THE COMMUNITY HEALTH CENTERS, INC.

~~~ PERFORMANCE IMPROVEMENT PROGRAM ~~~

-December 1996-
Approved by the Board of Directors:
September 25, 1997
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INTRODUCTION

The Community Health Centers, Inc.'s Performance Improvement Program has two parts: Part One: The Program discusses the goals, purpose, and structure of the program Part Two: presents the Performance Improvement Work Plan for the upcoming year. The Program's organizing principle is based on AmbuQual: An ambulatory quality assurance and quality management program. AmbuQual is based on the concept of a parameter of care. Each parameter is significant in that it represents an area that has the potential to affect the health of a patient in either a positive or a negative way. Ten Ambulatory Care Parameters provide a framework with which we can monitor and evaluate the quality and appropriateness of our delivery care system. Standards from the Joint Commission on Accreditation of Healthcare Organizations' Manual for Ambulatory Care fit within AmbuQual's ten parameters of care. The Ten Ambulatory Care Parameters are listed in Attachment A.

THE PROGRAM

I. Overview

A. Goals

The goals of The Community Health Centers, Inc.'s Performance Improvement Program are to continuously improve patient outcomes and to improve the health status of the community. By focusing upon key functions within the organization, believes it will enhance the delivery of primary health care provided and meet the expectations of the community it serves, and its funders.

B. Purpose

Working in collaboration with all health care providers and disciplines within the organization, and as appropriate the community, the organization's improvement plan is designed to:

1. identify opportunities for improvement
2. involve all staff members in the development and implementation of PI activities, maximizing their investment in and utilization of the program
3. establish, implement, evaluate, and sustain improvement activities
4. communicate results to all appropriate staff and the Board of Directors.

C. Principles of Improvement

All PI activities are carried out in a collaborative and interdisciplinary manner, in concert with s Mission and Values, and based on the strategic plan and goals. **PERFORMANCE IMPROVEMENT is to design our work well, check the performance of that work, and find ways to further improve the health of our patients.**

II. ORGANIZATION

A. Governing Body

1. Role

Performance is a governing body responsibility. The organization's Chief Executive Officer provides initial orientation and ongoing information about the structure, process, and outcomes of the Performance Improvement Program for the governing body.

2. Responsibilities

The Board of Directors establishes the organization's commitment to Performance Improvement and approves the annual Performance Improvement Plan. This assures that performance-related problems are resolved at the highest level of the organization.

The Board of Directors is responsible for the performance of care in the organization and, ultimately, for the standards of care. Standards of care, as they relate to the Performance Improvement Program, are recommended by senior staff, and are subject to confirmation by the Board of Directors.

This Board of Directors monitors the results of the Performance Improvement Program to detect trends in the delivery of health care. It considers these trends (both positive and negative), setting policy as necessary, to ensure an acceptable level of performance of patient care delivered by the organization.

The integrity of the organization's Performance Improvement Program is grounded in the ability of the Board of Directors to exert the necessary authority when necessary for the improvement of performance.

B. Senior Management Team

1. The Senior Management Team (SMT) is composed of the:

Chief Executive Officer
Vice President and Medical Director
Vice President of Finance
Vice President of Operations
Vice President of Information Systems
Vice President of Nursing and Patient Care
Vice President of Human Resources
Vice President of Performance Improvement

2. Responsibilities

The Senior Management Team (SMT) fulfills the responsibilities delegated to it by the Board of Directors to establish expectations, plan, prioritize, and manage the

performance improvement process. The Senior Management Team ensures implementation of processes to measure, assess, and improve the performance of the organization's governance, clinical, and support systems through the following:

- weekly Senior Management Team Meetings,
- monthly Management Team Meetings,
- monthly Clinical Staff Meetings, and
- quarterly reviews of Performance Improvement Committee reports,
- prioritization of issues for development of the annual PI Plan.

The Senior Manager is responsible for identifying opportunities for improvement in their respective departments. The Senior Manager then leads their department through the PI process. To decentralize the PI process, Site Directors and department heads are encouraged to lead their staff through the performance improvement process, using PDSA cycles for change when opportunities for improvement are identified. Root cause analyses can be helpful in the planning step. All departmental PI activities are reported to the PI Committee to be included in the report of the annual PI Plan.

C. Performance Improvement Committee (PIC)

The Performance Improvement Committee does NOT solve problems. The committee's role is to monitor and evaluate the Performance Improvement Plan of the organization, to refer any opportunities for improvement discovered to the appropriate administrative or clinical Senior Manager, and finally to assure that improvement has been accomplished. Individual sites do not routinely refer problems to the PIC.

1. Role

The role of the Performance Improvement Committee in the PI Program includes five primary functions:

a) to collect, aggregate, and analyze information received through:

<u>Clinical Audits</u>
<u>Patient Satisfaction Surveys</u>
<u>Incident Reports</u>
<u>Patient Complaints</u>
<u>Patient and Staff Idea Box</u>

b) to make recommendations for the annual PI Plan to the CEO
c) to monitor and evaluate progress on the annual PI Plan
d) to assign for improvement opportunities identified during data analysis
e) to track progress

The committee has the authority to:

a) Collect, request, or assign for collection data on clinical and non-clinical audits, patient satisfaction, patient complaints, incident reports, and ideas on opportunities for improvement from staff and consumers via an Idea Box

b) Review all audits and score the indicators

c) Identify opportunities for improvement and assign responsibility to the appropriate member of the Senior Management Team

2. Responsibilities

The PIC monitors and evaluates the progress of the annual PI Plan. Members are responsible for attending meetings and to report on assignments on a quarterly basis, as well as to serve as a resource for individual efforts.

Meeting agendas present data collected in the previous quarter, including follow-up to recommendations for improvements previously made. The Committee meets quarterly for one and one half hours.

3. Membership

The composition of the committee is multidisciplinary, and includes people with direct responsibility for service delivery. Including people on the committee with varied job-role perspectives enhances the comprehensive approach to monitoring and evaluation. The CEO appoints the membership of the PIC. The term of committee membership is two years; members may serve consecutive terms.

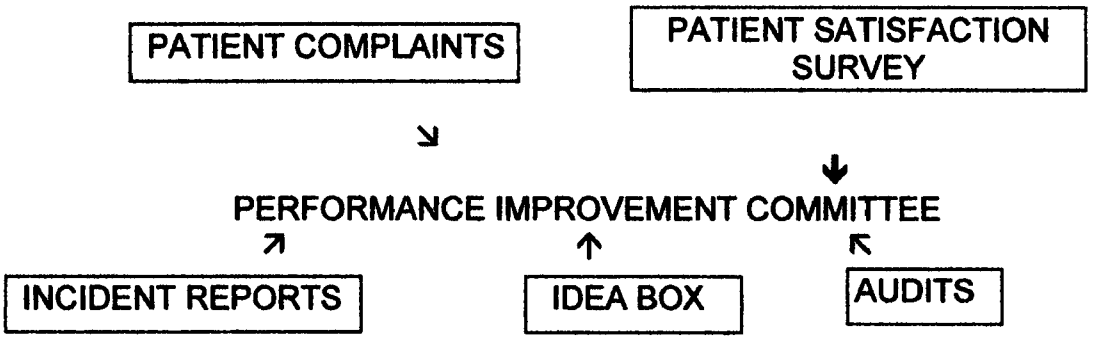
Members of the Committee include:

VP and Medical Director
VP of Performance Improvement, Chair
Physician(s)
Advance Practice Nurse
Health Center Director
VP of Finance
Billing Supervisor
Health Information Specialist

Reports from the PIC are distributed to the SMT, the Site Supervisors to be shared with their staff, all providers through the Clinical Staff Meetings, and the members of the Board of Directors' Performance Improvement Committee.

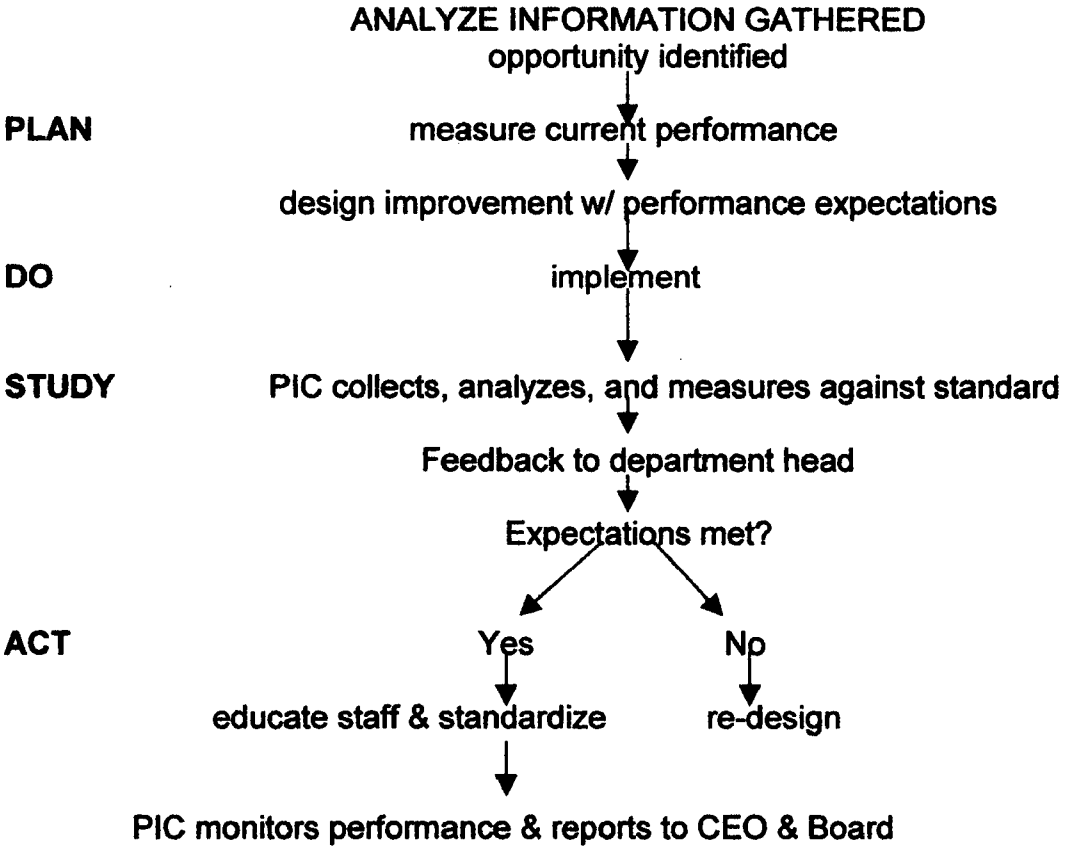
III. FRAMEWORK

The framework of the Performance Improvement Program is formed from data sent to or gathered by the PIC through five distinct mechanisms: 1) Clinical Audits done internally or by HMOs or the Department of Health, 2) Patient Satisfaction Surveys, 3) Incident Reports, 4) Patient Complaints, and 5) Patient and Staff "Idea Box" suggestions. Data is presented at the quarterly PIC meetings and is analyzed by the members.



IV. PROCESS FOR PERFORMANCE IMPROVEMENT

To improve patient outcomes, the organization must design processes well and systematically monitor, analyze, and improve its performance. Leadership prioritizes high risk, problem prone, or high volume issues to be monitored and analyzed. The essential processes for improvement are to plan, design& implement, measure, assess, improve, and sustain improvement (JCAHO, 1989-1999). The following schematic depicts the process for PI as it flows through the organization, involving all relevant staff.



V. SCOPE

The scope of the PI Program includes all sites, all services, and all functions. Opportunities for improvement are sought in the clinical, non-clinical, and business aspects of this organization. Ambulatory Care Parameters provide ten areas of focus.

VI. MECHANISM FOR OVERSEEING PROGRAM EFFECTIVENESS

The Performance Improvement Committee will compile an annual report of the PI Program's activities. The report will be distributed to the Senior Management Team, the Health Center Directors, and to the P. I. Committee of the Board of Directors for presentation to the full Board of Directors.

PART TWO: 2004 PERFORMANCE IMPROVEMENT

VII. The WorkPlan

While the PI Program spells out the philosophy and principles of performance improvement, the PI Plan is the actual work plan. The 2004 PI Plan will continue to direct the PI Committee's work in the five (5) established areas:

A. Clinical Audits: HEDIS measures as reported by the Health Maintenance Organizations, RI Department of Health immunizations audit, PCHC cervical cancer screening audits, NHPRI pediatric asthma incentive, and diabetes key measures from the Chronic Disease Care Model .

The Chronic Disease Care Model is a model developed by the Institute for Health Initiatives and adopted for community health centers by the Health Disparities Collaboratives of the Bureau of Primary Care. Collaboratives have national significance in serving to demonstrate to all primary care setting, public and private, an effective method of chronic disease management. Also called the Chronic Care Model (CCM), this comprehensive approach to management can be applied to all chronic diseases. joined the diabetes collaborative in July 2002 and adopted the Care Model as its standard of care for patients with chronic diseases in January 2003. The model is composed of six elements:

1. Community – identifies resources and collaborations that enhance the system of care
2. Organization of Health Care – how the organization supports the care of chronic diseases through Board awareness and senior management leadership
3. Clinical Delivery System – how the clinics operate
4. Decision Support – knowledge and information for providers in making care decisions
5. Self-Management Goal-Setting – activities that patients carry out to manage their disease

6. Clinical Information System – an electronic patient care registry to track individual patient's progress and healthcare team performance

B. Patient Satisfaction Surveys: Surveys will be carried out face-to-face using for the first time and instrument developed by the Bureau of Primary Care. has provided an incentive to use this method. Using a national tool enables to benchmark our achievements against other community health centers.

C. Incident Reports: gathered quarterly will be re-categorized to be in alignment with JCAHO's Patient Safety Goals.

D. Patient Complaints

E. Patient and Staff Idea Box : feedback from Health Center Directors, department supervisors, or members of the Senior Management Team to whom patient ideas, suggestions, or complaints have been referred. These will be reported to the Board of Directors with each quarterly report.

F. New in 2004 are:

1.Spreading the Chronic Disease Care Model to the Asthma/Allergy Clinic.

Key measures are:

ASTHMA MEASURES	GOAL
1. Current Severity Assessment	90%
2. Appropriate treatment with anti-inflammatory medication	95%
3. Self-Management Goal setting	70%
4. Symptom-free days in past two weeks	> 10
Optional:	
1. Influenza immunization	90%

2. Strategic Plan Workgroups: Model of Care and Hours of Operations will present recommendations in June. Customer-Focused (started 10/03) will conduct four (4)campaigns in 2004 each headed by a member of the SMT.

3. Enhanced and timely analysis and presentation of collected data. Data gathered through the PI Plan will be analyzed by the PI Committee on a quarterly basis and presented in a useful format to enable the Health Center Directors and other department heads to plan for improvement activities. The PI Committee will assist in the tracking of outcomes through subsequent data collection and reporting.

REFERENCES

Benson, D.S. and Miller, J. A. (1989). AmbuQual: An ambulatory quality assurance and quality management system. Indiana: Methodist Hospital of Indiana, Inc.

Joint Commission on Accreditation of Health Care Organizations. (1997). Performance Improvement in Ambulatory Care. Chicago.

ATTACHMENT A

AMBULATORY CARE PARAMETERS

I. Provider Staff Performance
Provider's ability to use the best available knowledge, skill and judgment to produce a desired outcome in health.

II. Support Staff Performance
The ability of support staff to contribute toward a positive change in the health status of the patient, utilizing thoroughness, efficiency, accurateness, patient rapport, and team interaction.

III. Continuity of Care
The concept that the plan of care for a particular patient progresses without interruption.

IV. Medical Record System
The concept that the medical record can contribute to the health of the patient by providing accurate, complete, and timely information to the provider at the time a clinical judgment is made.

V. Patient Risk Minimization
The concept that it is important to prevent unwanted change in the health status of the patient as a result of interaction with the health care system.

VI. Patient Satisfaction
The degree to which health care services and the resulting health status meet the expectations of the patient.

VII. Patient Self Management
The ability of patients to manage their disease.

VIII. Accessibility
The ease and timeliness with which health care services can be obtained.

IX. Appropriateness of Service
The concept that a service, whether delivered by the organization or by the individual provider, has a reasonable potential to enhance in a cost-effective manner the health status of the patient.

X. Cost of Services
The concept that the cost of the service can impact the health status of the patient by compromising either the ability of the organization to deliver the service or the ability of the patient to utilize the service.