El Dorado Community Health Centers

Quality Improvement & Risk Management Plan 2022

EDCHC
El Dorado Community Health Centers

El Dorado Community Health Centers
Quality Improvement & Risk Management Plan

Section 1. Introduction

EDCHC Quality Improvement & Risk Management Plan

El Dorado Community Health Centers' (EDCHCs) Quality Improvement & Risk Management (QI/RM) Plan is a detailed, and overarching organizational work plan for clinical and service quality improvement and risk management activities. The QI/RM Plan is developed with executive and clinical leadership support and must be approved annually by EDCHC's Board of Directors. The QI/RM Plan serves as a road map for quality and risk management activities. The QI/RM Plan outlines quality and risk management focus areas for the current calendar year and is in part developed as an outgrowth of the evaluation of the previous year's QI/RM activities, organizational priorities, and organizational program requirements.

2021 Quality Improvement & Risk Management Goals

EDCHC continued to play an essential role in fighting COVID-19 in El Dorado County during 2021. Staff, patient, and community vaccinations were prioritized in the 2021 Quality Improvement Plan goals. Most staff were fully vaccinated by April 2021 and more than 7,800 patient and community members received COVID-19 vaccinations by December 2021. With the emergence of new variants, including the Omicron variant, EDCHC continues to prioritize COVID-19 vaccination and boosters in its 2022 Quality Improvement & Risk Management goals with a special emphasis on Family Vaccination Clinics. While the continued fight against COVID-19 was prioritized in 2021, EDCHC also succeeded in completing most non-COVID related goals, including:

1. The development and Board approval of the 2021 Quality Improvement Plan;
2. Planning and piloting comprehensive diabetes care to include behavioral healthcare for patients struggling with their diabetes;
3. Establishing a tracking and documentation system for dental sealants (a UDS measure);
4. Employing the company FormDr to assist staff with the collection and upload of required patient forms to address the challenge of gathering documents for Tele-Video and Tele-Audio visits;
5. Organization and implementation of an EDCHC Safety Committee;
6. Upgrade eClinicalWorks, EDCHC's electronic health record, to Version 11 and pilot contactless patient check-in feature.

The on-going battle against COVID-19 and staffing shortages impacted a few 2021 Quality Improvement goals, including:

7. As part of the organization and implementation of an EDCHC Safety Committee, safety walk-throughs were planned for 2021. This portion of the goal was not complete in 2021 and is scheduled for 2022 as staffing permits.
8. EDCHC and Marshall had planned to co-coordinate "Back-to-School" Well Child and Vaccination activities in the community, including the County fair. These activities were cancelled due to COVID-19 and the cancellation of the County fair.
9. COVID-19 priorities and the focus on addressing staffing shortages also influenced finalizing and conducting staff training on suicidal, aggressive/disruptive, and minor patient protocols. This will be completed in 2022.

2022 Quality Improvement & Risk Management Goals

Quality Improvement & Risk Management goals set for 2022 are focused on fighting COVID-19 through testing, vaccinations, and boosters for staff, patients, and community members. Additional goals include efforts to address the challenges of Tele-Video and Tele-Audio visits and their continued impact on preventive care and chronic disease management. Visits which require in person contact to perform patient assessments, testing, and care include well visits, immunizations, blood pressure control, and diabetes management (A1c testing). Revising and implementing daily huddles to improve communication and promote team-based care for Tele-Video, Tele-Audio, and in-person visits and creating a plan and workflow for RN flip visits designed to improve chronic disease management are examples of the important quality work planned for 2022.

Other 2022 Quality Improvement & Risk Management goals address key compliance and risk areas. EDCHC will develop portal proxy access training and workflows to comply with The Confidentiality of Medical Information Act (CMIA). The patient portal proxy access allows parent or legal guardian access to a child or dependent's electronic health record to better manage their healthcare. EDCHC will also implement workflows to comply with the 21st Century Cures Act that requires EDCHC to allow patients access to their electronic health care data and prevents "information blocking." EDCHC will develop and implement a plan to educate patients and increase completion of patient Advance Directives, a health plan compliance requirement.

Finally, additional 2022 goals will continue performance improvement efforts in key HEDIS and UDS measures. The goal to develop a Diabetes Prevention and Management Program Sustainability Plan to continue grant funded activities like patient counseling with a Registered Dietitian and patient life-style coaching to prevent Type 2 diabetes will influence related HEDIS and UDS measures. Applying for State grant funding and implementing a program to advance tobacco cessation within EDCHC clinics will influence the tobacco use and cessation among EDCHC patients. Securing a contract with Relevant through grant funding will improve both HEDIS and UDS measures through provider and staff access to timely data for population health and care management.

2021 HEDIS Clinical Performance Goals

Due to the COVID-19 pandemic continuing strong in 2021, EDCHC experienced similar struggles with its Healthcare Effectiveness Data and Information Set (HEDIS) clinical performance measures as it did in 2020. HEDIS goals are set by the State of California and the requirements given to health plans. The goal was increased by the State of California in 2019 from the 25th percentile to the 50th percentile for each incentivized measure. In 2021, HEDIS measure goals stayed at the 50th percentile despite the pandemic. In 2020, California Health & Wellness (HealthNet) provided a second option to providers allowing provider incentives to be calculated using an alternative method not looking at clinical performance at the 50th percentile. This option was not provided in 2021. HEDIS clinical measure performance reported for 2021 is preliminary data based on performance through September 30, 2021. This occurs annually because HEDIS relies on claims data to determine performance in measures. Claims data can run 45-60 days behind service dates. Health plans conduct chart review and additional HEDIS work well into the new year and do not provide final data until May/June. Due to COVID-19, we are likely to see only a modest improvement in 2021 HEDIS measures at that time.

2021 UDS Clinical Performance Goals

2021 UDS clinical measure goals were set by EDCHC based on performance in 2020 and the on-going COVID-19 pandemic. UDS reporting is based on the 2021 calendar year and electronically reported to the Health Resources & Services Administration (HRSA) on February 15, 2022. Annual changes to clinical performance measures were not released by HRSA until June of 2021 and mapping and reporting setup guides and training were not available from BridgeIT and Heckman Consulting until October 2021. This is the norm annually for both, requiring EDCHC to make a fourth quarter push to address gaps in care and conduct mapping and cleanup of UDS clinical measures data. As a result, final and accurate reporting is not possible until the end of January 2022. EDCHC will receive approval of UDS Report submission in early March 2022. Included in this Quality Improvement & Risk Management Plan is the final 2021 UDS clinical performance data. This data shows EDCHC below 2021 performance goals in six measures and making progress towards goal in three measures. EDCHC has reached goal and is performing well in six measures. The 2022 proposed UDS clinical measure goals are set based on performance in 2021 as well as the UDS national average for each measure. The continuation of COVID-19 and EDCHCs focus on staff, patient, and community COVID-19 testing and vaccination efforts may result in changes to UDS clinical measure performance goals as 2022 unfolds.

EDCHC QI/RM Plan provides:

- A systematic process with identified leadership, accountability, and dedicated resources;
- Use of data and measurable outcomes to determine progress toward relevant, evidence-based benchmarks;
- A focus on linkages, efficiencies, and provider and patient expectations in addressing outcome improvement;
- A continuous process that is adaptive to change and that fits within the framework of other programmatic Quality Improvement (QI) and Risk Management activities (i.e. Medicaid and HRSA programs);
- Data collection and analysis used as feedback in the process to assure that goals are accomplished and they are concurrent with improved outcomes.

The QI/RM Plan is a living document, with the ability to address preventive health and chronic disease measures as well as compliance and risk management needs and to refine the Plan to achieve such goals going forward.

EDCHC Mission

The mission of El Dorado Community Health Centers is to improve the health of our community through quality healing and preventive services.

El Dorado Community Health Centers (EDCHC) is a Federally Qualified Health Center located in El Dorado County, California. EDCHC provides quality, comprehensive health care to county residents, regardless of ability to pay. Services offered include primary care, dental, pharmacy, integrated behavioral health, opioid addiction treatment, complex care management, immunizations, health coverage enrollment and preventive health services. The Center's focus is to provide exceptional health care to patients during every stage of life.

Consistent with its mission, El Dorado Community Health Centers strives to enhance patient health and ensure services are provided in a safe, patient-centered, timely, equitable and efficient manner:

Safe –Services provided incorporate evidence based, effective practices and risks to patients, providers, staff and others are eliminated or minimized.

Patient Centered – Services are responsive to individual patient needs and preferences and patients have the opportunity to participate in their health care decisions.

Timely – Services are provided in a timely manner.

Efficient – Procedures, treatments and services are conducted efficiently with appropriate coordination and continuity across all services.

Equitable – Care provided is standard in both quality and access and care does not vary based upon any personal patient characteristics or biases.

The above is accomplished through review of care quality, patient outcomes, peer chart review, patient experience, risk management and adherence to quality and compliance guidelines outlined by the Bureau of Primary Health Care (BPHC) and the National Committee for Quality Assurance (NCQA), and Federal Tort Claims Act (FTCA).

The Quality Improvement & Risk Management (QI/RM) Plan serves as the foundation of El Dorado Community Health Centers' commitment to continuously improve the quality of care and services provided and to mitigate risk through compliance to BPHC, NCQA and FTCA standards and requirements. It helps guide the development, implementation, monitoring and evaluation of clinical and department efforts that aim to improve patient outcomes and enhance the patient experience while maintaining the confidentiality of patient records.

Quality Improvement and Risk Management are important component of El Dorado Community Health Centers' performance management, in which data is used for decision-making and quality improvement and risk management tools and methods are applied to ensure adequate progress is made towards clinical and operational goals.

Quality Improvement Principles

Quality improvement is a systematic approach to assessing services and improving them on a priority basis. El Dorado Community Health Centers (EDCHC) approach to quality improvement is based on the following principles:

Customer Focus. We focus on both internal and external customers and on meeting or exceeding needs and expectations.

Recovery-oriented. Services are characterized by a commitment to promoting and preserving wellness and to expanding choice. This approach promotes maximum flexibility and choice to meet individually defined goals and to permit patient-centered services.

Employee Empowerment. Everyone has a role in quality and we involve staff at all levels of the organization in quality improvement activities.

Leadership Involvement. Strong leadership, direction and support of quality improvement activities by the governing body and Chief Executive Officer (CEO) are key to performance improvement. This involvement of organizational leadership assures that quality improvement initiatives are consistent with both mission and strategic plan.

Data Informed Practice. Successful QI processes create feedback loops, using data to inform practice and measure results. Fact-based decisions are likely to be correct decisions.

Statistical Tools. For continuous improvement of care, tools and methods are needed that foster knowledge and understanding. Continuous quality improvement organizations use a defined set of analytic tools in order to turn data into information.

Prevention before Correction. Continuous quality improvement entities seek to design good processes to achieve excellent outcomes rather than fix processes after the fact.

Continuous Improvement. Processes must be continually reviewed and improved. Small incremental changes make an impact and staff can usually find an opportunity to make process improvements that are manageable.

Continuous Quality Improvement Activities

Quality improvement activities emerge from a systematic and organized framework for improvement. This framework is understood, accepted and utilized by staff throughout the organization. Quality improvement involves two primary activities:

1) Measure and assess the performance of EDCHC services through the collection and analysis of data.
2) Conduct quality improvement initiatives, take action where indicated, and evaluate the effectiveness of the initiatives and actions.

Examples of tools used to conduct and measure quality improvement are described in Appendix A.

Risk Management Principles

Risk management is essential to prevent staff and patient harm. Effective risk management understands that leadership, managers, supervisors, staff and patients all play an important role in creating a culture of safety. EDCHC takes a proactive approach to risk management through the following principles:

- Everyone in the organization is responsible for creating a culture of safety
- Training and re-training are essential to safety and compliance and reducing risk
- Proactive risk management activities can prevent accidents, injuries and adverse events

- Timely intervention minimizes adverse effects when accidents or injuries do occur
- Legal, regulatory and accreditation compliance help to protect everyone in the organization

Section 2. Leadership & Organization

Board of Directors
El Dorado Community Health Centers' Board of Directors meets monthly and has overall responsibility to evaluate the performance of the health center and ensure health care services provided are accessible and meet quality and safety standards. The Board of Directors provides leadership for the quality improvement and risk management process by reviewing, evaluating and approving the Quality Improvement & Risk Management Plan annually. In addition, the Board of Directors reviews and approves Quality Improvement & Risk Management related policies as outlined in the Bureau of Primary Health Care's (BPHCs) Health Center Program Compliance Manual.

Quality Assurance & Risk Management Committee (QARMC)
The Board of Directors meets its quality oversight responsibility through the Board Committee known as the Quality Assurance & Risk Management Committee (QARMC). The QARMC provides leadership for care quality and patient safety at El Dorado Community Health Centers (EDCHC) and ensures the Centers' quality improvement and risk management efforts address the quality of EDCHC services, patient satisfaction and patient grievance processes, incident reporting, patient and staff safety, adverse events, compliance and risk management. The committee meets quarterly and not less than four (4) times per year and consists of the following individuals:

Board Members (Committee Chair and at least 2 additional members)
Chief Executive Officer
Chief Medical Officer/Associate Chief Medical Officer
Chief Operations Officer
Compliance & Quality Director
Quality Improvement Analyst
Registered Nurse Manager
Executive Administrative Assistant (Meeting minutes/documentation)

The responsibilities of the Quality Assurance & Risk Management Committee include:

- Reviewing and approving the annual Quality Improvement & Risk Management (QI/RM) Plan.
- Monitoring QI/RM Plan goals and indicators of care quality and patient safety.
- Periodically assessing objectives and reviewing actions taken by the Quality Improvement & Risk Management Committee (QIRMC) to address barriers to goals and objectives.
- Reporting to the Board of Directors on care quality and patient safety on a regular basis.

Quality Improvement & Risk Management Committee (QIRMC)
The Quality Improvement & Risk Management Committee provides ongoing operational leadership for care quality, patient safety, risk management, compliance and confidentiality of patient records at EDCHC. The committee meets monthly and consists of the following individuals:

Chief Executive Officer
Chief Medical Officer/Associate Chief Medical Officer
Chief Operations Officer
Communications Director
Behavioral Health Director
Compliance & Quality Director
Quality Improvement Analyst
Health Information Technology Manager
Dental Services Supervisor
Front Office Manager
Facilities & Safety Manager
Registered Nurse Manager
Development Director (as needed)
Chief Finance Officer (as needed)
Executive Administrative Assistant (Meeting minutes/documentation)

The Quality Improvement & Risk Management Committee (QIRMC) addresses all health center operational issues that relate to care quality, risk, compliance, patient safety and confidentiality of patient records. The QIRMC is responsible for establishing goals and overseeing the implementation of objectives and activities related to care quality, patient safety, risk management, and compliance throughout the organization. The Quality Improvement & Risk Management Committee (QIRMC) identifies annual care quality, patient safety, risk management, and compliance measures and sets goals and specific objectives to be accomplished each year. Specific responsibilities of the QIRMC are:

1. Select and prioritize care quality, patient safety, risk management and compliance goals and indicators to monitor
2. Develop the annual Quality Improvement & Risk Management Plan goals
3. Assess goals and indicators, taking action through quality improvement and risk management activities
4. Establish and support specific quality improvement and risk management activities
5. Include quality improvement and risk management activities that are based on information from patients, staff and community stakeholders via the grievance and complaint process and patient satisfaction studies
6. Use standard practices to assess and conduct quality improvement (such as Plan-Do-Study-Act cycles)
7. Use standard risk management process for incident and event reporting, analysis, and resolution
8. Coordinate quality improvement activities and documentation required by contract obligations and National Committee for Quality Assurance (NCQA) standards

9. Communicate quality improvement and risk management activities and results to staff, patients and other stakeholders as a means to engage and build a culture of quality and safety. Examples include:

    - Sharing of the annual Quality Improvement & Risk Management (QI/RM) Plan
    - Evaluate the annual QI/RM Plan based on identified goals and quality indicators
    - Report quarterly to the QAC organization quality improvement and risk management activities
    - QIC reporting to various stakeholder groups
    - QIC reporting during the organization's provider, staff, and leadership meetings
    - Message boards and/or posters displayed in common areas

Section 3. Quality Improvement & Risk Management Goals

Goals & Objectives

The following are the ongoing long-term goals for El Dorado Community Health Centers' Quality Improvement & Risk Management program and the specific objectives for accomplishing these goals for the year 2022.

- To implement quantitative measurements to assess care quality, patient safety, and risk management
- To bring leadership, managers and staff together to review quantitative data for care quality, patient safety, adverse events, and risk management
- To carefully prioritize care quality, patient safety, risk and compliance needs and set goals for their resolution
- To achieve measurable improvement in the highest priority areas
- To meet internal and external reporting requirements
- To develop or adopt necessary tools, such as policies, procedures, patient satisfaction/experience surveys and quality indicators to ensure continuous quality improvement, risk management and compliance.

Patient Safety

El Dorado Community Health Centers' (EDCHC) monitors health care services to improve patient safety, reduce risk and provide a safe environment. Recognizing that effective medical/health care error reduction requires an integrated and coordinated approach, EDCHC employs a systematic methodology to minimize physical injury and accidents. Patient and staff safety are the responsibility of all EDCHC employees and serious breaches are reported to the Quality Assurance Committee (QAC). Organization-wide safety includes activities that contribute to the maintenance and improvement of patient safety. The following are engaged to monitor patient safety:

Peer Chart Review: EDCHC has a formal process for providers to review/audit randomly selected charts to ensure care rendered is appropriate and safe.

Training: EDCHC has a process for ensuring that staff receive regular training in order to remain professionally competent and in compliance with the Federal Tort Claims Act (FTCA), HRSA, and CalOSHA.

Equipment & Facilities Maintenance: EDCHC has a dedicated Facilities and Safety Manager and processes in place to ensure equipment and facilities are maintained.

Incident Reports: Collect and trend data (quarterly) to monitor quality and safety.

Patient Concerns/Grievances: Collected, addressed and trended quarterly to monitor quality and safety.

Patient Satisfaction Surveys: EDCHC employs the use of the Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey developed by the Agency for Healthcare Research and Quality (AHRQ) to standardize questions about patient experience. CAHPS survey questions ask patients to share their experience on a range of services and at different points in the care delivery process. The CAHPS survey is available to patients on the El Dorado Community Health Centers website and is accessible at any time. The EDCHC Marketing and Outreach Department is responsible for the administration of the survey, as well as data collection, interpretation and reporting.

2022 Quality Improvement & Risk Management Goals

Working with key management staff, the Compliance & Quality Director is responsible for ensuring the implementation and updating of QI/RM operating procedures and related assessments and monitoring QI/RM outcomes. The Compliance & Quality Director works with the Quality Improvement & Risk Management Committee (QIC) to set annual quality improvement and risk management goals.

Quality Improvement & Risk Management Goal	Work Started	Work Completed
Development, review and Board approval of 2022 QI/RM Plan.	December 1, 2021	March 22, 2022
Increase COVID-19 testing for patients and community members due to Omicron and other variants.	January 1, 2022	December 31, 2022
Conduct COVID-19 Family Vaccination Clinics to provide vaccine and boosters to families and community members.	January 1, 2022	December 31, 2022
Provide on-site testing and COVID-19 vaccination and boosters to EDCHC employees.	January 1, 2022	December 31, 2022

Quality Improvement & Risk Management Goal	Work Started	Work Completed
Apply for State grant funding and implement a program to "Advance Tobacco Cessation in Community Clinics."	January 1, 2022	March 31, 2022
Revise and implement daily huddles to improve communication and promote team-based patient care for Tele-Video, Tele-Audio and in-person visits.	January 1, 2022	May 31, 2022
Secure contract with Relevant and implement services to improve patient outcomes through data and population health management (grant funded).	January 1, 2022	May 31, 2022
Assess provider views on opioid prescribing practices and begin implementation of the "Quality Improvement and Care Coordination: Implementing the CDC Guideline for Prescribing Opioids for Chronic Pain."	February 1, 2022	June 30, 2022
Develop proxy portal access training and workflows to comply with The Confidentiality of Medical Information Act (CMIA).	February 1, 2022	June 30, 2022
Develop and implement a modified Social Determinants of Health (SDOH) screening tool in dental to assess SDOH barriers to care.	March 1, 2022	July 31, 2022
Create plan and workflow for RN flip visits designed to improve chronic disease management.	April 1, 2022	July 31, 2022
Develop a Diabetes Prevention & Management Program Sustainability Plan to continue program services after the end of the grant period (7/31/2022).	April 1, 2022	July 31, 2022
Develop and implement a plan to educate patients and increase completion of patient Advance Directives.	April 1, 2022	August 31, 2022
Implement workflows to comply with the 21st Century Cures Act information blocking rule that will encourage transparency around patient safety issues in Health IT.	May 1, 2022	December 31,2022
Increase patient survey response rates through the implementation of a comprehensive, structured patient feedback model to improve patient services and overall patient experience.	July 1, 2022	December 31, 2022

*Goals may change with organizational needs and priorities.

Section 4. Performance Measurement

Performance measurement is the process of regularly assessing the results produced by goal related activities. It involves identifying processes, systems and outcomes that are integral to the performance of the service delivery system. It also involves selecting appropriate measures for each of these areas and analyzing related data on a regular basis to identify improvement opportunities.

The Quality Improvement & Risk Management Committee (QIC) will review performance on HRSA Uniform Data System (UDS) clinical measures and select Healthcare Effectiveness Data and Information Set (HEDIS) measures, with measures reviewed quarterly. The QIC may monitor additional measures based on relevance to the mission, strategic importance, contract requirements and clinical importance.

The purpose of measurement and assessment is to:

- Assess the stability of processes or outcomes to determine whether there is an undesirable degree of variation or a failure to perform at an expected level.
- Identify problems and opportunities to improve the performance of processes.
- Assess the outcome of the care provided.
- Assess whether a new or improved process meets performance expectations.

Measurement and assessment involve:

- Selection of a process or outcome to be measured, on a priority basis.
- Identification and/or development of performance indicators for the selected process or outcome to be measured.
- Aggregating data so that it is summarized and quantified to measure a process or outcome.
- Assessment of indicator performance at planned and at regular intervals.
- Acting to address performance discrepancies when a process is not stable, is not performing at an expected level or represents an opportunity for quality improvement.
- Reporting within the organization on findings, conclusions and actions taken as a result of performance assessment.

Selection of a Performance Indicator

A performance indicator is a quantitative tool that provides information about the performance of processes, services, functions or outcomes. Selection of performance indicators is based on the following considerations:

- **Scientific Foundation:** the relationship between the indicator and the process, system or outcome being measured.
- **Validity:** whether the indicator assesses what it purports to assess.
- **Resource Availability:** the relationship of the results of the indicator to the cost involved and the staffing resources that are available.
- **Patient Preferences:** the extent to which the indicator takes into account individual or group (e.g., racial, ethnic, or cultural) preferences.

- **Meaningfulness:** whether the results of the indicator can be easily understood, the indicator measures a variable over which the program has some control, and the variable is likely to be changed by reasonable quality improvement efforts.
- **Relevance to mission:** whether the indicator addresses the mission and population served.
- **Risk:** whether the indicator address high volume, problem prone or high risk services or processes.

Assessment

Assessment is accomplished by comparing actual performance on an indicator with:

1. Self over time
2. Pre-established standards, goals or expected levels of performance
3. Evidence-based practice
4. Other Federally Qualified Health Centers (FQHCs), community clinics, or similar service providers

Clinical Performance Measures for 2022

The table below outlines the HEDIS and UDS clinical performance measures anticipated in 2022. Measures prioritized by the Quality Improvement & Risk Management Committee (QIRMC) will be reviewed quarterly during meetings with the goal of achieving improved performance.

QIRMC will offer consultation, training, facilitation and support to help drive improvement in these measures. QIRMC members may do the following during process improvement:

1. Identify what is to be accomplished
2. Use the Plan-Do-Study-Act methodology, where appropriate
3. Document key steps of the process
4. Report results to the QARMC
5. Share documents, tools, lessons learned, etc. with others in the organization

2022 HEDIS Clinical Measures - California Health & Wellness (CH&W)

Measure	Measurement Name	2022 EDCHC Goal	2021 CH&W 50th Percentile	2021 EDCHC (Preliminary Data)*	2020 EDCHC
BCS	Breast Cancer Screening	58.67%	58.67%	43.21%	46%
CCS	Cervical Cancer Screening	60.65%	60.65%	54.25%	60%
CHL	Chlamydia Screening	58.34%	58.34%	25.06%	47%
WCC-BMI	Weight Assessment and Counseling Children (BMI)	79.09%	79.09%	8.04%**	60%
WCC-NUT	Weight Assessment and Counseling Children (Nutritional Counseling)	70.92%	70.92%	7.05%**	59%
WCC-PA	Weight Assessment and Counseling Children	64.96%	64.96%	5.69%**	57%
CDC-1	Diabetes HbA1c Testing	88.55%	88.55%	90.65 %	87%
W30	Well Child Visits in the First 30 Months of Life (New)	68%	68%	52%	63%
WCV	Child & Adolescent Care Visits Ages 3-21 (New)	66.21%	66.21%	14.78%	39%
PPC-2	Timeliness of Prenatal Care	83.76%	83.76%	81.70%	88%
PPC-1	Timeliness of Postpartum Care	65.69%	65.69%	63.10%	80%
IMA-2	Immunizations for Adolescents (Combo 2)	34.43%	34.43%	31.12%	46%
CIS-10	Childhood Immunization Status (Combo 10)	43.79%	34.79%	22.42%	19%
CBP	Controlling High Blood Pressure	61.04%	61.04%	30.28%**	51%

*2021 HEDIS data not finalized by health plan until May/June
**CPTII Coding impacted measures

2022 UDS Clinical Measures

Measure	2022 EDCHC Goal*	2021 EDCHC	2021 EDCHC Goal	2020 National Average	2020 EDCHC	2019 EDCHC
Cervical Cancer Screening	51%	48.40%	50%	51%	46.10%	48.36%
Breast Cancer Screening	50%	48.61%	45%	45.43%	46.42%	-----
BMI Screening & Follow-up Planning (Adult)	66%	59.34%	85%	65.72%	77.88%	89.15%
Tobacco Use Screening	90%	85.44%	95%	83.43%	91.68%	92.87%
Colorectal Cancer Screening	40%	37.46%	35%	40.09%	34.41%	38.80%
HIV Screening	15%	12.02%	15%	32.29%	12.98%	-----
Depression Screening & Follow-Up Planning	90%	89.18%	90%	64.12%	86.95%	83.30%
Childhood Immunization Status	30%	25.37%	25.00%	40.42%	26.55%	24.32%
Weight Assessment & Counseling for Nutrition & Physical Activity	90%	84.01%	85%	65.13%	82.90%	95.61%
Dental Sealants for Children	65%	61.02%	80%	48.68%	61.70%	80.68%
Statin Therapy for the Prevention of Cardiovascular Disease	60%	54.13%	55%	71.92%	54.09%	51.82%
Ischemic Vascular Disease: Use of Aspirin or Another Antiplatelet	60%	55.43%	60%	78.80%	55.88%	79.08%
Depression Remission at 12 Months	15%	1.23%	15%	13.69%	0.00%	-----
Controlling High Blood Pressure	60%	56.90%	75%	57.98%	69.13%	77.61%
Diabetes – Poor Glucose Control (A1c >9%) (inverse measure)	30%	36.11%	35%	35.60%	40.52%	28.57%

UDS Data finalized 3/7/22

*Goals may change based on organizational needs, priorities, and resources.

Section 5. Quality Improvement Initiative/PDSA

Once the performance of a selected process has been measured, assessed and analyzed, the information gathered by the above performance indicator(s) is used to identify a continuous quality improvement initiative to be undertaken. The decision to undertake the initiative is based upon El Dorado Community Health Centers' (EDCHC) priorities. The purpose of an initiative is to improve the performance of existing services, design new services, to reduce risk or improve compliance. The model utilized at EDCHC is a process improvement cycle called Plan-Do-Study-Act (PDSA).

Plan - The first step involves identifying preliminary opportunities for improvement. The focus is to analyze data to identify concerns and to determine anticipated outcomes. Ideas for improving processes are identified. This step requires the most time and effort. Affected staff or people served are identified, data compiled, and solutions proposed. (For tools used during the planning stage, see sections **"a" thru "k"** in APPENDIX: A)

Do - This step involves using the proposed solution, and if it proves successful, as determined through measuring and assessing, implementing the solution usually on a trial basis as a new part of the process.

Study - At this stage, data is again collected to compare the results of the new process with those of the previous one.

Act - This stage involves making the changes a routine part of the targeted activity. It also means "Acting" to involve others (other staff, program components or consumers) - those who will be affected by the changes, those whose cooperation is needed to implement the changes on a larger scale, and those who may benefit from what has been learned. Finally, it means documenting and reporting findings and follow up.

Section 6. Evaluation

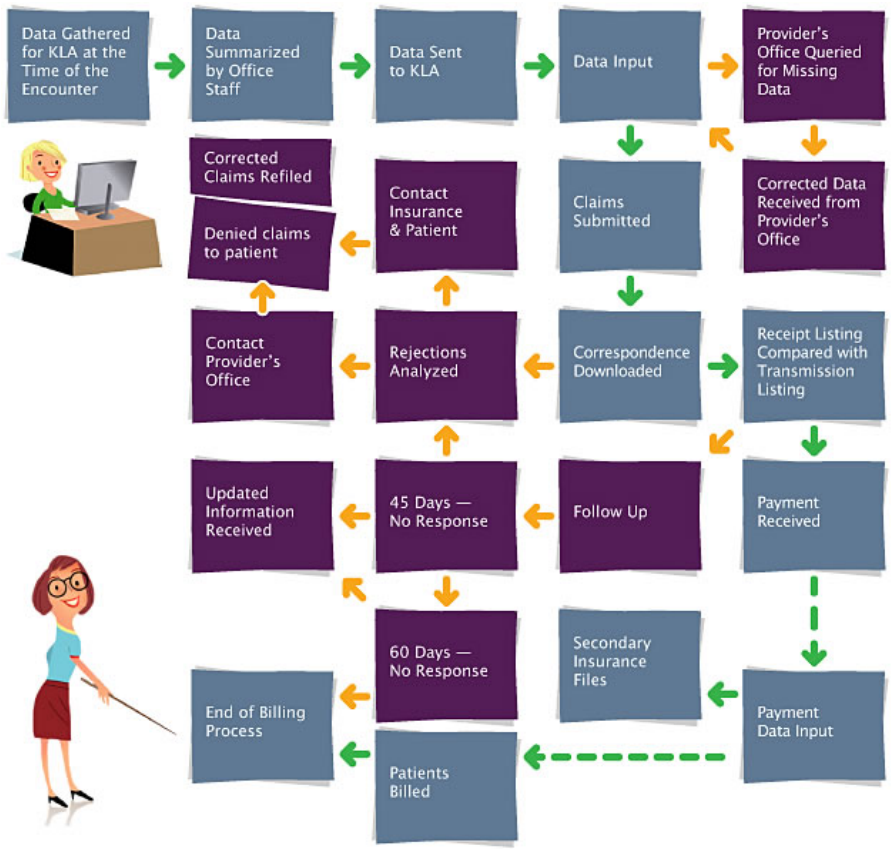
An annual evaluation of the Quality Improvement & Risk Management Plan will be conducted by El Dorado Community Health Centers (EDCHC) and kept on file along with the annual Quality Improvement & Risk Management Plan. The evaluation summarizes the goals of EDCHC's annual Quality Improvement & Risk Management Plan, the quality improvement, risk management, and compliance activities conducted during the past year, including the targeted process, systems and outcomes. It also includes the performance indicators utilized, the measurement findings, data aggregation and the quality improvement and risk management initiatives taken in response to the findings:

1. Summarize the progress towards meeting the annual QI/RM plan goals.
2. For each of the goals, include a brief summary of progress.
3. Provide a brief summary of the findings for each of the indicators used during the year. These summaries should include both the outcomes of the measurement process and the conclusions and actions taken in response to these outcomes.
4. Summarize process improvement progress and provide a brief description of what activities took place including the results on indicators. Include next steps and how measurement gains will be sustained.
5. Recommendations: Based upon the evaluation, state recommendations for the next year as well as any actions necessary to improve the effectiveness of the annual QI/RM Plan.

APPENDIX A. Quality Improvement Tools

Following are some of the tools available to assist in the quality improvement process.

a. Flow Charting: Use of a diagram in which graphic symbols depict the nature and flow of the steps in a process. This tool is particularly useful in the early stages of a project to help the team understand how the process currently works. The "as-is" flow chart may be compared to how the process is intended to work. At the end of the project, the team may want to then re-plot the modified process to show how the redefined process should occur.



The benefits of a flow chart are that it:

1) Is a pictorial representation that promotes understanding of the process
2) Is a potential training tool for employees
3) Clearly shows where problem areas and processes for improvement are

b. Brainstorming: A tool used by teams to bring out the ideas of each individual and present them in an orderly fashion to the rest of the team. Essential to brainstorming is to provide an environment free of criticism. Team members generate issues and agree to "defer judgement" on the relative value of each idea. Brainstorming is used

when one wants to generate a large number of ideas about issues to tackle, possible causes, approaches to use, or actions to take. The advantages of brainstorming are that it:

1) Encourages creativity
2) Rapidly produces many ideas
3) Equalizes involvement by all team members
4) Fosters a sense of ownership in the final decision as all members actively participate
5) Provides input to other tools: “brain stormed” ideas can be put into an affinity diagram or they can be reduced by multi-voting.

c. Decision-making Tools: While not all decisions are made by teams, two tools can be helpful when teams need to make decisions.

1) Multi-voting is a group decision-making technique used to reduce a long list of items to a manageable number by means of a structured series of votes. The result is a short list identifying what is important to the team. Multi-voting is used to reduce a long list of ideas and assign priorities quickly with a high degree of team agreement.
2) The Nominal Group technique is used to identify and rank issues in order of priority.

d. Affinity Diagram: The Affinity Diagram is often used to group ideas generated by brainstorming. It is a tool that gathers large amounts of language data (ideas, issues, opinions) and organizes them into groupings based on their natural relationship. The affinity process is a good way to get people who work on a creative level to address difficult, confusing, unknown or disorganized issues. The affinity process is formalized in a graphic representation called an affinity diagram. This process is useful to:

1) Sift through large volumes of data.
2) Encourage new patterns of thinking.

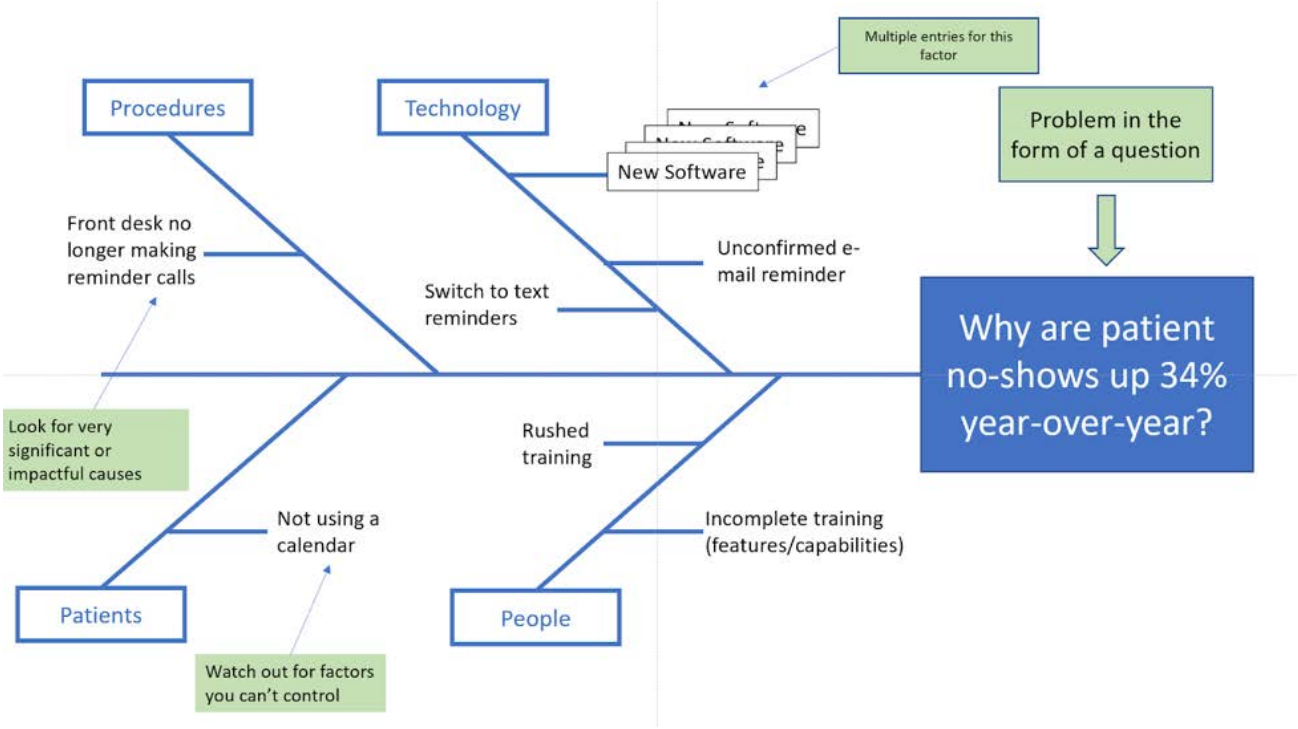
As a rule of thumb, if less than 15 items of information have been identified, the affinity process is not needed.

e. Cause and Effect Diagram (also called a fishbone or Ishakawa diagram): This is a tool that helps identify, sort, and display information. It is a graphic representation of the relationship between a given outcome and all the factors that influence the outcome. This tool helps to identify the basic root causes of a problem. The structure of the diagram helps team members think in a very systematic way. The benefits of a cause-and-effect diagram are that it:

1) Helps the team to determine the root causes of a problem or quality characteristic using a structured approach.

2) Encourages group participation and utilizes group knowledge of the process.
3) Uses an orderly, easy-to-read format to diagram cause-and-effect relationships.
4) Indicates possible causes of variation in a process.
5) Increases knowledge of the process.
6) Identifies areas where data should be collected for additional study.

CAUSE & EFFECT DIAGRAM



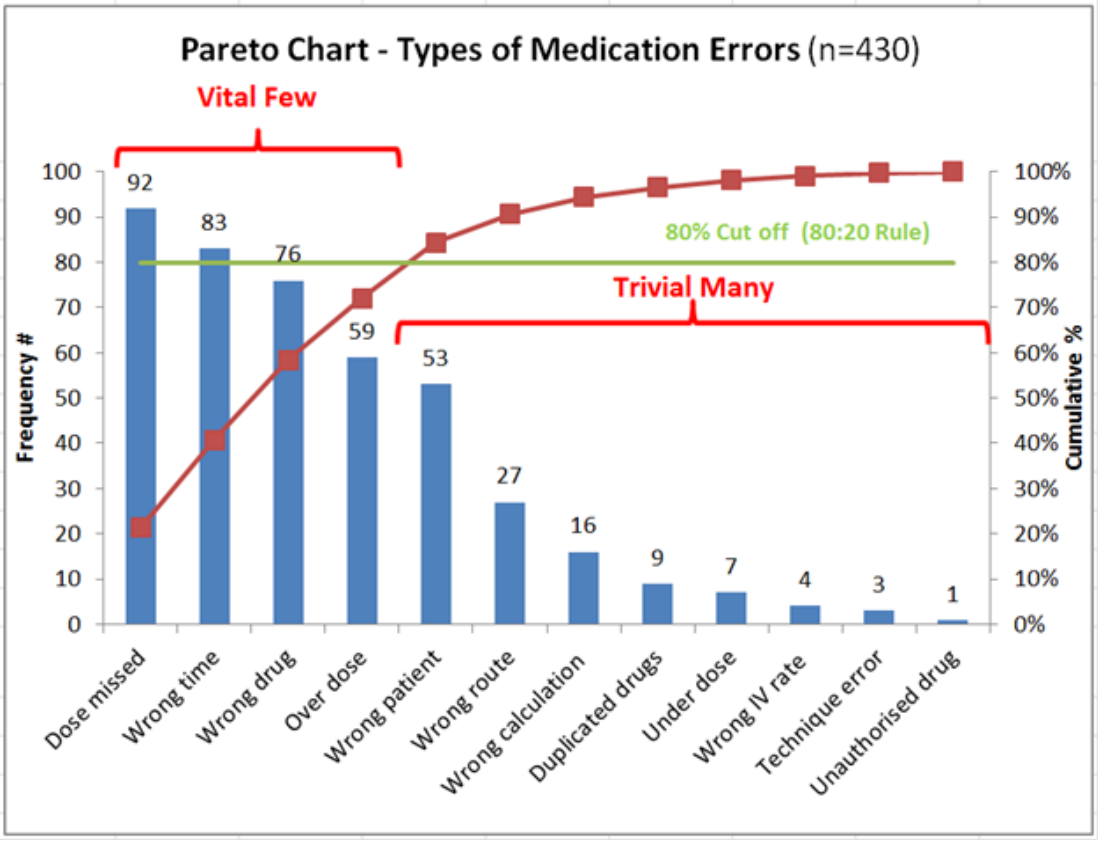
f. Histogram: This is a vertical bar chart which depicts the distribution of a data set at a single point in time. A histogram facilitates the display of a large set of measurements presented in a table, showing where the majority of values fall in a measurement scale and the amount of variation. The histogram is used in the following situations:

1) To graphically represent a large data set by adding specification limits one can compare.
2) To process results and readily determine if a current process was able to produce positive results assist with decision-making.

g. Pareto Chart: Named after the Pareto Principle which indicates that 80% of the trouble comes from 20% of the problems. It is a series of bars on a graph, arranged in descending order of frequency. The height of each bar reflects the frequency of

an item. Pareto charts are useful throughout the performance improvement process - helping to identify which problems need further study, which causes to address first, and which are the "biggest problems." Benefits and advantages include:

1) Focus on most important factors and help to build consensus.
2) Allows for allocation of limited resources.



The "Pareto Principle" says 20% of the source causes 80% of the problem. Pareto charts allow the team to graphically focus on the areas and issues where the greatest opportunities to improve performance exist.

h. Root Cause Analysis: A root cause analysis is a systematic process for identifying the most basic factors/causes that underlie variation in performance.

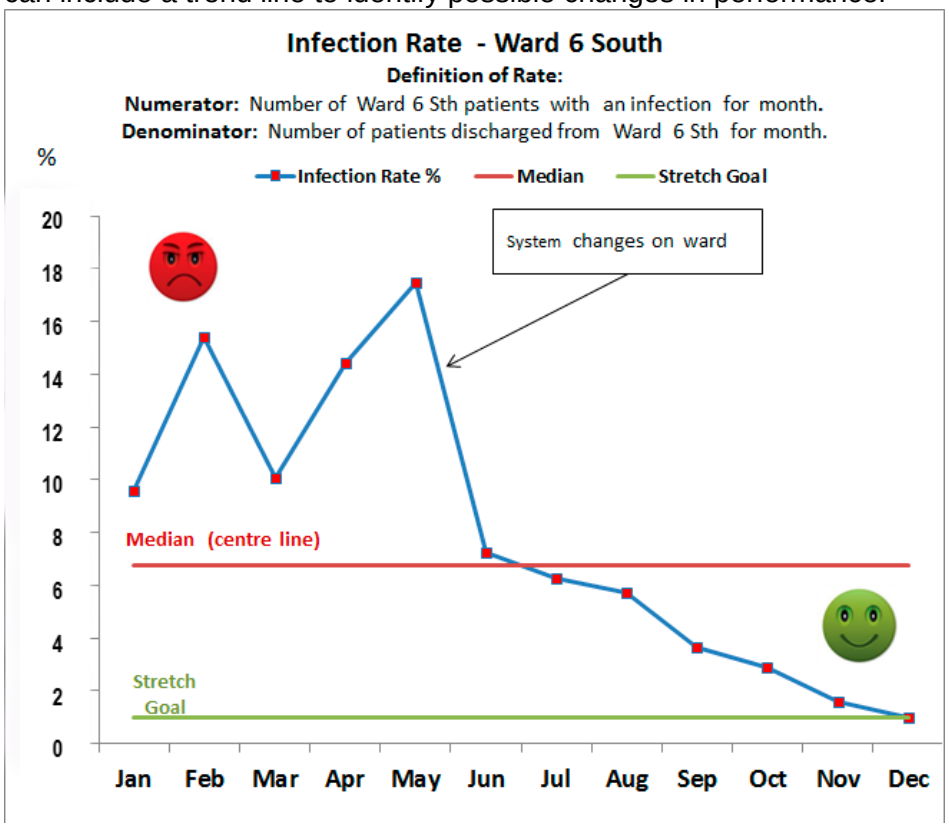
i. Run Chart: This is a basic tool to show how a process performs over time. Data points are plotted in temporal order on a line graph. Run charts are most effectively used to assess and achieve process stability by graphically depicting signals of variation. A run chart can help to determine whether or not a process is stable,

consistent, and predictable. Simple statistics such as median and range may also be displayed.

The run chart is most helpful in:

1) Understanding variation in process performance.
2) Monitoring process performance over time to detect signals of change.
3) Depicting how a process performed over time, including variation.

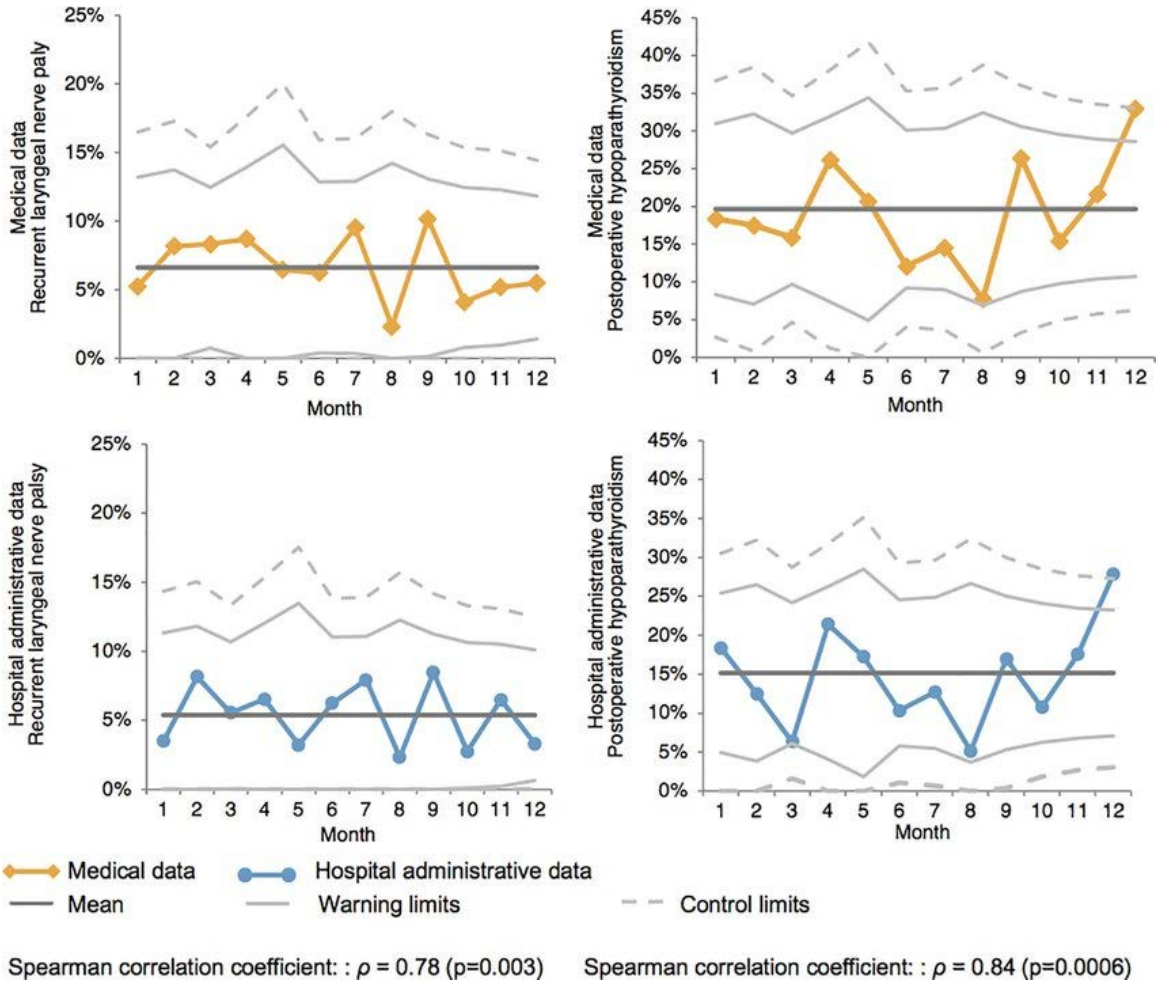
Run charts allows the team to see changes in performance over time. The diagram can include a trend line to identify possible changes in performance.



j. Control Chart: A control chart is a statistical tool used to distinguish between variation in a process resulting from common causes and variation resulting from special causes. It is noted that there is variation in every process. Some variation is the result of causes not normally present in the process (special cause variation). A common cause of variation is variation that results simply from the numerous, ever-present differences in the process. Control charts can help to maintain stability in a process by depicting when a process may be affected by special causes. The consistency of a process is usually characterized by showing

if data fall within control limits based on plus or minus specific standard deviations from the center line. Control charts are used to:

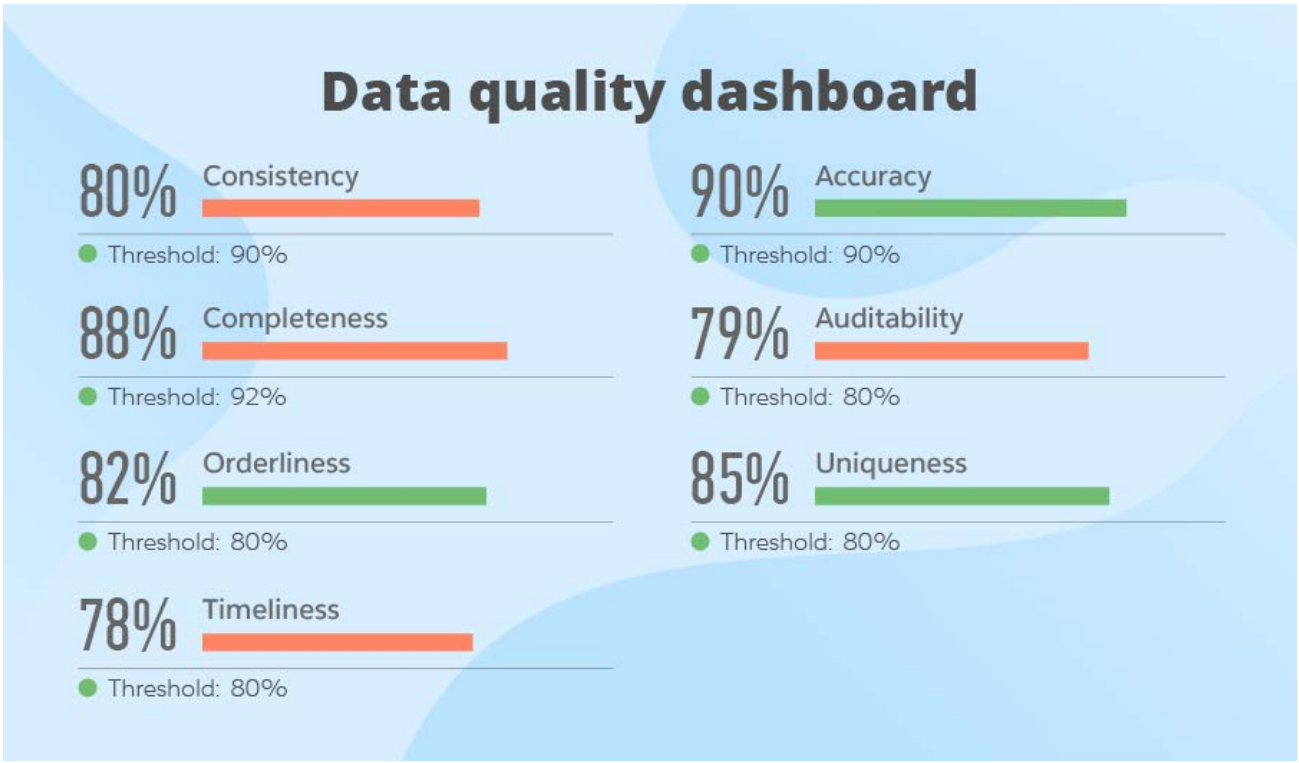
4) Monitor process variation over time.
5) Help to differentiate between special and common cause variation.
6) Assess the effectiveness of change on a process.
7) Illustrate how a process performed during a specific period.



Using upper control limits (UCLs) and lower control limits (LCLs) that are statistically computed, the team can identify statistically significant changes in performance. This information can be used to identify opportunities to improve performance or measure the effectiveness of a change in a process, procedure, or system.

k. Bench Marking: A benchmark is a point of reference by which something can be measured, compared, or judged. It can be an industry standard against which a

program indicator is monitored and found to be above, below or comparable to the benchmark.



Signatures of Approval

04/21/2022

Chief Medical Officer — Date

Digitally signed by Terri Stratton
DN: cn=Terri Stratton, o=El Dorado Community Health Centers, ou=Chief Executive Officer, email=tstratton@edchc.org, c=US
Date: 2022.04.11 13:48:54 -07'00'

4/11/22

Chief Executive Officer — Date

Michael Ungeheuer MN RN PHN Board Chair

Digitally signed by Michael Ungeheuer MN RN PHN Board Chair
Date: 2022.03.29 16:25:27 -07'00'

Board of Directors Chairperson — Date