COMC
CENTRAL OZARKS MEDICAL CENTER
MEDICAL · BEHAVIORAL · DENTAL

CONTINUOUS QUALITY IMPROVEMENT PLAN

PHILOSOPHY

The medical, dental and behavioral health staff, administration and board of directors of Central Ozarks Medical Center (COMC) is committed to providing quality care to all patients regardless of sex, race, religion, handicap, inability to pay or national origin, in adherence to established medical and professional standards in an organizational wide effort to continuously improve our processes and the delivery of health care services to the patients we serve.

PURPOSE

The purpose of the Continuous Quality Improvement Program is to:

1. Provide a mechanism for monitoring and evaluating the quality and appropriateness of the patient care provided by our centers;
2. Integrate and disseminate the information derived from these activities;
3. Ensure an ongoing effort to correct any deficiencies identified;
4. Recognize and encourage those instances of positive achievements in quality and capitalize on any opportunities.

AUTHORITY and RESPONSIBILITY

The Center's Quality Improvement Committee assumes the responsibility for the ongoing monitoring and evaluating of care given to the patients at Central Ozarks Medical Center. This committee is comprised of the QI Director, COO, CEO, Dental Director, Medical Director, Behavioral Health Director, Community Health Director, Nursing Manager, Dental Manager, Lab Manager and representative(s) of the Board of Directors (when available). The committee is chaired by the Quality Improvement Director. The committee may delegate any or all parts of the monitoring process, but the committee is responsible for final evaluation of information, trend tracking and developing action plans, as well as follow-up on areas of concern. The CQI Plan is reviewed and revised on an annual basis by the QI Committee and Board of Directors.

Structure

The Quality Improvement Committee consists of, but not restricted to:

- Director of Quality and Risk Management
- Dental Director
- Chief Financial Officer

Director of Operations

- Director of Behavioral Health
- Chief Executive Officer
- Medical Director
- Board Member (every other month)

The quality metrics discussed in the quality meeting and reported to the Board on a monthly basis as part of the QI assessment.

Operational Responsibilities

The Board of Directors is responsible for the quality of the health center and authorizes the CEO the resources to sustain the program. A board member will also be a member of the Quality Improvement Committee and will participate in bi-monthly meetings.

The Medical Director is an active member of the Quality Improvement Program. The Medical Director's responsibility is to support the Quality Improvement Program and its functions to promote high quality patient care.

The Director of Quality and Risk Management is responsible for the day to day activities of quality and risk management to include collection, review and presentation of data to the committee, on a quarterly basis (at minimum) and to provide reports and recommendations as appropriate for the health center. In addition, along with the Medical Director, is responsible to assure approved changes and/ or actions are carried out.

Role and Responsibility of Committee

The Quality Improvement Committee will:

- Meet monthly
- Identify opportunities for improving patient care and clinical performance by utilizing our electronic health record reports as well as the COMC Population Management Tool (DRVS).
- Prioritize current quality initiatives and activities
- Identify actual or potential problems related to patient care and clinical performance.
- Assess root cause and scope of problems related to patient care and clinical performance.
- Recommend process improvement for identified problems.
- Recommend policy and procedure changes for identified problems as needed.
- Monitor process improvement implementation via the PDSA model
- Ensure the ongoing monitoring, evaluation and improvement of process and systems.
- Charter quality improvement teams/subcommittees
- Report findings, actions, and recommendations to the Board of Directors monthly.
- Evaluate effectiveness of the program annually.

Key Aspects and Functions of Quality Management

- Policies and Procedures
- Medical Records
- Clinical Protocols
- Tracking Systems
- Trend Identification that impacts systems and processes
- Quality Planning
- Credentialing/Privileging
- Peer Review
- Compliance/Safety
- Risk Management
- Population Health Management Tool-DRVS

PROGRAMSCOPE

The scope and content of COMC's QI Program is designed to continuously monitor, evaluate, and improve clinical care and health service delivery provided to our patients. Specifically, the QI Program includes, but is not limited to:

- Monitorandevaluationof:
  - Primary care delivery
  - Preventive health services
  - Management of chronic disease
  - Acute care provided at the clinics
  - Specialty services-dental, behavioral health, population health management
  - All high volume, high risk services, and
- The continuity of care for our patients
  - Development, implementation and monitoring of practice guidelines, that are evidence-based
  - Regulatory compliance
  - Development and implementation of health and disease management programs
  - Medical record review/documentation audits
  - Patient and staff satisfaction surveys, and
  - Monitoring, evaluation, and resolution of patient complaints and grievances, through the risk management program

Topic selection and study design are prioritized based on an ongoing evaluation of the population in terms of age/sex characteristics, disease incidence and prevalence, and risk status.

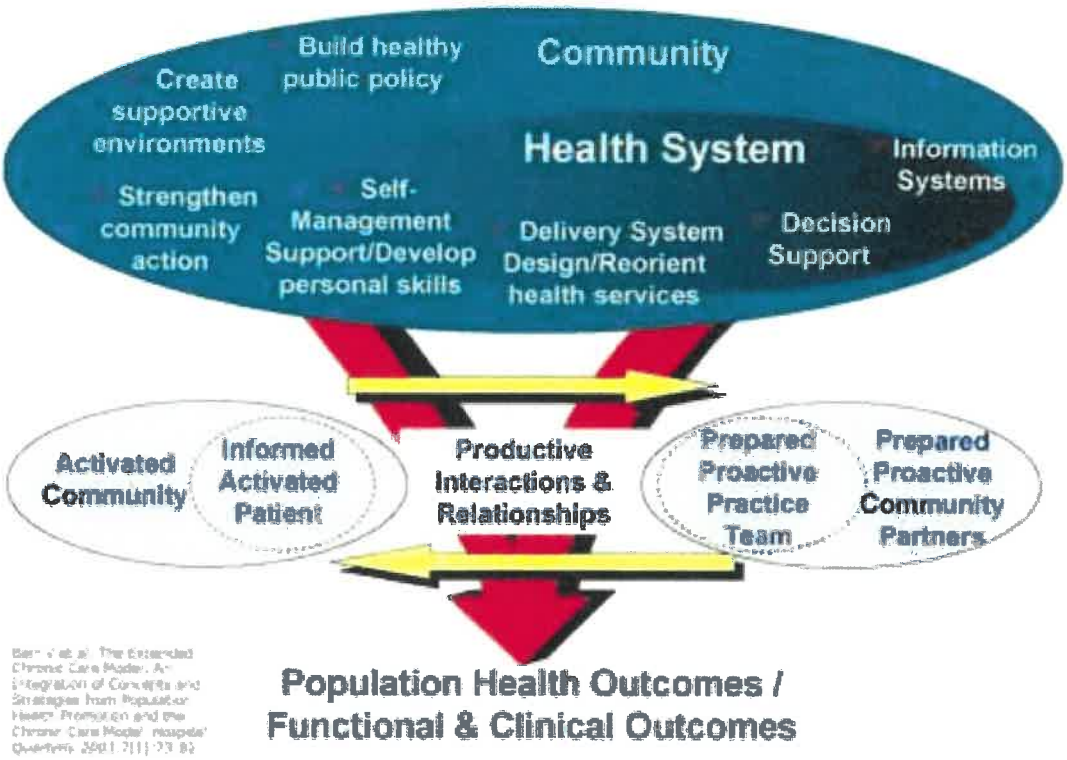
PROGRAM GOALS

- To assure that the monitoring and evaluation results are incorporated, as appropriate, in the medical, dental and professional staffs clinical measures.
- To establish guidelines and procedural operations with the objective of producing a positive impact on the delivery of patient care at COMC facilities.
- To assure that the clinic environment and equipment meets and/or exceeds the standards of safety for patients, visitors and employees.
- To provide a means for integrating the quality assurance responsibilities of all COMC staff and demonstrate that the organization's procedures, methods and systems are efficient and effective.
- To support the Board of Directors, medical, dental and other professional staff, administration and the employees of the facility in their commitment to continuously improve the care and services offered to the patients served.
- To provide a foundation for complying with regulatory and accrediting agencies

PROCESS/METHODOLOGY

The methodology for all improvement activities, including system and process issues, isthe Improvement Model. Clinical improvements use both the Improvement Model and Expanded Chronic Care Model (Barr, V. et al, 2002). The Improvement Model guides the QI Committee through identification of problems and tests of change based on data. The Expanded Chronic Care Model (Table 1) provides a systems approach for developing, implementing and sustaining quality health care delivery built on evidenced-based medicine and a population approach. The Expanded Care Model identifies the essential elements of a health care system that supports high-quality health care delivery while also supporting the intrinsic role that the social determinants of health play in influencing individual, community and population health. Strategies for improvement are continually measured, monitored, and implemented through the QI Committee.

Table 1: Expanded Chronic Care Model: Integrating Population Health Promotion



Measures: Clinical and operational Quality Measures are established and monitored on a regular basis in order to assess performance in the management of clinical and operational services. COMC focuses on UDS Clinical Quality Measures (CQMS) as well as other state and national benchmarks. Measures are monitored and trended for change over time and be included in the QI Committee reports to the board.

1. Audits: High risk, high volume, and problem prone situations will be reviewed as identified during monthly QI meetings. This will include clinical, financial, management, information system areas, as well as patient grievances/complaints, and incidents/occurrences.

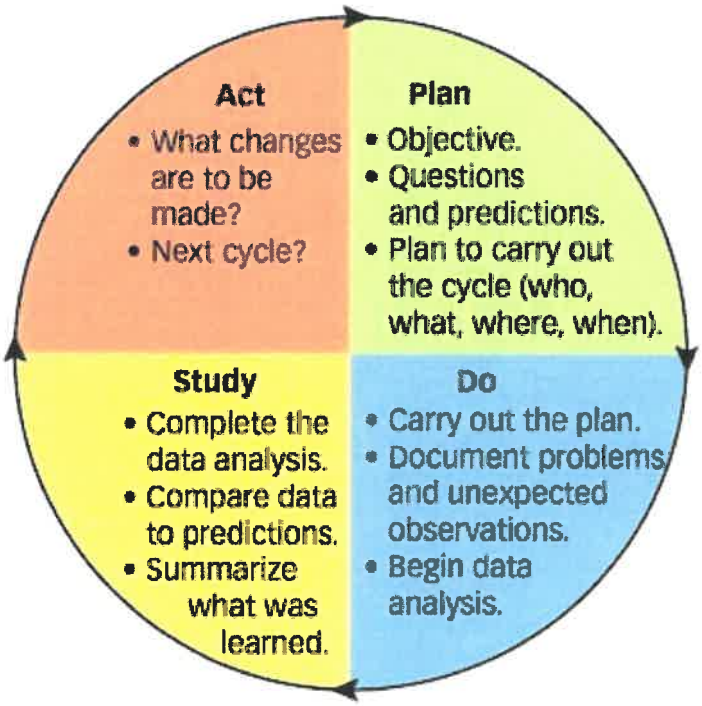
2. Data Evaluation: When the data has been collected and organized, the QI Director will evaluate the information for trends and patterns of performance as well as processes. The evaluator will attempt to determine the cause of problems and identify methods for improvement to present to the QI Committee for review, discussion and final development of corrective measures.

   Data Sources
   Data sources to identify organizational risks and promote quality improvement shall include, but not be limited to, the following:
   - Occurrences, incidents, adverse events, complications, and claims
   - Patient complaints/grievances
   - Patient satisfaction surveys
   - Incident investigation
   - Internal risk surveys and assessments, such as of the high-risk areas of
     - medical staff credentialing and privileging,
     - physician office management, and
     - environmental safety assessment.
   - Infection control and environmental surveillance
   - Risk and quality indicator monitoring and audits
   - Occurrence screens, near miss events
   - Employee and physician surveys and informal feedback
   - Third party payors
   - COMC Electronic Dashboard
   - Population Health Management Tool by AZARA called DRVS

3. Action Plan/PDSA: Once evaluation has been completed and problems or opportunities to improve care have been identified, action will be taken (Table 2). ACTION PLANS will be developed utilizing the PDSA model, approved at the appropriate level and enacted to solve the identified problem. Action plans will be documented in the QI minutes. The effectiveness of these actions will be assessed and documented. This assessment will be discussed at the monthly QI meeting, and documentation will be in the QI meeting minutes. The QI Minutes will include the problem identified, the plan, any additional responsible person, timeframe for completion and any other actions recommended by the QI Committee.

If the ACTION PLAN includes the development of a policy/procedure, the responsible person for drafting the document will be identified in QI Committee or Management Team meeting, draft will be presented to the QI Committee and Management Team with a final draft submitted to the Board of Directors for approval.

Table 2: Plan Do Study Act Model of Improvement



4. Reports: The relevant information will be communicated throughout the organization at board meetings, management team and provider meetings and general staff meetings, as well as one-on-one supervisor-supervisee meetings. A written summary of QI activities will be given to the Board of Directors on at least a monthly basis. Additionally, results of Clinical Quality and operational measures are posted in public areas for all COMC patients to see.

5. Process or systems changes requiring policy updates or development will be identified in the QI Committee meeting, policy drafted and presented to the Board of Directors for approval. Clinical protocol changes will be identified by the QI Committee with written protocol draft presented to providers and other appropriate staff for feedback before implementation.

TOOLS

A variety of tools are utilized to collect and analyze data. These include manual and electronic audits, peer reviews, the EMR reporting system for clinical and financial data, manual logs and check lists (for paper charts), paper surveys/questionnaires, written patient/employee complaint forms.

CREDENTIALING AND PRIVILEGING

All physicians, dentists and mid-level providers who practice at COMC must go through a formal credentialing and privileging process. This requires primary source verification of the provider's education, licensure, board certifications, and a direct query to the National Practitioner Data Bank. An exclusion query is also run through the government systems (SAM and OIG). Privileges for practice, procedures, treatments, etc., will only be granted based on this information and specific qualifications.

PEER REVIEW

Peer to peer review of providers' treatment practices and medical records documentation will be conducted on at least a **quarterly basis**. This will include a random chart audit as well as a 100% review of certain patient care outcomes-preventable incidents, morbidity, mortality, UDS Measures, etc. Clinical protocols will be utilized for guidance. Provider peer review findings/report will be sent to the Chief Medical Officer for review and any needed follow-up with individual providers of any adverse findings and corrections needed. A report will also be provided to the CEO.

RISK MANAGEMENT

The QI Committee also functions as the Risk Management Committee, whose focus is the establishment, monitoring, and maintenance of an effective environment of care management program. The Risk Management Committee reports are submitted and discussed at QI Committee meetings.

The primary role of the committee is to rigorously monitor the organization's environment of care and infection control program to identify and resolve or minimize any risks that may result in a work injury type of incident or sentinel event. This includes safety, compliance and regulatory oversight of the organization. The committee also has a monitoring function for patient complaints, employee occurrence reports, as well as issues related to patient satisfaction and customer service training. (Please refer to Risk Management Policy)

PATIENT SATISFACTION SURVEYS

Patient Satisfaction Surveys are sent via COMC's Electronic Health Record system to randomly selected patients via their primary contact method (email or telephone). Patients also can complete surveys through the patient portal. Results of the surveys will be tabulated monthly and a summary report provided to the QI Committee on a monthly basis and the Board of Directors quarterly. In addition, patients who wish to file a formal grievance/complaint will be encouraged to complete a Patient Grievance/Complaint form (please refer to the patient complaint policy), which will be routed to the QI Director for specific investigation. A file of these complaints will be maintained in the QI Director's office. Each formal complaint will be discussed with the employee(s) involved. Patterns of problems or repeated complaints of the same nature, or any risk management concerns will be discussed with the CEO, Medical Director, specific provider(s) and/or staff involved and in Management Team meetings, QI

Committee meetings and reported to the Board of Directors.

FINANCIAL, MANAGEMENT AND INFORMATION SYSTEM

Areas that are high volume, high risk, and problem-prone will be identified and monitored. Action Plans will be developed, approved at the appropriate level and enacted to solve the identified problem. Action Plans will be documented in the QI Minutes. This information will be included in the written summary to the Board of Directors.

GOVERNANCE

Reports of QI activities and results will be reported to the Board of Directors on a monthly basis. In addition, the Board of Directors will be encouraged to evaluate itself on a yearly basis. The evaluation will focus on the board's strengths and weaknesses. Checklists and governing board self-evaluation criteria will be utilized. A written summary of the evaluation will be presented to the board and documented in board meeting minutes. The Board will be encouraged to utilize the evaluation to set goals for itself for the coming year. This information, along with an Action Plan, will be provided to the board for review at the next year's evaluation. Goals the board sets for itself will be measured for results.

QI MEETING MINUTES

Complete and accurate minutes will be prepared and maintained for each meeting. The minutes will reflect all meetings, the persons present and names and titles of guests. The minutes will show the major decisions and recommendations, status of activities in progress, the implementation status of the recommendations and person(s) responsible. Applicable documentation and substantiating data will be included and will be appended for reporting purposes. The finalized minutes will be signed by the Medical Director and the Quality Director and kept in the QI file, which is protected as privileged information.

CONFIDENTIALITY

Records and information generated in the performance of the medical and dental staff and other allied professional staff and the QI program activities are confidential and protected as privileged information. Electronic records are password protected and paper records are maintained securely and away from patients and visitors. Patient information is strictly on a "need to know" basis. Health care providers duly appointed and acting within the scope and functions of the program are protected under Missouri Law from liability and damages. All members of the QI Committee will read the Confidentiality Policy and sign the Confidentiality Statement.

All copies of minutes, reports, worksheets and other data will be maintained in the locked QI Director's office, in a manner assuring strict confidentiality. A written confidentiality policy detailing procedure for maintenance and release of data and other QI information will be utilized to assure compliance with confidentiality. (please refer to COMC's HIPPA policy)

PROGRAM REAPPRAISAL

The structure, functions and methods of the Continuous Quality Improvement Plan will be evaluated at least annually to assure the plan is achieving its objectives, is demonstrating impact, is cost efficient, is consistent with regulatory and accrediting agency requirements, and is facilitating the organizations philosophy and mission of continuous quality improvement.

Tom Reagan, Board Chair

Date Signed: 4/28/20

Kelly Miller, CEO

Date Signed: 4/28/2020

Updated: 4.22.20

Reviewed and approval by Board of Directors: _____