Brazos Valley Community Action Agency, Inc
Community Health Centers (BVCHC)

Quality Management Plan

2013

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PURPOSE

The Quality Management (QM) Plan for Brazos Valley Community Action Agency, Inc Community Health Centers (BVCHC) is designed to ensure BVCHC is striving for ongoing excellence in quality and safety of the care and services BVCHC delivers. The QM plan also assures BVCHC is following its mission statement: to provide evidence-based healthcare utilizing patient empowered team approach, resulting in individual wellness. Compliance and Performance Improvement (CPI) integrates Quality Assessment (QA) and Quality Improvement (QI) in clinical and business operations to assure quality, effective, efficient, timely, equitable, and patient-centered care throughout the BVCHC system.

OBJECTIVES

1. To improve primary care through continuously improving organization of care around patients, through working in teams, and continuously improving the quality of coordination and tracking of patient care over time.
2. To provide patient-centered care that is safe, effective, timely, efficient, and equitable
3. To improve experience of care, improve health of populations, and to reduce per capita cost of health care
4. To extend the scope of quality and safety to all aspects of the organization
5. To continuously monitor, evaluate, and improve processes and the system with a patient-driven philosophy that focuses on preventing problems and maximizing quality of care
6. To ensure organizational compliance with appropriate state, federal, and other third-party standards, regulations, and policies
7. Fulfill legal, licensing, certifying, funding and/or accreditation requirements
8. Minimize the risk of injury to clients, visitors and staff

STRUCTURE AND ROLES OF QUALITY MANAGEMENT PROGRAM

I. DEFINITION

Quality is the degree of excellence of BVCHC's processes, provider, and support staff performance, decisions, and human interactions.

II. SCOPE

The scope of BVCHC's QM plan is comprehensive; quality and safety extend to all facets of BVCHC- clinical, environmental, managerial, administrative, financial, facility-related, and the patient experience. It extends to all clinical service lines- primary care, dental, behavioral health, etc.

The QM Plan addresses each of the health center's clinical programs; the precepts of the Patient Centered Medical Home model; national Meaningful Use criteria; and requirements / guidelines of, the National Committee for Quality Assurance (NCQA), the Bureau of Primary Health Care (BPHC), the Health Resources and Services

Administration (HRSA), and the Federal Tort Claims Act (FTCA). The Quality Management program also ensures organizational compliance with appropriate policies concerning *Confidentiality* and *Conflict of Interest*, as well as with all Health Insurance Portability and Accountability Act (*HIPAA*) requirements.

BVCHC health centers have multiple other systems that contribute to quality and safety, including utilization review, risk management, credentialing / re-credentialing, and so forth.

III. ACCOUNTABILITY

The Board of Directors is ultimately accountable for the level of safety and quality at BVCHC.

BVCHC's Clinical Chief Executive Officer (CEO) and Chief Medical Officer (CMO) are delegated by the Board of Directors to oversee the BVCHC QM plan.

IV. BOARD OF DIRECTORS

The Brazos Valley Community Action Agency, Inc. (BVCAA) Board of Directors will provide general oversight for meeting regulations and standards to create a safe, therapeutic environment for high quality patient care services that are in full compliance with laws, regulations, and professional standards.

FUNCTIONS

1. Accountable for the quality and safety of services of BVCHC
2. Establishes corporate quality culture
3. Establishes and evaluates CPI program
4. Approves quality management plan
5. Receives and acts upon periodic reports from CPI committee
6. Approves/authorizes availability of resources and systems to support quality management activities
7. Approves/authorizes the necessary resources for the Quality Management program.
8. Reviews and approves pertinent policies and procedures
9. Approves/authorizes the center policies and procedures

V. CLINICAL CEO

The Clinical CEO ensures the CPI Program activities are carried out in good faith and without malice. The Clinical CEO reviews and/or evaluates individuals/entities external to the center to assure objectivity, if sought as needed. The Clinical CEO gives the Director of Quality Assurance & Compliance authority to conduct thorough investigations and take important steps toward compliance as CPI Coordinator.

FUNCTIONS:

1. Accountable to the Board for organizational quality and safety
2. Designates the CPI Coordinator as chair of the CPI program to coordinate CPI program, activities, and subcommittees
3. Provide for staff time and resources for meetings, data collection and other tasks in order to allow the CPI Committee, CPI Coordinator and the staff with whom CPI Coordinator works on various reviews to carry out their functions.
4. Ensures enforcement of the policies and procedures reviewed and updated by the CPI Program

VI. CHIEF MEDICAL OFFICER

The CMO is responsible for overseeing the clinical aspects of the CPI Program, assisting the CPI Coordinator in CPI for clinical services at the center and, with the Clinical CEO, is responsible for determining that the quality of services meets the accepted standard of care and is appropriate to the scope of services of the center.

FUNCTIONS:

1. Accountable to the Clinical CEO for the quality and safety of the clinical program, performance of provider staff, and provider performance assessment/improvement component of quality management program
2. Keeps the Board advised through a summary of the activity of the program, reporting particular matters under development or resolved by the CPI Program and deemed appropriate for Board information or action on a monthly basis.
3. Reports on a regular basis to the Clinical CEO, CPI or Professional Review Committee, then directly to the Board on review, recommended action, policy and procedure updates, and the success of the CPI Program itself. (Monthly written reports to the Board and quarterly in person appearance at board meeting)
4. Conducts professional review
5. Participates in the credentialing process concerning credentials and privileges for the scope of practice of clinical staff and makes recommendations regarding privileges of licensed and certified health care professionals at the center through the credentialing function of the CPI Program

VII. Director of QA/Compliance

The Director of QA/Compliance acts as the CPI Coordinator. The Director of QA/Compliance coordinates the CPI Program and activities of the CPI Committee. The CPI Coordinator is responsible for carrying out the QM plan across BVCHC. The CPI Coordinator tracks and maintains CPI program documentation (i.e. occurrence reports, tracking and documentation of PI activities, audit reports, meeting minutes, etc). He/she works closely with QA Committee, QI Committees, and the CMO.

FUNCTIONS:

1. Responsible for developing the agenda, scheduling, and conducting CPI committee meetings

2. Maintain the documents of the CPI Program and its committees and agents (meeting minutes, occurrence reports, tracking and documentation of PI activities, audit reports, etc)
3. Serves as the lead for program reviews/audits by funders, insurance audits, etc
4. In the case of a complaint, incident of policy violation, or harm occurring, or other CPI problem, CPI Coordinator should investigate, report to Chief Medical Officer who then reports to the Clinical CEO, CPI Committee and Board, then responds appropriately
5. Provide reports on oversight and investigations for prevention of errors and investigations of adverse events, root cause analysis for sentinel events, and intensive investigations to the CPI Committee, CMO, Clinical CEO, and Board, as appropriate
6. Make assignments and follows up for completion of tasks, assignments, and documentation
7. Prepare reports of the review for the CPI Program
8. Provide orientation for new staff members about the CPI Program and their role in it
9. Work with staff to draft original, modify existing, or adapt policies and procedures, including relevant tools, such as forms, for the center
10. Work with staff draft an annual CPI review plan to be approved as the CPI review plan for the year by the Clinical CEO and then the Board
11. Use checklists and the policies themselves to review policy and procedure implementation and recommend CPI actions, including policy and procedure updates

VIII. COMPLIANCE AND PERFORMANCE IMPROVEMENT COMMITTEE

The CPI Committee will provide leadership and is responsible for developing, supporting, and operating the quality management program. CPI Committee oversees all organizational quality activity, including actively addressing any corporate-level issues related to quality and patient safety. The focus of the CPI Committee is to support the intentional work of improving and maintaining high quality patient care. It also is responsible for how process improvement plans are carried out and the documentation of these activities. This committee is responsible for reviewing the previous quarter's departmental performance improvement activities, funding source chart audits, occurrence reports, patient complaints and suggestions and focused audits.

MEMBERS

CPI Committee consists of staff with leadership or management responsibility and authority. This may include six to eight leaders, including members of the Executive Staff, the Chief Medical Officer, representative providers, representatives of other major job categories, and representatives of Health Center programs such as dental and behavioral health.

Included member areas: Operations, Finances, Compliance, HIPAA Privacy, Information Technology, Chief Medical Officer, Practice Management, Dental, Behavioral Health, Human Resources, and Clinical Quality.

**For detailed member responsibilities and functions, see attached CPI Organization Chart & Responsibilities*

FUNCTIONS

1. Meets monthly
2. Chaired by the CPI Coordinator
3. Selects and prioritizes metrics to monitor with a performance goal for each program area or funding source
4. Determines acceptable performance thresholds and benchmarks for each metric
5. Ensures all necessary data are supplied to the appropriate quality improvement committees
6. Manages ongoing improvement activity
7. Assumes ultimate responsibility for resolving identified quality and safety problems as well as taking advantage of any other opportunities to improve
8. Ensures performance improvement teams are adequately trained and supported
9. Ensures solutions to quality related problems are implemented across the agency
10. Develop policies and procedures as needed
11. Responsible for managing and updating Quality Improvement Plans annually, and all changes to be documented in CPI Committee minutes and approved by CPI Committee, CMO, BVCAA Clinical CEO of Health Services and the BVCAA Board of Directors
12. Occurrence Reports are reviewed, analyzed, tracked and reported to the CPI by the CPI Coordinator. These duties also include proper follow up action, distribution and safekeeping of all Occurrence Reports.
13. Patient complaints are reported to the CPI Coordinator by the appropriate clinic/practice manager who has obtained the complaint, investigated the circumstances and offered resolution of the concern to the patient, if possible. CPI Committee reporting is meant to identify potential trends and/or to help the clinic/practice manager to resolve the concern, if necessary.
14. Periodically evaluates overall CPI program

IX. QUALITY ASSESSMENT COMMITTEE

The Quality Assessment (QA) Committee is a cross-functional team that actively monitors and reports quality management for a specific program or area (e.g. practice management). The QA committee is not responsible for actually solving quality related problems. The QA works closely with CPI Coordinator.

MEMBERS

Chief Information Officer
Director of Practice Management
Director of System Development
Practice Management Specialist
eCW Specialist
Data Specialist / Auditor
Director of Clinical Quality
Clinical Specialist/Trainer
Patient Immunization/Employee Health Coordinator

FUNCTIONS

1. Collects necessary data to monitor predetermined metrics of quality and safety
2. Compile and report data using dashboards, charts, and graphs
3. Analyze data to identify trends, patterns, and performance levels suggesting areas for improvement
4. Provide recommendations for improvement
5. In conjunction with CPI Coordinator, ensures
    a. metrics not meeting pre-established performance thresholds are being moved into the quality improvement phase of activity
    b. quality improvement is being actively carried out
    c. identified quality related problems are fully resolved
6. Accountable to the CPI Committee for providing data, reports, and monitoring of Performance Improvement endeavors

X. QUALITY IMPROVEMENT COMMITTEE

The Quality Improvement (QI) Committee(s) is a cross-functional team(s) that is responsible for *solving* quality related problems using PDSAs, root cause analysis, and other improvement strategies. The QI committee works closely with CPI Coordinator.

MEMBERS

The QI committee is broadly representative of the staff. The committee is led by the subject matter expert (administrator or manager) who may choose to delegate responsibility of chairing the committee and getting the work done to appropriate personnel. The committee may include five to six front line employees who do not have leadership or management responsibility. This may include medical assistants, front desk staff, health educators, providers, and staff nurses. It is appropriate for supervisors to sit on the QI Committee since their role is to supervise performance rather than to develop/manage programs. This committee also may consist of an eClinicalWorks (eCW) expert and trainer in the appropriate area.

FUNCTIONS

1. Designs, tests, and measures solutions to quality related problems
2. Documents improvement plan and results
    a. Tracks and reports on progress until improvement has been fully realized

3. Provides recommendation to CPI Committee regarding solution to quality related problem
4. Works with QA Committee to measure and monitor improvements
5. Evaluate effectiveness of quality improvement activities and documents improvements
6. Accountable to CPI Committee for obtaining and documenting solutions to quality and safety issues

XI. CLINICAL PROVIDERS

Clinical Providers are critical to the quality and safety of the entire community health center program. A clinical provider is defined as one who is considered a "licensed independent practitioners," thus he or she has the independent authority to write prescriptions.

As part of the QM plan, providers ensure their care is of the highest possible quality by monitoring/measuring/improving processes, performance, decisions, and human interactions. Providers will participate in specific activities that are mandated by the FTCA deeming process:

1. Clinical guidelines
   Providers identify and adopt/adapt specific evidence-based clinical guidelines – including, but not limited to, health promotion, disease prevention, and clinical outcome metrics- that are grounded in state and federal standards.
2. Peer Review and Clinical Guidelines Audits
   The CMO is responsible for ensuring that Peer Review and Clinical Guideline Audits are conducted as scheduled, and that these audits periodically assess the appropriateness of utilization of services and the quality and safety of those services. Audits are based on systematic collection and evaluation of patient records and are conducted by licensed professionals under the supervision of the CMO.
3. Provider Performance Improvement Activities
   The CMO appoints provider representative to the appropriate committee(s), as well as to process improvement or reengineering teams as needed. The CMO is ultimately responsible for resolving identified clinical problems, as well as for performing ongoing quality improvement in the clinical arena.
4. Integration with the Organization-wide QM Program
   Provider-specific assessment and improvement activities are integrated into the overall QM program via the CMO's active leadership and through integration of clinical quality activity reports into the overall reporting structure for CPI Committee.

The medical staff adopted nationally recognized standards of care as its own in 2009. These standards are generated by the Institute of Clinical Systems Improvement (ICSI).

The agency maintains and regularly updates an internal website with the appropriate ICSI standards in effort to ease of access of these standards for the medical staff. The ICSI standards also serve as practice guidelines for midlevel provider. Each midlevel provider undergoes regular face-to-face visits and chart audits as required by Texas state law.

XII. PROFESSIONAL REVIEW BOARD

The Professional Review Committee meets quarterly and is composed of the Medical Director, Associate Medical Directors and a permanent representative of the midlevel providers. Its activities, as outlined in the Professional Staff Bylaws, include:

- Implementing continuous performance improvement and conducting periodic assessments of the utilization and the quality of services provided, or proposed to be provided, by the Center for the purpose of providing patient services consistent with professionally accepted standards of quality care and patient safety.
- Evaluating the cost effectiveness of patient care treatment alternatives; delivery of patient services within the professionally accepted standards of quality care and patient safety; and the capacity, scope of services, and utilization levels of the Center.
- Adopting criteria, standards, and clinical protocols and Policies and Procedures for providing patient care services consistent with accepted professional standards and the scope of services and purposes of the Center, and subject to approval by the Professional Staff, the Executive Director and the Board.
- Providing for the review of applications of licensed and certified Healthcare Practitioners for employment or contract and granting credentialed privileges, and, after investigation, making recommendations to the Executive Director.
- Conducting routine and special investigations of issues or complaints and adverse events and making recommendations to the Executive Director.
- In peer review functions, the Professional Review Committee, with input by the Executive Director, as a whole only acts to review Providers or Midlevel Providers as allowed by law. If necessary, subcommittees of Health Care Practitioners will be formed to do peer review in conformance with the law.
- Determining that the CPI Program meets the applicable requirements for state and federally funded public health programs and liability coverage by the Federal Tort Claims Act.
- Reviewing these Bylaws, Policies and Procedures, rules and regulations and making recommendations accordingly to the Executive Director.
- Making recommendations, as deemed appropriate or as requested, to the Executive Director.

COMPONENTS FOR ONGOING MANAGEMENT OF QUALITY

XIII. QUALITY ASSESSMENT

The QA Committee actively monitors and reports quality management for a specific program or area by compiling, reporting, and analyzing data and trends for performance improvement recommendations and to ensure the highest level of quality of patient-centered care. The QA Committee is not responsible for solving quality related problems, but may provide suggestions.

Data Analysis

BVCHC uses an Electronic Health Record (EHR) system which allows for the tracking of data such as encounters, visits, and insurance status of patients, etc. It allows for the QA Committee to review primary diagnosis identified and track referrals. Other data for analysis will come from internal surveys, chart and peer reviews, and evaluations.

All collected data will be presented for analysis during monthly CPI Committee meetings where identification and suggestions for priorities will occur; as well as quality improvements being tested. Priorities will be determined using measures such as high risk for patients, existing low performance measures, high volume areas, and areas of focus. If historical data exists then trends will be examined.

Data Sources

Gathering data will occur through several mechanisms, and staff and patient confidentiality will be a priority throughout the QM process. BVCHC operates using a fully integrated electronic medical record system. Each patient has an individual record where interactions with the patient (visits, telephone, and other facility records) are maintained on a secured database that undergoes routine back-up. The comprehensive record system facilitates the capture, tracking and thorough documentation of referrals, diagnostic imaging, laboratory testing, and hospitalizations. This technology also enables the organization to gather data more efficiently, accurately and completely both improving the range and quality of its audits and reviews. The agency is also actively seeking to meet compliance with Meaningful Use standards set forth by Department of Health and Human Services (DHHS).

The QA Committee will internally manage this system, creating reports on clinical services through diagnosis and visit codes, laboratory orders, and appointment management in patient follow-up, recalls, and reminders. These reports are provided based on the audit schedule (see Attachment: Master Audit Schedule).

Additionally, clinical outcomes data may be gathered through periodic peer and chart reviews, which are coordinated by the CMO. Providers and clinical staff are responsible for periodic medical record reviews of a sample of patient charts, and use chart review template forms to standardize data reporting. In addition, chart reviews also will include compliance checks for HIPAA and other administrative policies and procedures.
Data also will include the interests and feedback of patients. Patient experience data is integral to the QM process and will be collected through several means; including, but not limited to patient surveys and spontaneous suggestions or complaints. Patient Satisfaction surveys are collected monthly, but may be reported to CPI quarterly to

ensure systematic evaluation of patient needs and their subsequent incorporation into health center policies, procedures, and plans. Patient complaints are reported to the CPI Coordinator.

For BVCHC staff data, BVCAA Inc's Human Resources in coordination with the contracted local Health Care Business Management firm responsible for credentialing will submit names of employees due for re-credentialing and/or credentialing to CPI Committee and CPI Coordinator and audit credentialing files and submit reports to CPI Committee and CPI Coordinator. In addition, Human Resources will maintain documentation of staff training, skill assessments, CPR certification, CMEs, etc.

Data related to BVCHC's internal incident reporting procedure will come from written documentation of incidents that cause harm or have the potential to cause harm to a person at the health center. Incident reports are submitted to the Director of QA/Compliance for review and attention.

Monitoring Performance

Baselines and benchmarks for performance may be set internally by management; however will generally follow, and be identified as, benchmarks set by governing entities such as HRSA, TACHC, NCQA, Meaningful Use, Healthy People 2020, etc. When developing benchmarks and performance measurement goals, processes will always include identification of the measurement population, eligibility criteria, a data collection plan and/or tools, a means of reporting and communication, as well as intervals for data collection.

The six standards which will be measured that align with the Patient Centered Medical Home (PCMH) philosophy are:

1. Enhanced Access and Continuity
2. Identification and Management of Patient Populations
3. Planned and Managed Care
4. Patient Self-Care Support and Community Resources
5. Tracking and Coordination of Patient Care
6. Measure and Improved Performance

For areas measured of each standard, see Master Audit Schedule Attachment

At each meeting, committee members discuss the outcomes of quality metrics, identify weaknesses and strengths, and provide performance improvement recommendations. Information regarding the QM processes is reported to the CEO, CMO, and Board of Directors at least quarterly. All reports will specifically identify the finding's relationship to organizational performance or a specific performance standard; and will include a plan for sustained improvement from the QI committee.

Legal Licensing and Credentialing of Staff

The policies and procedures that guide the Human Resources Department and Credentialing department address these areas for all staff hired as employees/contract employees of the Brazos Valley Community Health Centers.

It is a requirement that all certified and licensed healthcare professionals participate in the credentialing process. Credentialing is provided by contract with a local Health Care Business Management firm in coordination with BVCAA, Inc's Human Resources Director and Medical Director. Completed files are submitted to the Professional Review Committee under direction of the CMO, the Clinical CEO and Board of Directors for review and approval upon the hire of the healthcare professional and at least every two years thereafter. The granting of privileges to practice within the Community Health Center system is based on the outcomes of the credentialing process and the approval of the Board of Directors.

The contracted Health Care Business Management firm monitors licensure status of all credentialed clinical staff members. This information is reported through the Professional Review Committee and the CPI Committee regularly. The CMO has oversight of the credentialing and re-credentialing processes.

Continuing Medical Education (CME) documentation is kept as part of the licensed clinical staff member's Human Resources file and reviewed upon re-credentialing to ensure completion of the required number of hours per staff members licensing requirement.

Documentation of Compliance with Laws, Regulations, and Professional Standards

BVCHC's Quality Assurance Committee is responsible for the periodic assessment of the services provided to ensure that these services are in compliance with all applicable laws, rules, regulations, and professional standards.

There are two levels of monitoring that occur within the agency. The BVCHC assures quality of services and continual performance improvement at the organizational level via the CPI Committee and at the clinical level via the Professional Review Committee (PRC) and its Medical Peer Review subcommittee.

The first level of review is performed for the CPI Committee by the Quality Assurance Committee. This level of review and auditing focuses on the documentation of patient care. The standards against which the reviews and audits are conducted are governed by funding sources, insurers and reimbursement entities as well as established standards of care and performance as they apply to BVCHC.

Annually the CPI Committee publishes a schedule of audits delineating what will be audited in which quarter or month of any particular calendar year. Audits and reviews also conducted on an as needed basis when driven by requests from competent authority. Competent authority would include CPI Committee, the CMO, COO or a Clinic/Practice Manager asking for a focused review of an aspect of their clinic's operations.

Additionally Quality Assurance is guided by the attached Grid and Calendar which delineates performance subjects and the level of performance required. The level of compliance, unless otherwise noted, is no less than 80% compliance rate.

All review and audit results are compiled, analyzed and reported to the CPI Committee and distributed as directed by the CPI Committee. Results are also provided to the authority who requested any focused audit. All results are assessed for performance and quality improvement opportunities and recommendations are documented and made as appropriate.

When it has been determined by the authorities indicated above that a Plan of Correction (POC) is necessary it is ordered and results tracked. Follow up reviews and audits are performed on no less than a monthly basis until results indicate the level of compliance has attained the threshold compliance rate.

At a higher level, the Professional Review Committee operates as an organized Peer Review Committee under applicable federal and state laws and regulations, including without limitation, the Federal Healthcare Quality Improvement Act, the Texas Medical Practice Act, the Texas Dental Practice Act, and all the collective regulations promulgated there under. To accomplish its peer review function, members of the Professional Review Committee along with designated Lead Physicians perform continuous peer review chart audits of agency healthcare providers.

The chart audit consists of the following elements:

- Appropriateness of medical data / history gathering
- Appropriateness of examination skills
- Adherence to agency Standards of Care
- Appropriateness of preventive healthcare offered
- Provision of patient education

If, during the peer review process, a significant occurrence or a pattern of quality concerns is identified, the Professional Review Committee may choose to initiate a special investigation, as defined in the Professional Staff Bylaws, to determine appropriate action necessary to ensure patient safety. In addition, the agency's healthcare providers are encouraged to self-report adverse or potential adverse outcomes via standardized documentation to the Professional Review Committee as a proactive measure in the event of future complaint or litigation.

XIV. QUALITY IMPROVEMENT

QI Committee(s) is/are cross-functional team(s) that is responsible for solving quality related problems using PDSAs, root cause analysis, and other improvement strategies. At QI meetings, team members discuss the outcomes of quality metrics, identify weaknesses and strengths, and create proposals for improvements using the PDSA model for improvement. Information regarding the QI processes is reported to the Clinic

CEO, CMO, and Board of Directors at least quarterly in the CMO's board report. All reports will specifically identify the finding's relationship to organizational performance or a specific performance standard; and will include a plan for sustained improvement.

QI Process

When a measure falls below threshold or quality improvement is needed for a measure, the CPI Committee identifies whether QI can take place at the site level or whether a subcommittee need to be established to do the work of improving the measure. The CPI Coordinator will coordinate QI activities with the clinic/practice manager or subject matter expert who will then be responsible for driving the QI process and gathering documentation. The Quality Improvement plan is submitted to the CPI Coordinator who is responsible for maintaining QI documentation and records. Human Resources will coordinate training for quality/performance improvement per recommendation of Quality Improvement Committees.

The QI plans will be updated as the clinic/practice managers or subject matter expert monitors progress and identifies the methods (e.g. verbal emphasis and reminder, formal training, etc) needed to move the measure to the threshold. Progress on improving the measure will be reported at the following CPI Committee meeting. CPI Committee also establishes the time frame for quality improvement on a measure. This may vary from 30 to 90 days depending on measure and the depth of QI needed.

PDSA Cycle

Identified CPI projects will be reviewed using the Plan, Do, Study, Act (PDSA) process outlined briefly below:

Plan - a change or a test, aimed at improvement. In this phase, analyze what you intend to improve, looking for areas that hold opportunities for change. The first step will be to choose areas that offer the most return. To identify these areas for change CPI Committee may use, but are not limited to; Flow charts or Pareto charts.

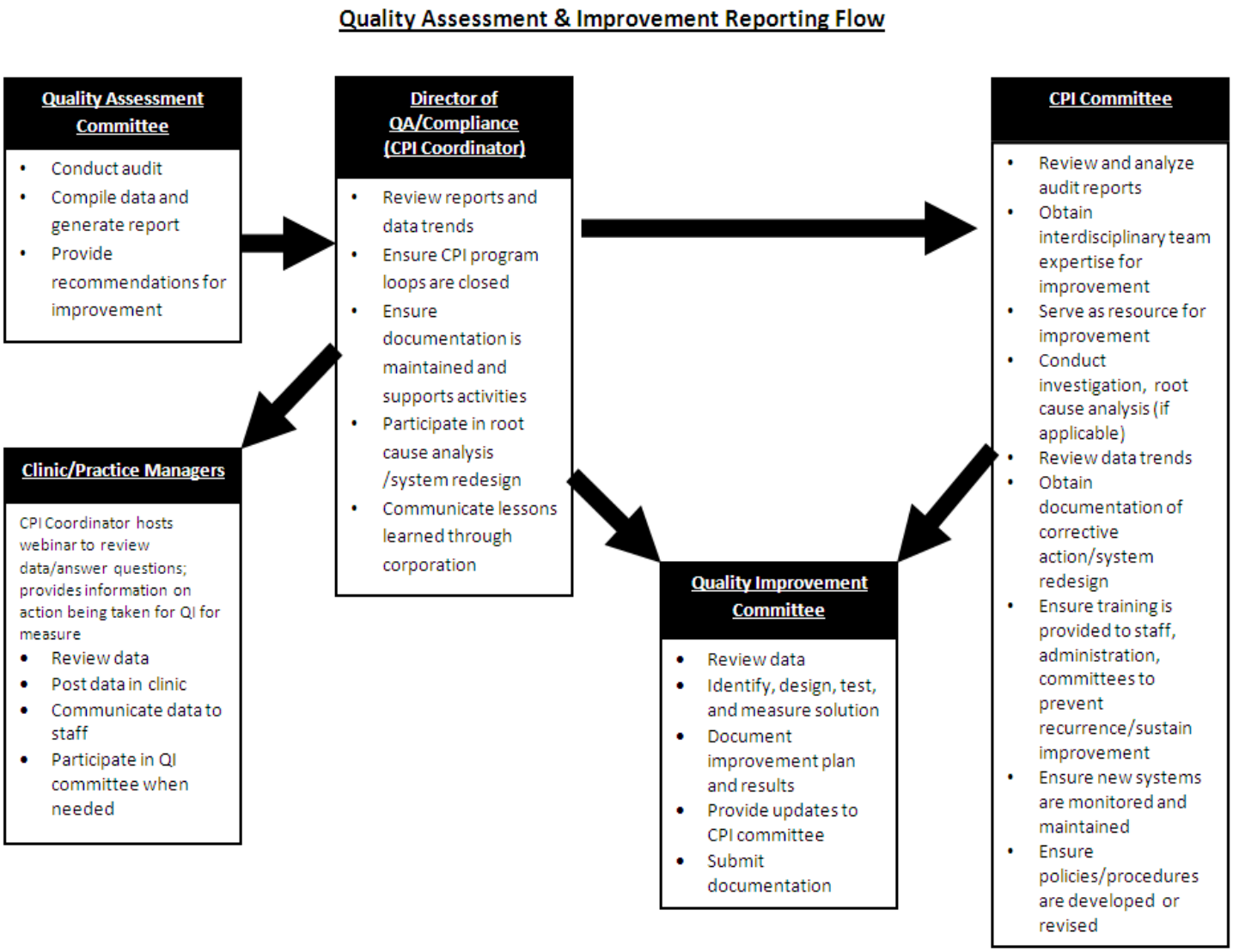
Do - Carry out the change or test; initially on a small scale. Implement the change you decided on in the plan phase.

Study - The results. What was learned? What went wrong? This is a crucial step in the PDSA cycle. After CPI Committee has implemented the change for a short time and determined how well it is working. Several measures will be used to present and monitor the level of improvement; including but not limited to; Pie and Bar graphs; Run charts.

Act - The identification of processes which CPI Committee will adopt the change, abandon it, expand it or run through the PDCA cycle again.

PDSA is an effective method for monitoring quality assurance because it analyzes existing conditions and methods used to provide the service to patients. The goal is to ensure that excellence is inherent in every component of the process. Quality assessment also helps determine whether the steps used to provide the service are appropriate for the time and conditions. In addition, if the PDSA cycle is repeated throughout the lifetime of the product or service, it helps improve internal company efficiency.

XV. QUALITY ASSESSMENT AND IMPROVEMENT REPORTING FLOW



XVI. TRACKING SYSTEMS

Tracking QM processes, outcomes, and measures is one of the important elements demonstrating the effective provision of health care to patients. As part of this QM Plan, the tracking systems will include;

1. Agendas and minutes for all CPI Committee and Board of Directors meetings where discussions are held.

2. Informal documentation of all PDSA cycles completed, notes, worksheets, etc.
3. Documentation and reports of all data analysis; including any required health care metrics, survey results, tracking tools, peer reviews and chart audits, and evaluations.
4. Quarterly reports presented to Clinic CEO, CMO, and Board of Directors.

All reports and documentation will be reviewed at CPI Committee meetings and approved officially in the minutes.

CPI Committee Reports

The CMO will include the CPI Committee reports in the quarterly report to the Board of Directors.

Internal reports may be more or less detailed, depending on audience. The QA and QI Committees' members generally see the greatest detail, enabling them to constantly analyze and address indicators and related issues. The CPI Committee (including the Clinical CEO and CMO) sees less ground-level detail but is kept informed on current metrics and how performance is improving over time. Finally, the Board of Directors generally sees a broad quality overview. For the CPI Committee / CEO/ CMO and the Board of Directors, further detailed data can be made available if desired. Internal Reports should include:

1. Identification of the metrics
2. Specific metric measurements relative to pre-established goals and quality action points
3. Improvement activities initiated
4. Ongoing results of quality improvement

CPI Coordinator will additionally report QA and QI activities and current measures to all BVCHC staff and providers on a regular basis. This can be accomplished electronically via internal email or intranet, through paper-based summaries handed out in staff meetings, by posting quality reports in common areas, etc.

CPI QM Plan Review

The purpose of the annual QM Plan Review is to coordinate the review load and frequency based on the scope of review by certain topics or categories.

This review is completed as preparation for a new activity year by the CPI Coordinator to reflect the review in the areas assigned to the CPI Committee. It can be modified and updated as needed to accurately reflect the review and scope of work. Some non-clinical CPI Committees will not have a specific review schedule, but should still identify concerns in their designated areas that need to be reviewed and considered for study and improvement. The report is submitted to the CPI Coordinator and becomes a part of the CPI Committee Records, to be shared with the Clinical CEO and CMO. Certification and accreditation surveyors may ask to see this schedule and review a sample of studies or reviews performed.

As part of this review, CPI Committee will evaluate overall trends for clinical indicators, finance indicators, staff evaluations, peer review, chart audits, CPI Committee reports, and patient experience. The QM plan will be updated by the CPI Coordinator to reflect recommended priorities and presented to the Board of Directors for approval. Prior to taking action, the Board of Directors may request the CPI Committee review the proposed QM Plan and provide recommendations to the full governing body.

XVII. PERFORMANCE METRICS

Evaluation and Priorities

The following will additionally be included as measurements for the 2013 BVCHC Quality Management Plan:

- Uniform Data System (UDS)
- FQHC Performance Measures
- Meaningful Use Metrics
- Optimizing Comprehensive Clinical Care (OC^3)
- NCQA Patient Centered Medical Home (PCMH)
- Accountable Care Organization (AC)
- Texas Department of State Health Services (DSHS)
- Safety
- Texas Association of Community Health Centers (TACHC)
- Health Information Portability Act (HIPAA)
- Fundamental Primary Care Metrics
- Program-Specific Quality Metrics

Goals and Benefits

BVCHC community health centers' FTCA 2013 Performance Improvement Plan, baselines, measurement tools, and audit schedules are contained at the end of this document as attachments.

Clinical CEO	**Date**
CMO	**Date**
Board of Directors President	**Date**

ATTACHMENTS

1. CPI Organization Chart & Responsibilities
2. 2013 Master Audit Schedule