Effectiveness

- a. The practitioner's performance of both the art of care (interpersonal skills) and the science of care, including adherence to health center standards of care;
- b. Support staff performance and support systems functioning;
- c. The working of the medical record system, both as permanent documentation and as practitioners' tool;
- d. Risk minimization or preventing unwanted change in health status as a result of interaction with the health system.

2. Acceptability to patient

As reflected in patient satisfaction or the degree that the care meets the patient's expectations and in patient compliance with their health care plan.

3. Access/Availability

Access relates to ease and timeliness in obtaining care and thus to the appropriateness of hours of operation, the after-hours on-call system, to waiting times and scheduling systems. It also relates to success in reducing barriers to needed health care, such as financial, transportation, and cultural.

Judging the availability of care relates to whether the center maintains the appropriate scope of services to meet the health needs of its service population for all the life cycle stages. It relates to the adequacy of services provided on-site and by referral.

4. Efficiency/Appropriateness:

Efficiency refers to the challenge of using available resources to produce the highest quality health services. Resource utilization and productivity must be evaluated in light of resources available to the organization and its capacity to deliver services.

Appropriateness of service refers to whether a service provided or referral made was indicated and whether needed services were delivered. The issue here is the clinical necessity of the service provided or ordered and success in having patients obtain needed services.

5. Continuity of Care

This refers to the role of primary care in maintaining continuity of care over time and in managing all the health care received by the patient. Thus, of concern will be such issues as missed appointments, follow-up and referral tracking, the proper flow of information among providers of services, and systems for assuring proper follow-up for preventive care and ongoing care of chronic problems.

III. Audits of Important Aspects of Care or Services

The following is a process for auditing important aspects of healthcare service delivery. The procedure is applicable both to direct clinical care and to auditing the performance of support functions in the health center.

A. The Audit Process

1. The important aspect of care is selected.

Suggestions may be made to the Committee by staff members, departments or work groups. The clinical activities selected shall be those most important in providing patient care as reflected in the high volumes of the services or diagnosis, the high degree of risk to patient, or that tend to produce recurrent problems for patients or staff.

2. The indicators for quality are determined.

An indicator is a defined measurable dimension of quality. Indicators specify the patient care activities, or outcomes that are to be monitored and evaluated to determine whether standards of acceptable practice are met.

3. The criteria or standards are selected against which the actual performance is measured.

The criteria may reflect the structure, the process, or outcome of care. The criteria are developed with the active participation of the providers or other staff who are involved in the activity monitored.

4. Collect and analyze relevant data.

Data is collected from a sample or an entire population of a category of patients. If using a sample, it should be of sufficient size to be representative of the entire population. Data collection forms and/or computer databases must be developed for recording data. Definitions of compliance must be arrived at and the auditors must be trained.

5. Conclusions are reached and corrective action is called for if needed.

B. Corrective Action

A goal of the Quality Improvement Program is to continually make needed improvements in health center systems and in the knowledge, attitudes, and behavior of the staff. Potential actions that may be taken in response to QI audit findings include the following:

1. Actions to improve staff knowledge, such as changes in orientation, in-service training and continuing education programs.
2. Actions to improve systems, such as making changes in policies and procedures, staffing, the budget, equipment or facilities, and communications.
3. Actions to improve attitudes or behavior, including individual staff counseling, assignment or duty changes, disciplinary action.

Management may assign the task of developing and carrying out a corrective action plan to department or existing team, or may form an ad hoc team for this purpose.

C. The Organization and Process of the Audits of Important Aspects of Care

Each department and/or team shall select at least one important aspect of care of service to audit annually and shall develop a plan for carrying out this audit. The plan shall be submitted to the QI Committee for review and comment. The plan shall include all the above listed components. The QI Committee or management may direct a department to develop a plan to audit a specific important aspect of care.

The deadlines for audit results shall be noted on the QI Calendar maintained by the QI Coordinator. QI audit results shall be forwarded to the QI Coordinator for check-off and for review by the QI Committee.

Note that some audits are required by funding agencies and these shall be assigned to the appropriate workgroup to carry out.

IV. Standing Clinical Audits

There shall be several standing audits that monitor important clinical objectives of the health center or represent requirements of funding agencies or payers.

1. Abnormal Pap Smear Tracking (See attached description)

This procedure establishes a system to monitor the follow-up testing and treatment for all patients with abnormal Pap smears. Summary reports are generated monthly.

2. Audits of Perinatal Client Records

Audits of selected indicators of perinatal care shall be carried out on all enrolled perinatal patients three times during their care:

- At before 20 weeks.
- At 36 weeks.
- At two weeks post-partum (See attached form).

3. Positive Pregnancy Tracking report

4. Audit of BPHC Clinical Outcome Measures

Annually, at least a sample of 25 records shall be audited for the following:

- Perinatal Outcome Measures.
- Pediatric Outcome Measures
- Adolescent Outcome Measures
- Adult and Geriatric Outcome Measures

5. Provider Performance Audit

The Provider Performance Audit entails the quarterly audit of ten charts of each NRHA provider to determine compliance with nine quality indicators. Non-compliance causes feedback to the provider and a summary of all audits is prepared semi-annually and reviewed by the QI Committee to determine whether additional corrective action is required.

The responsible person is the medical Director and QI Coordinator. (See attached procedure for Provider Performance Audit and data collection form.)

V. Other Standing Quality Improvement Procedures

The NRHA has several ongoing procedures for monitoring and improving quality of services. These procedures address the entire quality component.

A. Clinical Protocol Review and Revision

At least four clinical protocols are assigned a reviewer or review team by the Medical Director annually. The new draft protocol is presented to the medical staff for review and comment before the final revised protocol is approved by the Medical Director. The clinical protocols are used as standards in the above-described Provider Performance Review.

B. Requirement for Medical Staff Membership

Before putting a physician under contract the following must be secured:

- a. WV State Medical or osteopathic license, nurse practitioner physician assistant or nurse midwife license
- b. Malpractice insurance coverage assured
- c. DEA Certification for physician and physician assistants who qualify
- d. Three references obtained and evaluated as satisfactory
- e. Results of a query of the National Practitioner Data Bank are satisfactory
- f. Statement of physical fitness by an independent provider (See attached
- g. form)
- h. Review of liability claims and adverse reactions

Annually, the Administrator shall certify that the following requirements are met by each provider:

- i. WV State medical license, nurse practitioner, physician assistant or
- j. nurse midwife license
- k. Malpractice insurance coverage
- l. DEA Certification for physician and physician assistants who qualify
- m. Continuing Medical Education credits obtained
- n. Statement of physical fitness by an independent provider
- o. Review of liability claims, adverse actions, and patient and staff
- p. complaints

C. Continuing Education

The Medical Director shall annually develop and cause to be implemented a plan for medical staff Continuing Education and training. The plan shall be reviewed by the Quality Improvement Committee and the medical staff and then referred to the Executive Director for approval.

D. Incident and Complaint Review Process

Significant clinical incidents or patient complaints about health care raised by staff, patients, or Board Members shall be written up on an Incident Report Form, referred to the appropriate person for follow-up investigation and corrective action taken if required. All such incidents or complaints will be discussed with staff involved. The description of the incidents and follow-up action will be filed in the Incident Report file. The file will be reviewed by-annually by the Quality Improvement Committee.

E. Orientation and Training of New Clinical Staff

Each department and the medical staff shall develop and review annually a procedure for orienting and training new staff.

F. Efficiency and Access Review

The following reports shall be produced and reviewed by management.

- a. Weekly report providing the number of clinical sessions, visits, DNKA's, WI/CI's and initial visits by provider and department or site.
- b. Patient Access Report at the end of each month: Provides number of days to obtain an appointment for non-urgent care for established and new patients for adults, prenatals, and children at each site.
- c. Cycle time review. The cycle time is the amount of time elapsed from the time of sign-in at the reception desk to the time of checkout by the cashier. The standard is that 80% of all provider visits should have a cycle time of less than 50 minutes. Each provider will be audited one day per week.
- d. A Patient Satisfaction Audit shall be conducted with the patients of each provider for two days per month. See the attached Patient Satisfaction Audit form.

VI. Mid-level Practitioner (MLP) Supervision and Audits

Each NP or PA shall be assigned a primary and secondary physician supervisor. The PA or NP shall only practice within the range of practice of the supervising physicians.

Mid-level providers should consult with a supervising physician before making referrals to certain off-site specialists or for certain specialized diagnostic X-ray specified by the supervising physician.

The supervising physician shall review all the medical records related to all patient visits within two weeks of the time of the patient visit meeting the following characteristics:

- A psychotropic or pain-relieving drug, or any Section B drug in the Board of Medicine PA formulary is prescribed;
- Complicated medical management;
- The MLP requests that a record be reviewed; or care transferred to physician;
- A referral is made to a specialist or for an off-site diagnostic procedure;
- All initial patients; and
- Encounters related to accidents, injury, compensation, or disability.

If quality issues are raised in the review, the supervising physician completes the Record Review Form and takes one of the following actions:

- a. Contacts the MLP immediately and makes a plan for corrective action.
- b. Attaches the Review Form to the chart and forwards to the MLP for review and follow-up as required.

If there are no quality issues it is not necessary to make an entry on the form.

After review, the MLP will return the form with comments to the Supervising physician.

VII. The QI Committee:

Committee Composition-The QI Committee shall be made up of Department Supervisors as are present in the weekly Supervisor Meetings and two consumer members selected by the Board of Directors.

The Medical Director shall chair the Committee and the Committee shall meet at least monthly.

Committee Responsibilities:

1. The Committee shall monitor the audit process carried out under this plan, review audit results and recommend corrective actions.
2. The Committee shall receive recommendations of problems or issues requiring QI action and recommendations of performance indicators and audit methods from the NRHA Department and Workgroups.
 - a. The Committee will review and modify such recommendations as are required and recommend to management and the workgroup quality improvement corrective action. Management is responsible for assigning resources to carry out the quality improvement corrective action.
3. The QI Committee may cause Departmental or Workgroup representatives to report to the Committee regarding problem definition, analysis, or resolution.

4. Direct that certain Quality Audits be conducted. Such audits may be referred to an appropriate workgroup or assigned to an ad hoc team.
5. The Committee shall review this QI plan annually in the month of June or July, modify as required and submit the revised plan to the Medical Staff for review and comment and to the Board for approval.
6. The Committee shall review the QI Tracking Log (see attached) at each meeting as a method of monitoring all NRHA QI activities.
7. The Committee shall review the CE Plan and clinical-related Departmental Orientation and training plans, prepared by the DME and Department Heads.
8. The QI Committee shall bi-annually summarize its work in QI Summary Report. The Report shall be prepared by the Administrator and Medical Director and reviewed by the Committee.

IX. QI Tracking Log (See Attached Sample Format)

The QI Tracking Log is a tool for tracking and monitoring the NRHA QI Program. It is to be completed by the QI Coordinator and presented at the monthly QI Committee meetings.

The Log shall track problems identified, audits performed, corrective actions and responsible persons, will as CE developed and carried out and clinical protocols and clinical policies modified or created.

The Log will be compiled by the QI Coordinator and will be posted in a place accessible for review by staff and Board members.