PRIMARY HEALTH CARE, INC.

PERFORMANCE IMPROVEMENT PLAN

September, 2003

I. PURPOSE. The Performance Improvement Plan for Primary Health Care, Inc. establishes a planned, systematic, organization-wide approach to process design and performance measurement, analysis and improvement for the health care services we provide.

II. INTEGRATION OF PI PROGRAM WITH MISSION, VISION, AND STRATEGIC PLAN. This plan will assist PHC staff in actively achieving our mission to provide 100% access to, and 0% disparities in, quality health care for our community. As an organization, we have established priorities around three major areas: growth and expansion of services, improved productivity and efficiency, and improved quality. These organizational priorities will guide our performance improvement efforts and help us to achieve our strategic goals.

III. GOAL. The goal of the program is to increase the value of our services, by enhancing quality and strengthening our ability to deliver cost effective care.

OBJECTIVES:

A. To design effective processes to meet the needs of our patients which are consistent with the health center's mission, vision, goals and plans.

B. To collect data to monitor the stability of existing processes, identify opportunities for improvement, identify changes that will lead to improvement, and sustain improvement.

C. To aggregate and analyze data on an ongoing basis and to identify changes that will lead to improved performance and a reduction in errors.

D. To achieve improved performance and sustain the improvement throughout the organization.

E. To promote collaboration at all levels of the organization enabling the creation of a culture focused on performance.

F. To educate leaders and staff regarding responsibilities and effective participation in performance improvement activities.

IV. SCOPE AND ORGANIZATION: See *Figure 1.*

1. **Board of Directors**: The Board of Directors is the final authority and is ultimately responsible for the Performance Improvement Program. It may delegate any and all program operations to the staff of Primary Health Care, Inc.

2. **Performance Improvement Committee of the Board**: The Performance Improvement Committee of the Board is accountable to the Board of

Directors for the quality of care and services provided by the health center.

The Committee identifies and prioritizes improvement opportunities, and ensures that adequate resources are available to accomplish performance improvement initiatives. The Committee receives, reviews and evaluates performance improvement reports. The Committee conducts an annual evaluation of the Performance Improvement Program.

See the Board of Directors Bylaws for more details about this committee. See Figure 1 for reporting structure and Figure 2 for schedule of reports.

3. **Staff Performance Improvement Committee:** The Performance Improvement Committee is responsible for implementing the Performance Improvement Program at the health center. The committee will meet on a monthly basis.

The Operations Director, who serves as Chair of the Committee, will act in a facilitative and consultative manner and will assist the Performance Improvement Committee in the implementation of policies, plans and projects aimed at performance improvement or achieving and maintaining accreditation.

Membership in the Performance Improvement Committee will include individuals from multiple disciplines throughout the organization as well as representatives from each of the different sites and programs. The Executive Director and the Medical Director shall be members of the Performance Improvement Committee.

Responsibilities of the committee include: 1) evaluate data and information received from units, programs, subcommittees and teams; 2) monitoring and evaluating reports relating to patient satisfaction, complaints, medical record review, and others as defined by the organization; 3) implementation and management of a patient safety program, and 4) review of JCAHO compliance teams. *See Figure 2 for reporting schedule.*

Reports will be made to the Performance Improvement Committee of the Board on a quarterly basis.

Members	
Operations Director, Chair	Dental Director
Medical Director	Outreach Director
Executive Director	Finance Director
Infection Control Coordinator	HIV Program Representative
Safety Officer	Pharmacy Director

MT Primary Health Center Director	Physician
BEC/ESC/GVC Clinic Director	Midlevel Provider
ESC/GVC Clinic Manager	

4. **Credentials Committee:** The Credentials will meet as necessary to accomplish assigned tasks.

   The Medical Director is the Chairperson of the subcommittee and, in conjunction with the Executive Director, will be responsible for the establishment, implementation, and rigorous review of the clinical competency within the organizations facilities.

   The responsibilities of the committee include: 1) appointment of licensed independent practitioners to the organization's medical staff, 2) rigorous and confidential review of the clinical practice of medicine by Licensed Independent Practitioners and other clinical staff, and 3) reappointment of licensed independent practitioners by participating in the development, implementation and monitoring of clinical practice guidelines within the facilities.

   If, and when necessary, the committee can be expanded to include all of the organization's currently privileged licensed independent practitioners.

   Reports will be made to the Board of Directors as necessary.

5. **Safety and Infection Control Subcommittee:** The Safety and Infection Control Committee is a permanent subcommittee of the Performance Improvement Committee. The subcommittee will meet quarterly, or more frequently as determined by the chairpersons.

   The Safety Officer and the Infection Control Coordinator are the Co-Chairpersons of the committee and will be responsible for the organization's overall management of the working and care delivery environment.

   The committee will be representative of as many sites and services as possible and will include members from administration, clinical and maintenance staff.

   The responsibilities of the committee include:
   1) establishment, monitoring and maintenance of an effective Environment of Care program,
   2) establishment, monitoring and maintenance of an effective Infection Control program,
   3) monitoring and evaluating event reports,
   4) providing a physical environment free of hazards,
   5) reducing the risk of human injury,

6) review and evaluation of each of the environment of care functions to ensure that problems are identified, actions taken and follow up documented,
7) referral of problems to senior leadership if resolution can not be accomplished at the subcommittee level,
8) annual evaluation of the objectives, scope, performance and effectiveness of the plan,
9) review and approval of safety and infection control policies at least every three years, and
10) JCAHO compliance activities for EOC and IC standards.

Reports are presented to the staff Performance Improvement Committee and the Performance Improvement Committee of the Board on a quarterly basis.

Members	
Safety Officer, Co-Chair	Line Staff:
Infection Control Coordinator, Co-Chair	• Marshalltown Clinic
Medical Director	• Dental Clinic
Operations Director	• Engebretsen Clinic
Environmental Services Technician	• East Side Center
	• Grand View Health Center
	• Outreach (Medical)
	• Outreach (Social)
	• Pharmacy
	• Ryan White Program

6. **<u>Pharmacy and Therapeutics Subcommitee:</u>** The Pharmacy and Therapeutics Subcommittee is a permanent subcommittee of the Performance Improvement Committee.

The Pharmacy Director is the chairperson of this committee.

Responsibilities of the committee include: 1) preparation of the health center's formulary, 2) development of a safe medication management system including policies and procedures relating to selection and procurement, storage, ordering and transcribing, preparing and dispensing, administration and monitoring, and evaluation.

Reports are presented to the Performance Improvement Committee on a quarterly basis.

Members	
Pharmacy Director, Chair	Dentist
Medical Director	HIV Program Director

Operations Director	Physician &/or Midlevel Provider (2)
Pharmacist (CAP Representative)	

7. **Diabetes Collaborative Team:** Utilizing the improvement and chronic care model, this team is focused on the improvement of diabetic care throughout the organization.

   This team reports to the Performance Improvement Committee on a quarterly basis.

   As the diabetes collaborative is spread throughout the organization, a spread team may also be initiated to address implementation of the collaborative in other locations other than the population of focus.

Members	
Operations Director, Team Leader	Dental Director
Physician Assistant (Champion)	CMA
Medical Director	Nurse Practitioner
Applications Analyst	Board Member
Dietician	Pharmacist

8. **Other Permanent and Ad hoc Subcommittees or Teams:** The Performance Improvement Committee can create permanent subcommittees, ad hoc subcommittees, performance improvement teams or task forces.

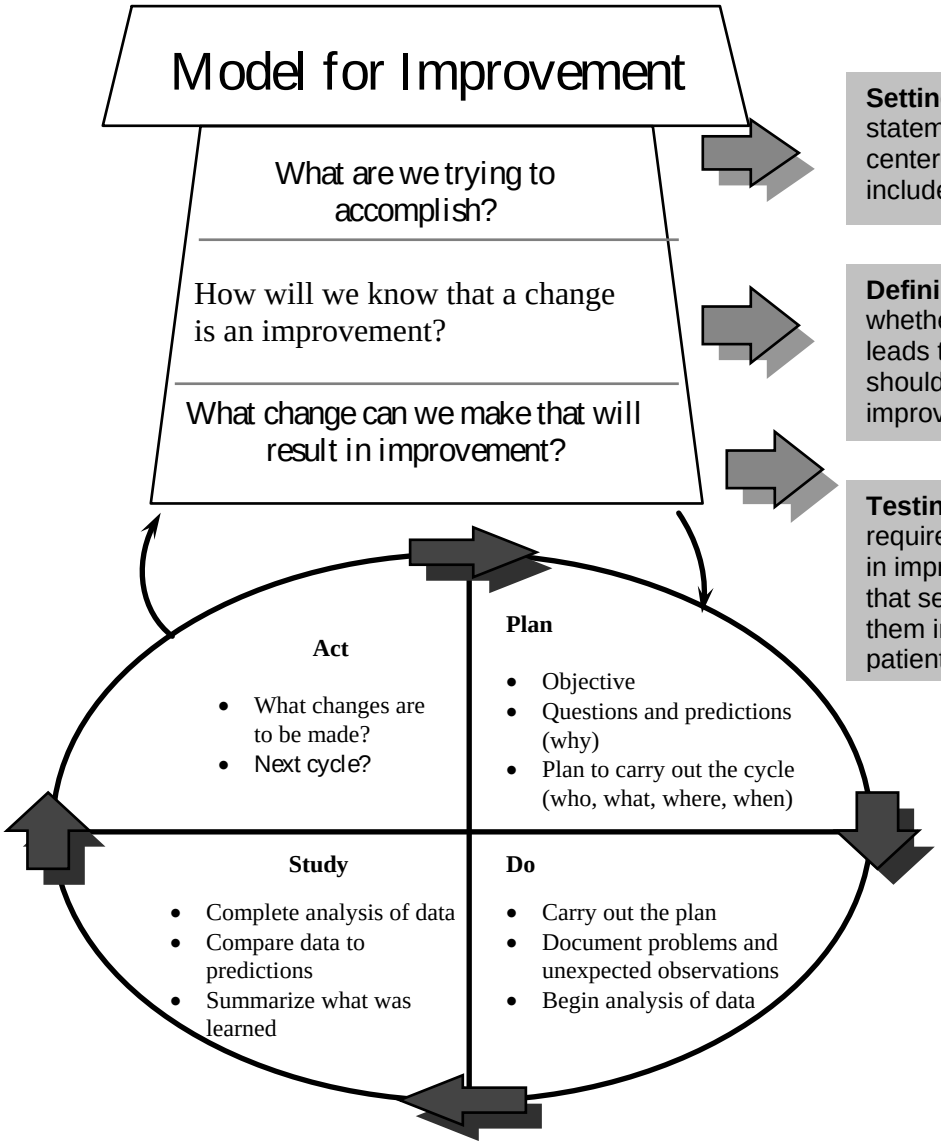
   The role of these committees and teams will be to conduct specialized studies in particular areas of concern and submit their findings to the Performance Improvement Committee. Ad hoc subcommittees and teams will be identified in the Performance Improvement committee minutes and will include their charge, a time frame for completion, and suggested dissolution dates. Ad hoc committees and teams may be elevated to permanent status with their inclusion in the appropriate section of the Performance Improvement Plan.

9. **Clinical Units/Programs:** The Board of Directors delegates the responsibility for the monitoring, evaluation and improvement of unit/program-specific measures and performance improvement activities to the Director or Manager of the Unit/Program. Section XII of this plan outlines the specific activities to be addressed. Reports of activities are presented at least semi-annually to the Performance Improvement Committee.

V. PERFORMANCE IMPROVEMENT PROCESS

The following sections will detail an approach for performance improvement that will integrate the Improvement Model and the Chronic Care Model.

Improvement Model. The improvement model consists of three fundamental questions and a Plan-Do-Study-Act cycle to test and implement changes.

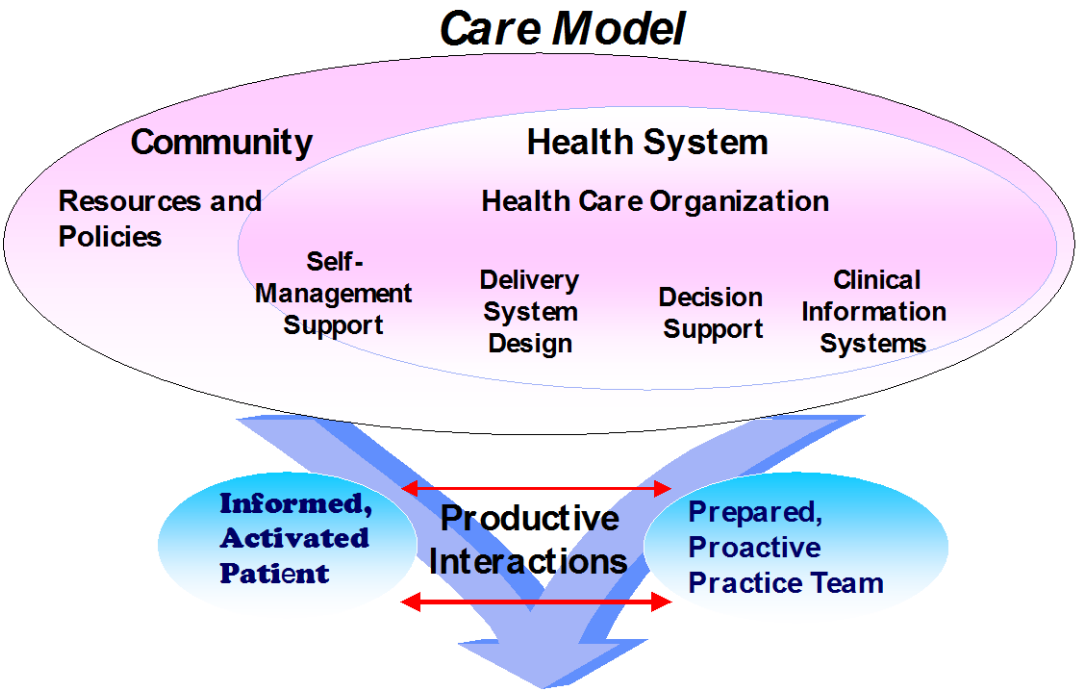


Setting Aims: An aim is a written statement summarizing what the health center team hopes to achieve. It includes time-specific, measurable goals.

Defining Measures*:* Measures tell us whether a change we've made actually leads to improvement. Measurement should be designed to accelerate improvement, not slow it down.

Testing the Change. All improvement requires changes, but not all changes result in improvement. We will choose changes that seem most promising, and then test them in specific practice settings with specific patient populations.

Care Model. The care model is an organizational approach that can be utilized to care for people with chronic disease in a primary care setting. The system is population-based and creates practical, supportive, evidenced-based interactions between an informed, activated patient and a prepared, proactive practice team. The Chronic Care Model emphases evidence-based, planned, and integrated collaborative chronic care.



Chronic Care Model Change Concepts

Health Care Organization

- Goals for chronic illnesses are a measurable part of the organization's annual business plan.
- Benefits that health plans provide are designed to promote good chronic illness care.
- Provider incentives are designed to improve chronic illness care.
- Improvement strategies that are known to be effective are used to achieve comprehensive system change.
- Senior leaders visibly support improvement in chronic illness care.

Community Resources and Policies

- Effective programs are identified and patients are encouraged to participate.
- Partnerships with community organizations are formed to develop evidence-based programs and health policies that support chronic care.
- Health plans coordinate chronic illness guidelines, measures and care resources throughout the community.

Self-management Support

- Providers emphasize the patient's active and central role in managing their illness.
- Standardized patient assessments include self-management knowledge, skills, confidence, supports, and barriers.

- Effective behavior change interventions and ongoing support with peers or professionals are provided.
- Collaborative care-planning and assistance with problem-solving are assured by the care team.

Decision Support

- Evidence based guidelines are embedded into daily clinical practice.
- Specialist expertise is integrated into primary care.
- Provider education modalities proven to change practice behavior are utilized.
- Patients are informed of guidelines pertinent to their care.

Delivery System Design

- Team roles are defined and tasks delegated.
- Planned visits are used to provide care.
- Continuity is assured by the primary care team.
- Regular follow-up is assured.

Clinical Information Systems

- There is a registry with clinically useful and timely information.
- Care reminders and feedback for providers and patients are built into the information system.
- Relevant patient subgroups can be identified for proactive care.
  Individual patient care planning is facilitated by the information system

VI. COLLECTION AND CONTINUOUS MONITORING OF DATA

The organization's on-going 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 the organization's leaders. Leaders will consider the populations served by the center as well as high risk, high volume and problem prone activities which 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 is a summary of the data collection efforts currently underway at the health center as well as a schedule outlining how data will be collected, analyzed and reported. This data will be collected within the organization's limited resources.

Performance Improvement Committee: ***(Reports quarterly to the Performance Improvement Committee of the Board)***		
Performance Measure	***Collected***	***Reported***
Medical Record Review	Monthly	Quarterly (Mar/Jun/Sep/Dec)
Patient Satisfaction	Weekly	Quarterly (Feb/May/Aug/Nov)
Patient Complaints	Daily	Quarterly (Feb/May/Aug/Nov)
Diabetes Collaborative Reports for Population of Focus and Spread: • Average HgbA1c • % of pts with 2 HgbA1c's • % of pts with self mgmt goals • % of pts on statins • % of pts with dilated eye exams • % of pts with microalbumin screen • % of patients with dental exam	Monthly	Quarterly (Mar/Jun/Sep/Dec)
Other Patient Safety Measures: • Staff perceptions of patient safety • Suggestions for improving patient safety • Staff willingness to report errors	Semiannually	Semiannually (Apr/Oct)
Staff Satisfaction (including satisfaction with PI program)	Annually	Annually (July)
Event Reporting (including sentinel events and near misses)	Daily	Monthly
Pharmacy and Therapeutics Subcommittee: (Reports Quarterly to PI Committee)		
Medication Errors	Daily	Quarterly (Jan/Apr/Jul/Oct)
Adverse Drug Reactions	Daily	Quarterly (Jan/Apr/Jul/Oct)
Emergency Medications	Daily	Quarterly (Jan/Apr/Jul/Oct)
Medication System Validation for Sites (Samples/Outdating)	Monthly	Quarterly (Jan/Apr/Jul/Oct)
Formulary Review	Semiannually	Semiannually (Apr/Oct)
Safety/Infection Control Subcommittee: (Reports Quarterly to PI Committee)		
Safety Measures:		
Safety Surveillance Tours	Monthly (all sites 2x/year)	Quarterly (Mar/Jun/Sep/Dec)
Medical Equipment (biomed testing)	Monthly	Semiannually (Jun/Dec)
Utility Systems	Monthly	Semiannually (Mar/Sep)
Security	Monthly	Semiannually (Jun/Dec)
Emergency Preparedness	Monthly	Semiannually (Mar/Sep)
Life Safety	Monthly	Semiannually (Jun/Dec)

Hazardous Materials and Wastes	Monthly	Semiannually (Mar/Sep)
Event Reporting	Monthly	Quarterly (Mar/Jun/Sep/Dec)
Laboratory Proficiency Testing (Waived Testing)	Daily	Quarterly (Mar/Jun/Sep/Dec)
Infection Control Subcommittee: ***(Reports Quarterly to PI Committee)***		
Nosocomial Infections	Daily	Quarterly (Mar/Jun/Sep/Dec)
Communicable Diseases Reportable to State	Monthly	Quarterly (Mar/Jun/Sep/Dec)
Sharps Exposures	Daily	Quarterly (Mar/Jun/Sep/Dec)
Employee Illness (Communicable)	Monthly	Quarterly (Mar/Jun/Sep/Dec)
Employee PPD Testing	Annually	Annually (March)
Vaccination Status of Employees: • Hepatitis B	Annually	Annually (March)
Vaccination Status of Patients: • Pneumovax • Pediatric Immunizations	Monthly	Quarterly (Mar/Jun/Sep/Dec)
Sterilization (Spore Testing)	Daily	Quarterly (Mar/Jun/Sep/Dec)
Refrigerator Monitoring	Daily	Quarterly (Mar/Jun/Sep/Dec)
Safety Surveillance Tours	Monthly (all sites 2x/year)	Quarterly (Mar/Jun/Sep/Dec)
Credentials Subcommittee: ***(Reports to Board of Directors)***		
Peer Review: • Medical Record Review • Perinatal Outcomes (where applicable) • RVU reports/charts • Diabetes Collaborative Measures (see list of measures under PI Committee)	Monthly	Per appointment schedule
Appointments/Reappointments	Per provider schedule	
Human Resources Measures: ***(Reports Annually to PI Committee)***		
Staff Turnover	Annually	Annually (January)
Staff Competency Patterns and Trends	Annually	Annually (January)
Financial: ***(Reports Semiannually to PI Committee)***		
Payment Denials	Quarterly	Semiannually (Jun/Dec)
Cost Per Encounter	Monthly	Semiannually (Jun/Dec)
Self Pay Collections (UDS)	Annually	Annually (Jun)

Medical User Growth (UDS)	Annually	Annually (Jun)
Units/Programs*:*		
The following measures will be aggregated and reported by all units/programs: • Medical Record Review • Patient Satisfaction • Patient Complaints • Diabetes Outcome Measures (see specific breakout under PI Committee) • Immunizations (Pneumovax and Pediatric)		
South Side Center	Monthly	Semiannually (Jan/Jun)
East Side Center	Monthly	Semiannually (Mar/Sep)
Grand View Center	Monthly	Semiannually (Feb/Aug)
Primary Health Care – Marshalltown	Monthly	Semiannually (Apr/Oct)
Outreach Project	Monthly	Semiannually (May/Nov)
HIV Program	Monthly	Semiannually (Feb/Aug)
Dental Program	Monthly	Semiannually (Jun/Dec)
Pharmacy	Monthly	Semiannually (Jun/Dec)

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

VII. AGGREGATION AND ANALYSIS OF DATA

Decision-making will be based upon data collected. 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 the health centers 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 the organization as priorities for improvement.

VIII. CLINICAL PRACTICE GUIDELINES

Clinical practice guidelines are used throughout the health center to evaluate and treat specific diagnoses, conditions, and/or symptoms.

Criteria has been established for use in selecting and implementing these guidelines in the health center. The criteria includes:

- Diagnoses, conditions, and/or symptoms which are high volume, high risk or problem prone
- Special consideration will be given to guidelines established as part of the BPHC's Health Disparities Collaborative activities

Clinical practice guidelines currently in use at the health center include: diabetes, HIV, mammograms, and pap smears (through BCCEDP).

IX. RISK REDUCTION STRATEGIES

The organization has defined a process for identification, management, and intensive analysis of sentinel events which is outlined in Appendix A. This process allows the organization to identify root causes for sentinel events that can be addressed on a proactive basis to prevent further injuries.

In addition, the organization will proactively seek to identify and reduce risks to the safety of patients by selecting a high-risk process to be analyzed on at least an annual basis. This will be accomplished through a Failure Mode and Effects Analysis which can be found in Appendix C.

X. PERFORMANCE IMPROVEMENT INITIATIVES.

Information from data analysis will be used to make changes that improve performance and patient safety and reduce the risk of sentinel events.

In order to prioritize opportunities for improvement and to effectively and efficiently utilize resources, the health center has established criteria to assist in selection of PI activities.

PI initiatives selected by the health center should meet 3 of the 4 criteria:

1. Consistent with the organizations mission and vision statement
2. Facilitates achievement of the strategic plan
3. Promotes patient safety
4. Addresses needs and expectations of patients and staff

Performance improvement initiatives will be facilitated through an existing committee, subcommittee, or by developing a performance improvement team.

The PI Initiatives identified as priorities for this period include:

- Implementation of the Patient Safety Goals through increased awareness and focus on Patient Safety
- Improved Diabetic Outcomes
- Improved Customer Service
- Improved Financial Outcomes

XI. PATIENT SAFETY PROGRAM

The health center is committed to improving safety for our patients at all of our sites and centers. This performance 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:

- 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 reporting
- Safety improvement activities included in Section VI of this plan under "Collection and Continuous Monitoring of Data"
- Reporting of results to staff, committees, executive leadership and governance
- Process for proactive risk reduction and analysis of sentinel events

XII. UNIT/PROGRAM ACTIVITIES. Units and/or programs will monitor, evaluate and improve important functions and/or services provided as outlined in their Scope of Service document.

1. The Director/Manager is responsible for and actively participates n monitoring, evaluation and improvement activities for its unit or program.

2. All units/programs will have a Scope of Service document which is updated annually and includes the following elements:

    a. Mission or purpose
    b. Key functions or services provided
    c. Types of patients/customers served
    d. Description of staff providing service
    e. Hours of service

3. All departments shall implement a plan for improving performance for their assigned areas. The plan will outline the following:

    a. Identify performance improvement initiatives for the department in keeping with the organizational plan for performance improvement.

    b. Identify performance measures to assess improvement relative to these initiatives.

c. Quality control measures

d. Standard performance measures defined by the organization's leaders.

e. Report findings to Performance Improvement Committee on a semiannual basis.

XIII. DOCUMENTATION OF PI ACTIVITIES

PI activities will be documented utilizing a variety of tools and forms.

Teams, committees, subcommittees and task forces will document their activities in the minute format approved by the health center.

In addition, 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. Templates are available on the S:drive in the forms manual.

XIV. EDUCATION. Educational needs for performance improvement will be identified by the various teams, committees and subcommittees and will be incorporated into the organization wide training calendar and in other settings as designated by the leaders of the organization.

XV. PLAN FOR COMPLIANCE WITH JCAHO STANDARDS. The health center has an extensive plan to assure on-going compliance with standards. This is outlined in Appendix C.

XVI. ANNUAL EVALUATION: The Performance Improvement Committee of the Board is responsible for the annual evaluation of the appropriateness and effectiveness of the Performance Improvement Program. This annual evaluation is accomplished through the efforts of the Performance Improvement Committee. A summary of the annual evaluation is provided to the Board of Directors for review at a Board of Directors meeting.

XVII. CONFIDENTIALITY: All information generated as a result of the Performance Improvement Program is considered confidential and will be exempt from subpoena or discovery in accordance with Chapter 147.135 of the Iowa Code

Discussions in the context of a peer review are completely confidential. This information can only be used within the health center and in the context of valid peer review. Discussion of peer review activities/information in established committees or meetings is protected by law. However, peer review information discussed outside of committee meetings may be considered <u>discoverable</u> by the court.

XVIII. RESPONSIBILITIES OF STAFF.

A. Board of Directors. The Board of Directors is ultimately accountable for the quality of care and services provided by the health center through the development of a comprehensive performance improvement program. The Board delegates responsibility for implementation and evaluation of this program through the Performance Improvement Committee of the Board to the Executive Director and management team.

B. Executive Management. The executive management team is responsible for implementation and evaluation of the performance improvement program as outlined in the above plan. In collaboration with the Board of Directors, the management team aligns the performance improvement activities with the strategic plan and prioritizes improvement efforts.

C. Directors/Managers/Supervisors. Directors, managers and supervisors are responsible for implementation of the PI program for their respective units/clinics/programs. In addition, these managers and directors may serve as chairs, team leaders or as members of committees, subcommittees, teams, and/or task forces. When serving in these roles, consideration of the overall impact on the organization should always be of prime concern.

D. Medical Staff. Medical staff members should be familiar with the performance measures and PI initiatives of the health center and their respective unit/program/clinic. Medical staff will be active participants in the performance improvement activities through participation on committees, subcommittees, teams and task forces as appointed. The purpose of this participation is to bring the “front line” perspective to the performance improvement opportunities and initiatives of the health center as well as resolution of problems.

E. Line Staff. Staff should be familiar with performance measures and PI initiatives underway for the health center and their specific unit/program/clinic. Staff will be asked to participate in these activities as well as on other committees, subcommittees, teams and task forces as appointed. The purpose of this participation is to bring the “front line” perspective to the performance improvement opportunities and initiatives of the health center as well as resolution of problems.