The Anytown Medical Clinic

Coordinated Quality Improvement Program Plan

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Coordinated Quality Improvement Program
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Coordinated Quality Improvement Program Plan

I. Mission

The mission of the Coordinated Quality Improvement Program is to improve the quality of health care services rendered to patients and to identify, control and reduce adverse health outcomes and medical malpractice events.

In support of that mission, the Program will

1. provide a coordinated framework for assessing, evaluating and improving quality patient care and organizational functions
2. collect, maintain and analyze information pertinent to health care quality improvement
3. educate and assist health care providers to lead and participate in quality improvement activities such that health care quality is improved and medical malpractice events are reduced.

This framework will focus on patient satisfaction and quality care ensured through involving participants in all aspects of providing services to patients.

II. Coordinated Quality Improvement Program administration, authority and accountability

The Coordinated Quality Improvement Program will be administered by the Quality Improvement Committee. The Committee shall be appointed by the

administrative leadership of the medical group and/or the Board of Directors. The Committee derives its authority from the Board of Directors.

The ultimate accountability for quality improvement at the Anytown Medical Clinic rests with the Board of Directors (attached appendix). The Board of Directors has delegated to the Quality Improvement Committee the primary responsibility for quality improvement activities. It is the Board's expectation that quality improvement activities will involve all levels of the institution acting together collaboratively. The Board of Directors will review reports from the Committee, request further review or action as necessary, implement action plans and set policy for the institution and offer direction during planning activities of the Coordinated Quality Improvement Program.

III. Quality Improvement Committee responsibilities

The Quality Improvement Committee provides guidance and inspiration for process development to design, assess, monitor and redesign program and service changes consistent with the goal of improving health care quality. The Committee is charged with the responsibility to implement and monitor system improvements to improve health care quality.

The Anytown Medical Center will have a written annual Quality Improvement Plan to identify and implement quality improvement measures consistent with the overall goals and resources of the Center. The plan will be based upon a calendar year and shall identify priorities for quality improvement activities. The plan will describe the core functions, structure, dimensions of focus and assigned responsibility for quality improvement activities. Creation, implementation and monitoring of the plan shall be the responsibility of the Quality Improvement Committee.

The Quality Improvement Committee shall at a minimum have the following responsibilities:

1. Planning and structure of the Coordinated Quality Improvement Program

The Program shall include three dimensions of focus: systems and processes, resource utilization and risk management.

Within each area of focus, quality improvement may consist of the following activities:

- *issue identification and assessment*
- *prioritization*
- *process improvement*
- *monitoring*

A. Issue identification and assessment

Issues may be identified via a number of different data sources:

- *patient input*
- *patient comment forms*
- *quality control procedures*
- *utilization review*
- *incident reports*
- *credentialing*
- *clinician peer review*
- *cost accounting or productivity data*
- *referral data*
- *satisfaction surveys from patients and clinicians*

Issues may be assessed in accordance with process performance compared internally over time and/or process performance compared with external standards. The dimensions of process performance may include whether the process is appropriate, available, timely, effective, efficient, safe, and respectful.

B. Prioritization

After issue identification and assessment, areas of process improvement shall be prioritized in accordance with the overall goals and resources of the Clinic.

C. Process improvement

Improving health care quality may be accomplished by improving the process of health care delivery. Process improvement may include:

1. *Identifying a potential process improvement through issue identification and assessment and prioritization*
2. *Formulating a plan of action*
3. *Testing the strategy of change*
4. *Assessing the results of the test strategy*
5. *Implementing the process improvement*

D. Monitoring

System improvement shall be monitored to ensure that the goals of the Program are being met. System improvement activities may be modified as indicated by assessing the effects of the improvement activity as related to the mission of the Program.

2. Oversee and coordinate the Program;

The Quality Improvement Committee is responsible for overseeing and coordinating the Coordinated Quality Improvement Program. The Committee will maintain managerial oversight to ensure that Program activities are consistent with the Program's mission and emphasize the improvement of health care and the reduction of adverse health outcomes and medical malpractice events. At its discretion, the Committee may delegate Program activities to sub-committees, employees and agents of the medical group while retaining oversight responsibility.

3. Quality Improvement Committee membership

The Committee shall be comprised of individuals who are broadly representative of the medical group and who are in a position to effectively assess, evaluate, plan and implement strategies pertinent to patient care and organizational processes. The membership of the Committee shall include personnel from the following departments or job responsibilities:

Co-Chairs

Medical Director

Quality Improvement Program Coordinator

Medical staff members	*Other staff members*
Family Practice	*Medical records*
Internal Medicine	*Managed care coordinator*
Pediatrics	*Administration*
Surgery	*Clinical services*

Obstetrics/gynecology *Others as needed*

Others as needed

4. Quality Improvement Committee sub-committees

The Committee shall have the authority and responsibility to appoint sub-committees as necessary. All such sub-committees shall report directly to the Quality Improvement Committee.

5. Quality Improvement Committee meetings

Meetings shall be held at least monthly or more often as needed at the discretion of the Committee.

6. Confidentiality

Members, participants and visitors of the Committee shall sign an agreement of confidentiality relevant to the functions of the Coordinated Quality Improvement Program and its activities.

7. Retrospective and prospective review of services to improve the quality of health care and reduce medical malpractice events by measuring key characteristics such as effectiveness, accuracy, timeliness and cost;

Retrospective and prospective review of services will be accomplished by:

- *review of incident report forms (attached appendix)*
- *providing and monitoring preventative health care*
- *clinician peer review*
- *patient satisfaction surveys*

- *outcomes research*
- *review of patient comment forms (attached appendix)*
- *contract review data from health care payors*

8. Review the categories and methodologies of services offered and to be offered in the future in order to improve health care outcomes;

Review of services offered currently and to be offered in the future will be accomplished to ensure those services provide quality patient care in a cost-effective manner that improves health care outcomes.

9. Collect, maintain, analyze and review Program information in order to revise health care policies and procedures as necessary;

Using the data sources noted in sections 1 or 7 above, the Committee will collect, maintain, analyze and review data in order to

- *recommend further analysis or study;*
- *recommend revision of Clinic policy and/or procedure; or*
- *recommend training and/or education of clinicians and staff.*

10. Report at least semi-annually on Program activities and actions to the governing body of the medical group.

The Committee shall report on Program activities and actions to the Board of Directors at least semi-annually. An annual written report shall be submitted by the Committee to the Board of Directors which includes a report of quality improvement activities, actions, outcomes, trending of clinical and service indicators and other information pertinent to the mission of the Committee. Reports may be made more often as necessary

or on an ad-hoc basis. An annual summary of Program activities and actions shall be made available to the governing body or other interested parties.

11. The clinical staff members of the Quality Improvement Committee are responsible for educating, counseling and monitoring the clinical staff of the Clinic to ensure adherence to all applicable policies, procedures and standards.

12. The non-clinical staff members of the Quality Improvement Committee are responsible for educating, counseling and monitoring the non-clinical staff of the Clinic to ensure adherence to all applicable policies, procedures and standards.

13. Reporting requirements

The Committee will develop a process to assure compliance with any reporting requirements to appropriate state, local or federal authorities. Items to be reported include professional misconduct, malpractice payments to patients and other items required by law.

IV. Coordinated Quality Improvement Program documentation

Minutes shall be recorded at all meetings of the Quality Improvement Committee and any appointed sub-committees. Any quality improvement studies, recommendations of studies, incident reports, provider evaluations, and other recorded information pertinent to the Coordinated Quality Improvement Program shall be attached or incorporated by reference into the Committee minutes. It is the intent of the Committee that any Program

documentation shall be protected from legal discovery to the fullest extent allowed by law.

The Committee minutes will be available for internal review within the medical group on a need to know basis as determined by the Committee. Summaries of the minutes with identifying names removed may be divulged or provided to health care payors, governmental or regulatory agencies or other entities at the sole discretion of the Committee. Such disclosure will only be made when disclosure will not effect confidentiality requirements or impair any legal position of the medical group in any future legal or regulatory proceeding.

All Committee minutes, incident reports, provider evaluations and all other recorded information pertinent to the Coordinated Quality Improvement Program shall be clearly marked as follows: "Coordinated Quality Improvement Program work product".

V. Information collection and maintenance

The Committee shall continually collect and maintain information concerning :

1. experience with negative health care outcomes and injurious incidents; and
2. professional liability premiums, settlements, awards, and costs for injury prevention, safety improvement and health care improvement activities.

Information on adverse health care outcomes and injurious incidents will be collected concurrently and maintained using incident reporting, peer review, patient comment forms and patient records of unexpected individual adverse health care outcomes.

Information on professional liability premiums, settlements, awards and costs for injury prevention, safety improvement and health care improvement activities will be jointly provided to the Committee by the malpractice insurer and administration of the medical group.

3. Safety improvements, health care system improvement activities and resource utilization

Information on safety improvements, health care system improvement activities and resource utilization will be provided to the Committee by the administration, employees, or agents of the medical group using whatever external or internal data sources are deemed appropriate by the Committee.

This information shall be periodically provided to the governing body and the providers of the medical group.

VI. Incident reporting

Accidents, injuries, negative health care outcomes, patient complaints and other information pertinent to health care quality improvement will be reported to the Committee as an incident under the Quality Improvement Program. An incident report form shall be used to ensure consistent reporting. Employee incident reports will be sent for review to the Center's safety officer. Patient incident reports will be sent for review to the Center's Medical Director. All incident reports will be reviewed and analyzed by the Quality Improvement Program Coordinator with appropriate action taken as necessary.

Maloccurrences that may result in adverse health outcomes or health care malpractice claims will be investigated and either resolved internally by the

medical group, to the extent feasible, or reported to the malpractice insurer of the medical group for appropriate investigation and resolution.

VII. Quality Improvement education

The Quality Improvement Committee shall sponsor quality improvement educational activities for health care providers at least annually or more often as needed at the discretion of the Committee. These educational activities will be in addition to other continuing education activities provided or facilitated by the Center. These educational activities may include, but are not limited to:

1. Quality improvement in health care

Education in health care quality improvement may be provided by local health care facilities; or providers, employees, agents or consultants of the medical group. The Quality Improvement Coordinator shall be responsible for ensuring that quality improvement data and information is communicated to the clinicians and staff of the Center.

2. Safety and injury prevention

Safety and injury prevention, infection control or hazardous materials education may be provided by local health care facilities; providers, employees, agents or consultants of the medical group; or the risk management educational programs of the medical group's malpractice insurer. Safety and injury prevention education is provided to all staff at the time of employment orientation, on an ad hoc basis and as a result of mandatory continuing education or activities that may be required by law or regulation.

3. Responsibilities for reporting professional misconduct

Education on responsibilities for reporting professional misconduct may be provided by state and/or federal regulatory or enforcement agencies; or providers, employees, agents or consultants of the medical group.

4. Legal aspects of providing health care

Education on legal aspects of providing health care may be provided by local health care facilities or the risk management educational programs of the medical group's malpractice insurer. All clinicians will comply with State requirements for continuing medical education on risk management.

5. Improving communication with patients

Education on improving communication with patients may be provided by local health care facilities; providers, employees, agents or consultants of the medical group; or the risk management educational programs of the medical group's malpractice insurer.

6. Causes, prevention and reduction of malpractice claims

Education on the cause, prevention and reduction of malpractice claims may be provided by the risk management educational programs of the medical group's malpractice insurer.

VIII. Provider evaluation

The Anytown Medical Center has a physician and mid-level provider credentialing process. Offers of employment are contingent upon satisfactory

passage of the credentialing process. Credentialing included verification of licensure, DEA certification, education, residency, board certification or eligibility, and information from the National Practitioner Data Bank.

As appropriate to the scope of the provider's practice, every provider employed by the Center shall be periodically evaluated for mental and physical capacity, competence in delivering health care, verification of licensure, medical staff appointments, and reports from the National Practitioner Data Bank. Periodic evaluation of all providers will be done at least every two years.

The provider evaluation may include any of the following elements as deemed appropriate by the Quality Improvement Committee:

1. Patient satisfaction survey
2. Evaluation by peer providers within the same clinical department and throughout the medical group as appropriate
3. Evaluation by support staff as appropriate
4. Verification of licensure
5. Verification of current medical staff appointments
6. Verification of reports to the National Practitioner Data Bank
7. Evaluation of CME participation
8. Evaluation of risk management issues
9. Review of a representative sample of current charts
10. Productivity

IX. Complaint resolution

The Program will incorporate a procedure to investigate and resolve, in a timely fashion and to the extent feasible, patient complaints pertaining to accidents, injuries, treatment and other events that may result in adverse health

outcomes or claims of health care malpractice. The Quality Improvement Committee shall appoint a member to serve as a patient liaison for complaint resolution. Records shall be kept of patient complaints and the response thereto. These records shall come under the purview of the Program and are Program work product.

X. Coordinated Quality Improvement Program information concerning providers

Program information regarding a provider will be maintained within the medical group's personnel or credential file for that provider. Patient confidentiality will be maintained to the extent necessary to facilitate Program activities. All such information maintained on a provider pertinent to the Coordinated Quality Improvement Program shall be clearly marked as falling under the purview of the Program.

Draft eight: 8/14/95
M.G. Lloyd

Appendix A

Confidentiality agreement

I, _____, acknowledge and agree that I am a participant in the Coordinated Quality Improvement Program (CQIP) conducted under the auspices of the Quality Improvement Committee at the Anytown Medical Center. As a participant, I understand and agree that maintaining confidentiality is vital to the quality improvement process.

I agree to respect and maintain the confidentiality of all discussions, records, and information, whether oral or recorded in any form or medium, produced in connection with the CQIP. I further agree to not disclose any such information except as required by the activities of the CQIP or by law.

_____

Signature

_____

Date

Clinician credentialing application

Clinician name: _____

Date of birth: _____ Place of birth: _____

Please attach the following items to this application:

- ❑ Current Washington State license
- ❑ Current DEA certificate
- ❑ Professional school diploma
- ❑ ECFMG (if applicable)
- ❑ Residency certificate (if applicable)
- ❑ Fellowship certificate (if applicable)
- ❑ Board certification: _____
- ❑ Report from the National Practitioner Data Bank
  (Call 1-800-767-6732 to obtain the report)

Additional credentialing information

If you answer yes to any of the listed questions, please explain further on a separate sheet of paper.

1. Has your license to practice or DEA certificate ever been denied, restricted, limited, suspended, subject to probationary terms, revoked, or voluntarily surrendered?

   ❑ Yes ❑ No

2. Have you ever been subject to disciplinary proceedings by any governmental agency, medical or professional society resulting in reprimand, censure, sanction, restriction or modification of your practice, either voluntary or involuntary, or are you currently the subject of an

administrative, judicial or disciplinary proceeding or review by any such agency or society?

❑ Yes ❑ No

3. Have your privileges or membership at any hospital or medical institution ever been denied, restricted, suspended, reduced, modified, terminated, subject to probationary terms, voluntarily surrendered or not renewed or have disciplinary proceedings at any hospital or medical institution ever been instituted against you?

❑ Yes ❑ No

4. Has your membership in any medical society or professional organization ever been denied, suspended, revoked, restricted or voluntarily surrendered?

❑ Yes ❑ No

5. Do you have any physical or mental health problems that may limit your ability to practice within the scope of existing hospital medical staff privileges or within the scope of your capacity as a provider of medical services in any other setting?

❑ Yes ❑ No

If so, are there any reasonable accommodations that you may require or request?

_____

_____

6. Have you ever been convicted for an act committed in violation of any law or ordinance other than traffic offenses?

❑ Yes ❑ No

7. Has any claim or suit for alleged medical malpractice ever been brought against you, your professional corporation, your employer or your hospital or medical institution involving medical care provided by you.

❑ Yes ❑ No

8. Has your professional liability insurance ever been declined, cancelled, non-renewed or issued on special terms such as a premium surcharge or deductible?

❑ Yes ❑ No

Applicant's representation (read carefully)

I hereby represent that the information contained in this application and any supplemental submission is complete and true and that no material facts which are reasonably likely to influence the judgment of Anytown Medical Clinic in considering this application have been omitted. I understand and agree that this application will in part be the basis of the employment requested and that I will notify Anytown Medical Clinic of any changes in the information contained therein.

Applicant's authorization and release (read carefully)

I acknowledge that as a condition precedent to acceptance of this application, an inquiry and investigation of my professional background, qualification and competence, including any other matters deemed relevant by the Anytown Medical Clinic, may be conducted by the Anytown Medical Clinic or its duly authorized representatives. I expressly consent to any such inquiry and investigation and hereby authorize the release and exchange of information pertaining to such inquiry and investigation between any professional organizations in which I am or have been a member; their insurance consultants or agents; any hospitals or medical institutions at which I hold or have ever held staff privileges or have had an application for staff privileges denied; any state licensing agency; any university, college, school or institution of higher learning; any attending or treating physicians; any prior insurance carriers; prior employers; professional associates; and the Anytown Medical Clinic or its duly authorized representatives. I hereby release and discharge the providers of information, the Anytown Medical Clinic, its duly authorized representatives and the members or consultants or any established peer review committees from any and all legal liabilities which might otherwise be incurred as a result of any communications, reports, disclosures and recommendations made, or any acts performed, in good faith, in connection with any inquiry or investigation initiated by the Anytown Medical Clinic or its duly authorized representatives.

_____

Applicant's signature Date

Declaration

I declare under penalty of perjury under the laws of the State of Washington that the information provided in this Clinician Credentialing Application is complete, true and correct.

_____	_____
Date and place	Signature

The Anytown Medical Clinic
1995 Quality Improvement Plan

The Anytown Medical Clinic has a planned, systematic, organization-wide approach to assessing, measuring, and improving performance. Organizational performance activities are carried out collaboratively, and include appropriate departments and staff. Preparation of each year's plan will begin in December of the prior year. Monitoring activities will work through the calendar year with quarterly and annual reports submitted to the Quality Improvement Coordinator.

Monitoring activities, data collection and data sources

Monitoring activities will be derived from the clinics core functions. The core functions or processes of the Clinic are defined through management structuring and include the following:

Operations Services	Information Services
Clinical Services	Managed Care Services
Business Services	Financial Services
Human Resource Services	Medical Staff

Data gathering about the performance on each of these processes will be obtained internally and externally in order to compare to other data bases. Internal information may be gathered from the following sources:

- Medical Record Review
- Case Reviews
- Patient Satisfaction/Comment Surveys
- Staff Meetings
- Clinical Indicator Measurements
- Risk Management Outcome Data
- Patient Grievance Data
- Audits from health care payors

External comparative information comes from peer group data including:

- MGMA Annual Cost Survey
- UMGA - Bench-marking
- National Clinical Standards
- Clinical Health Plan Data

The aspects of care and service choices will be those which are deemed to be most important to the quality of patient care and service based upon available organizational resources. Areas of focus will be based upon the following elements:

- High risk to patients
- High volume aspects of care

All patient care and service that the Anytown Medical Clinic provides will be considered in determining priorities for ongoing monitoring. The key patient care and service functions at the clinic shall encompass the following:

- The appointment system
- Practice guidelines
- Infection control
- Managerial and governance activities, such as patient accounts, marketing
- Human Resources - Regular staff and physician reviews, orientation, training, continuing education
- Patient/Family education
- Referral systems
- Telephone system (triage)
- Utilization management system
- Patient representation
- Patient conditions and diagnoses served
- Service accessibility - times care and service are provided
- Return clinic visits

Quality improvement priorities for 1995

Clinic priorities will be reviewed on an annual basis. The 1995 priorities are:

*Service Excellence

Affects all patients
Positions clinic for improved marketability
Improves internal morale
Plays a role in reducing risk management

*Clinical Areas of focus

Immunizations follow-up
Tracking system for radiologic risk area
High cost pharmaceuticals

Mammography,
Patient instruction
Asthma treatment modalities
Patient Recall System (paps, hemocult, etc)

Places patients at serious risk if not performed or performed well
Places clinic at great risk if not done effectively & efficiently

Plays a role in increased costs to our patients
Standardizes treatment & assists in clinical staff education
Represents a wide age distribution
Represents HEDIS clinical outcome indicators

Quality improvement methodology

The approach for improvement for the 1995 organization priorities will be carried out in the following manner:

Process design is based upon the organization's
Mission
Strategic Plan
The needs and expectations of patients, staff, and physicians
Current information about the performance of the processes & their outcomes from reference organizations

Data will be collected to assess processes, measure the level of performance & stability of important existing processes, to identify areas for possible improvement. Data will relate to the following dimensions of performance:

- Efficacy
- Appropriateness
- Availability
- Timeliness
- Effectiveness
- Continuity
- Safety
- Efficiency
- Respect & Caring

After the data is collected and priorites are set, process improvement shall be conducted as set forth in the CQIP plan.

Assigned Responsibility for quality improvement

The Administrative leaders are responsible for overseeing the design and fostering clinic wide approaches to improving quality, assigning quality

improvement responsibilities within the organization, and setting strategic priorities for quality assessment and improvement throughout the clinic.

Administrative leaders shall be defined as the Governing Board, The Medical Director, the CEO, the Director of Operations, the Clinical Services Manager, the Director of Human Resources, and the Director of Managed Care of the Anytown Medical Clinic.

The Quality Improvement Coordinator is responsible for coordinating, educating, monitoring and counseling the non-medical staff to ensure departmental implementation of the quality improvement process.

Clinical, Ancillary, and Support managers and service/program supervisors will be responsible for ensuring that the activities in their areas are encompassed by the quality improvement monitoring and evaluation activities.

It shall be the responsibility of every clinic employee to participate in improving organizational performance and improving quality of care.

INCIDENT REPORT
Coordinated Quality Improvement Program work product
Do not file or reference in medical record

Date of incident:	Time:	Incident location:

Affected party ❑ Patient ❑ Visitor ❑ Employee ❑ Medical staff	Sex ❑ Male ❑ Female	Age:

Affected party name and address:	Phone number:

Description of affected party's injury or complaint:

Name and phone number of witnesses:

Incident description: _____

_____

_____

_____

_____

_____

Possible contributing causes: _____

_____

Corrective action taken: _____

_____

Recommendations to prevent future incidents: _____

_____

_____

Action taken by person reporting incident	❑ Physician notified (name) _____ ❑ Administration notified (name) _____ ❑ Employee supervisor notified (name) _____ ❑ Equipment removed from service ❑ Affected party examined by physician ❑ No ❑ Yes (name) _____ ❑ Other _____

Reported by	Title/department/clinic:	Date:

INCIDENT REPORT
Coordinated Quality Improvement Program work product
Do not file or reference in medical record

Coordinated Quality Improvement Program management review

Action taken by QI reviewer

- ☐ No further action necessary
- ☐ Staff/clinician education
- ☐ Policy/procedure change
- ☐ Referred to Business Office
- ☐ Attending clinician notified
- ☐ Staff/clinician counseling
- ☐ Referred to QI committee
- ☐ Maintenance notified
- ☐ Referred to Administration
- ☐ Referred to Medical Director
- ☐ Fee waiver/reimbursement
- ☐ Equipment repair or replace
- ☐ Insurer notified
- ☐ Malpractice
- ☐ WC
- ☐ Property
- ☐ Liability
- ☐ Auto
- ☐ Other: _____

Date: _____ Insurance company: _____ Contact person: _____

Other actions taken: _____

Additional comments: _____

Copies sent to: _____

QI Reviewer's signature	Date: