Quality Improvement Program

Definition and Purpose:
The quality improvement program is a system to assess the effectiveness of health care delivered, identify and establish an action strategy re improvement opportunities, and satisfaction of the population served. The assessment and necessary modifications will be accomplished with the personnel and financial resources allocated per the HFHC Board of Directors.

Goals:
Quality improvement refers to the activities and programs designed to evaluate health care delivery and outcome. These activities and programs will identify, study, correct, and document known or suspected problems in or opportunities to improve the health care delivery system at HFHC. The quality improvement program will monitor activities throughout HFHC to address the following dimensions of quality:

- Effectiveness: doing the right thing to achieve the desired outcome in a cost efficient manner
- Efficiency: maximum quality units per resources available
- Accessibility: service available at the time of need; ie appropriate life cycle, spectrum of illness, timeliness of appointments, telephone access to providers, sliding fee scale, language barriers etc.
- Acceptability: patient satisfaction regarding their service, which motivates them to improve their health.

Clinical monitoring and assessment will be completed utilizing:
- Patient questionnaires designed to assess understanding, outcome and satisfaction.
- Concurrent and retrospective studies of patient care (at least 3 major clinical issues will be examined annually)
- Follow-up to previous audit findings
- Cost benefit analysis

Administrative monitoring and assessment will be completed utilizing:
- An annual review of the health center plan to meet community needs along with goals, objectives and center policies and procedures in all functional areas ie governance, management, personnel, finance, and plant and facilities.

Objectives:

The Quality Improvement Program objectives are to:

- Establish an ongoing monitoring system for identifying opportunities to improve the delivery and outcome of health care
- Determines the cause and scope of identified opportunities
- Set priorities for the resolution of identified opportunities
- Implement mechanism for brainstorming and problem solving through the approval of an action plan, referral to appropriate committee or departments or through the management structure for resolution.
- Assure appropriate action is taken by following up on opportunities at the level of referrals

Responsibility / Authority / Accountability:

The governing body has overall responsibility for the quality improvement program. The Clinical Director leads the clinical management section; the CE/CFO appoints the Program Director to lead the managerial section of the quality improvement program. Both these leaders report their findings and progress to the governing Board through the Quality Improvement activity report, reflecting committee activity.

The Quality Improvement Committee consists of standing members: Clinical department members including: Clinical Director, Program Director, Providers (Medical, Dental, Chiropractic, Mental Health) Nursing, Lab, and Governing Board and adjunct members: support staff members: Medical records, Receptionist, Billing and Housekeeping. The committee is responsible for coordinating and integrating all quality improvement efforts within the health center. The Quality Improvement Committee reports its findings to the Management Committee, general staff and Board of Directors for review and approval of recommendations to improve. The Quality Improvement Committee will convene at least quarterly.

Monitoring and Evaluation:

The Quality Improvement Committee measures effectiveness of performance utilizing approved indicators and criteria. The indicators will relate to all major functional areas in the health center.

Minutes from the Quality Improvement Committee meetings will reflect studies, audits completed, opportunities identified, actions recommended or taken. Actions recommendations to improve will be implemented utilizing Evidence Based Care Model: PLAN-DO-STUDY-ACT (PDSA) cycles.

Minutes from the Quality Improvement Committee will be forwarded to the health center's Board of Directors.

Appraisal:
The Quality Improvement Program shall be evaluated on an ongoing basis to assure that it meets the quality improvement needs of the health center.

Annually, the Program will be reviewed and revised as indicated by the Quality Improvement Committee. The annual evaluation and proposed revisions will be submitted to the health center's Board of Directors for approval.

Quality Improvement Committee minutes, evaluations, reports to health centers Board of Directors and a will be maintained by the Program Director.

Confidentiality:
Activities related to Quality Improvement are considered confidential and are protected under all applicable Federal and State statutes.

Quality Improvement Program: Reviewed and approved:

D. CLINICAL OUTCOMES BY LIFECYCLES

1. Perinatal Cycle

CLINICAL OUTCOMES MEASURE	SMOKING CESSATION
GOAL	Reduce smoking in prenatal users
OBJECTIVE/INTERVENTION	Continue use of individual counseling for smoking cessation and document amount of smoking
PERFORMANCE	Baseline percentages were established in 2000
ACTION STEPS	PROGRESS, OUTCOMES, EVALUATION, COMMENTS

Smoking during pregnancy is a recognized risk factor that results in lower than normal birth-weights in infants and in premature labor.
In order to reduce this risk, all prenatal patients who smoke will be counseled against smoking and given educational materials that promote smoking cessation

Population: Prenatal patients seen at HFHC between 09/01/01 and 08/31/02.

Number of charts sampled: ALL (23)

1. Patients who were smokers at the time of their initial prenatal visit:
   Number: 9
   Percent: 39%

2. Patients with documentation that they were counseled against smoking:
   Number: 1
   Percent: 11%

3. Patients documented as having reduced the amount they smoke:
   Number: 3
   Percent: 33 %

4. Patients documented as having stopped smoking:
   Number: 5
   Percent: 22%

Distribute publications about smoking cessation.

Continue assertive, population-appropriate, smoking cessation counseling.

Monitor and evaluate activities

FISCAL YEARS 2003-2005
HEALTH CARE GOALS AND OBJECTIVES

CLINICAL OUTCOMES BY LIFECYCLES

2. PEDIATRICS LIFECYCLE (NEWBORN-11 YEARS)

CLINICAL OUTCOMES MEASURES	IMMUNIZATIONS
GOAL	1. 90% COMPLIANCE WITH RECOMMENDED SCHEDULE OF IMMUNIZATIONS AS DETERMINED BY CHART AUDIT OF CHILDREN 18-24 MONTHS AND 4-6 YEARS WITH MORE THAN 3 VISITS TO HFHC. 2. SAFE STORAGE AND HANDLING OF ALL VACCINES TO INSURE EFFICACY OF VACCINE AND PREVENTION OF EXPENSIVE WASTING OF VACCINE.
OBJECTIVE/INTERVENTION	Maintain "tickler file" for tracking and follow-up. Follow policy for outreach to families with under immunized children.
PERFORMANCE	Baseline numbers and percentages were established in 2000.
ACTION STEPS	PROGRESS/OUTCOMES/EVALUATION AND COMMENTS

	Numbers and Percentages for 2002
Conduct annual pediatric provider performance audit: Perform immunization audit on 25 (or ALL if less than 25) randomly selected charts from age groups 18-24 months and 4-6 years of age (Clinical Coordinator responsible)	Children 18-24 months: (22 charts) ALL 1. 4 DTP/DTaP: 2001: 18 (72%) 2002: 9 (41%) 2. 3 OPV/IPV: 2001: 20 (80%) 2002: 11 (50%) 3. 4 HIB: 2001: 19 (76%) 2002: 11 (50%) 4. 3 HBV: 2001: 19 (76%) 10 (45%) 5. 1 MMR: 2001: 20 (80%) 2002: 11 (50%) 6. 1 Varicella: 2001: 16 (64%) 2002: 8 (36%) Children 4-6 years old: (17 charts) 1. 5 DTP/DTaP: 2001: 13 (76%) 2002: 16 (89%) 2. 4 OPV/IPV: 2001: 14 (82%) 2002: 16 (89%) 3. 4 HIB: 2001: 14 (82%) 2002: 16 (89%) 4. 3 HBV: 2001: 14 (82%) 2002: 16 (89%) 5. 2 MMR's: 2001: 13 (76%) 2002: 16 (89%) 6. 1 Varicella 2001: 10 (59%) 2002: 15 (83%)
Annual provider reinforcement on ways to reduce "missed opportunities" to immunize.	
Annual update and training for safe handling, storage and administering vaccines for Nursing/MA staff.	We will be purchasing a new refrigerator/freezer with separate controls for each compartment to insure that vaccine remains efficacious and doesn't have to be wasted.
Distribution to parents of most up-to-date immunization information to reinforce verbal counseling regarding immunization issues.	

FISCAL YEARS 2003-2005
HEALTH CARE GOALS AND OBJECTIVES

CLINICAL OUTCOMES BY LIFECYCLES
3. ADOLESCENT LIFECYCLE

CLINICAL OUTCOME MEASURES	FAMILY PLANNING COUNSELING
GOAL:	95% compliance with protocol for documentation of family planning counseling as determined by chart audit of patients between the ages of 13-19 with 3 or more visits to HFHC
PERFORMANCE	Baseline numbers and percentages were established in 2000
ACTION STEPS	**PROGRESS/OUTCOMES/EVALUATION AND PROGRESS**
Audit 25 charts of adolescents between the ages of 13-19 years for documentation of counseling for family planning	25 randomly selected charts from adolescents 13-19 years of age: Number and percentage with positive documentation of family planning counseling: 2001: 17 (68%) 2002: 23 (92%) Audit results will be discussed at next clinical staff meeting and possible action steps to improve numbers will be documented in minutes.
Distribute patient education materials dealing with family planning issues/methods of contraception/safe sex to reinforce verbal counseling. Continue to collaborate with Down East Family Planning Services to obtain family planning supplies and to take advantage of the auditing/quality assurance program that they assist us with	Currently we have 69 (an increase of 10 over 2001) female patients of which a significant number are adolescents participating in our collaborative effort with Down East Family Planning. This program offers free family planning supplies to adolescent males and females.

FISCAL YEARS 2003-2005
HEALTH GOALS AND OBJECTIVES

CLINICAL OUTCOMES BY LIFECYCLE
4. ADULT LIFECYCLE (AGES 20-64)

GOAL	ACTION STEPS	PROGRESS/OUTCOMES/EVALUATION COMMENTS
1. 75% compliance with recommended protocol for performance of pap smear as determined by chart audit of 25 female patients between the ages of 20-49 and 25 patients between the ages of 50-64 with 3 or more visits to HFHC over the past 3 years	1. Purchase patient education materials dealing with cervical cancer detection, follow-up, and treatment to reinforce verbal counseling.	Baseline numbers and percentages were establish 2000. Results of audit for 2002: From 25 charts of patients ages 20-64, positive documentation of pap smear having been done: 2001: 15 (60%) 2002: 17 (68%)
2. 85% compliance with recommended protocol for breast cancer screening as determined by chart audit of patients between 50-64 with 3 or more visits to HFHC.	2. Purchase and distribute educational materials about the benefits of SBE (self breast exam), and mammography at recommended intervals. Continue to work with the Maine Breast and Cervical Health Program to provide free paps and mammograms to uninsured and underinsured women.	Baseline numbers and percentages were establish 2000. Results of audit of 2002: From 25 charts of female patients between the ag 50-64, positive documentation of mammogram: 2001: 20 (80%) 2002: 19 (72%)
3. 95% compliance with recommended protocol for cardiovascular risk assessment for hypertension, hyperlipidemia, smoking, and obesity as determined by chart audit of patients between the ages of 20-64 with 3 or more visits to HFHC.	3. Provide verbal counseling about risk factors and prevention with every visit. 3a. Purchase and distribute patient educational material explaining risk factors for chronic disease resulting from lifestyle habits to reinforce verbal counseling.	Baseline numbers and percentages established in Results of audit of 25 charts of patients 20-64 for Documentation of assessment of evaluation HTN: 2001: 25 (100%) 2002: 25 (100%) Documentation of assessment for smoking 2001: 25 (100%) 2002: 22 (88%) Documentation of assessment for obesity: 2001: 25 (100%) 2002: 24 (96%) Documentation of labs to determine blood lipids: 2001: 18 (72%) 2002: 22 (88%)

FISCAL YEARS 2003-2005
HEALTH CARE GOALS AND OBJECTIVES

D. CLINICAL OUTCOMES BY LIFECYCLES
5. GERIATRIC LIFECYCLE (AGES 65 YEARS AND OLDER)

CLINICAL OUTCOMES MEASURE	**MEDICATION PROFILE LISTS**
GOAL	Every patient's chart will contain a Medication Flow Sheet that will be updated with each visit for routine follow-up care.
OBJECTIVE/INTERVENTION	To better monitor patient medications for patient safety and to improve medication-related quality of care
PERFORMANCE	Baseline numbers and percentages obtained in 2000
ACTION STEPS	**PROGRESS/OUTCOMES/EVALUATION COMMENTS**
1. Check each chart prior to putting patient in room to be sure that it contains a Medication Flow Sheet. 2. Monitor medication at each office visit 3. Annually, a random sample of charts will be pulled for audit 4. Results of audit to be shared with providers at first Clinical Staff Meeting following audit	Medical Records personnel to do this as they prepare the chart for the patient's visit 2. Providers to review patient's medications with patient at each visit for routine follow-up care. 3. Charts will be pulled, audited for up-to-date Medication Flow Sheet by Clinical Coordinator annually in October. Results of audit for 2002: Number of charts audited: 25 Number of charts with up-to-date Medication Flow Sheet: 23 (92%) Providers will be advised of these results and will be congratulated on the improvement.