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 plan also outlines quality and risk management focus areas for the current calendar year and is in part developed as an outgrowth of the evaluation of QI & RM activities from the previous year, organizational priorities, and organizational program requirements.

2022 Quality Improvement & Risk Management Annual Report

The Quality Improvement & Risk Management goals set for 2022 were focused on fighting COVID-19 through testing, vaccinations, and boosters for staff, patients, and community members. Additional goals included 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 required in person contact to perform patient assessments, testing, and care included 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 completed in 2022.

Other 2022 Quality Improvement & Risk Management goals addressed key compliance and risk areas. EDCHC developed 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 also implemented 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 worked towards the development and implementation of a plan to educate patients and increase completion of patient Advance Directives, a health plan compliance requirement. Incident reporting and responding to patient complaints and grievances continued in 2022 with 100% of incidents closed and patient complaints and grievances addressed.

Additional 2022 goals focused on 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 influenced related HEDIS and UDS measures. Applying for State grant funding and implementing a program to advance tobacco cessation within EDCHC clinics influenced tobacco use and cessation among EDCHC patients. Securing a contract with Relevant through grant funding improved both HEDIS and UDS measures through provider and staff access to timely data for population health and care management.
<table>
<thead>
<tr>
<th>2022 QI &amp; RM Goals</th>
<th>Work Started</th>
<th>Final Report</th>
<th>Work Completed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Development, review, and Board approval of 2022 QI/RM Plan.</td>
<td>12/1/21</td>
<td><strong>Complete.</strong> Quality Assurance &amp; Risk Management Committee (QARMC) reviewed the plan on 1/18/22. Board approval received on 3/22/22.</td>
<td>3/22/22</td>
</tr>
<tr>
<td>Increase COVID-19 testing for patients and community members due to Omicron and other variants.</td>
<td>1/1/22</td>
<td><strong>Complete.</strong> During 2022 EDCHC continued the fight against COVID-19 by providing testing, vaccine, and boosters to staff, patients and community members. The total number of COVID-19 vaccine and boosters given as of 12/31/22: 9,849.</td>
<td>12/31/22</td>
</tr>
<tr>
<td>Conduct COVID-19 Family Vaccination Clinics to provide vaccine and boosters to families and community members.</td>
<td>1/1/22</td>
<td><strong>Complete.</strong> EDCHC conducted (and assisted with) family vaccination clinics through March 2022. Beginning in April 2022, COVID-19 vaccinations and boosters became available in clinic M-F at various EDCHC clinic sites.</td>
<td>3/31/22</td>
</tr>
<tr>
<td>Provide on-site testing and COVID-19 vaccination and boosters to EDCHC employees.</td>
<td>1/2/22</td>
<td><strong>Complete.</strong> EDCHC provided on-site COVID-19 testing, vaccination and boosters to EDCHC employees. Most (&gt;95%) employees received at least one required booster by February 1, 2022, in accordance with state requirements for healthcare workers. On 9/3/22, emergency use authorization was granted for updated boosters bivalent Moderna (18+ years) and Pfizer (12+ years) and bivalent boosters are available M-F at various EDCHC clinic sites.</td>
<td>12/31/22</td>
</tr>
<tr>
<td>Apply for State grant funding and implement a program to “Advance Tobacco Cessation in Community Clinics.”</td>
<td>1/1/22</td>
<td><strong>Complete.</strong> Submitted grant application for “Advancing Tobacco Cessation in Community Clinics” on 3/4/22. Grant funded and contracting completed 10/3/22. This is an 18 month grant focused on improving tobacco cessation among patients through improved screening, tracking, referral &amp; follow-up at Cameron Park 2 clinic.</td>
<td>3/31/22</td>
</tr>
<tr>
<td>Revise and implement daily huddles to improve communication and promote team-based patient care for Tele-Video, Tele-Audio and in-person visits.</td>
<td>1/1/22</td>
<td><strong>Complete. Follow-Up Needed.</strong> RN Manager and Care Teams worked on revisions to daily huddles and piloted methods. Daily visit planning was mapped in Relevant for use in daily huddles. <strong>Iterations will continue into 2023 to ensure Relevant Visit Planning module is effective and useful to care teams.</strong></td>
<td>12/31/22</td>
</tr>
<tr>
<td>Secure contract with Relevant and implement services to improve patient outcomes through data</td>
<td>1/1/22</td>
<td><strong>Complete. Follow-Up Needed.</strong> Relevant grant funding secured for three years. Contracting completed. HIT and QI teams completed weekly implementation meetings and basic mapping</td>
<td>12/31/22</td>
</tr>
<tr>
<td>2022 QI &amp; RM Goals</td>
<td>Work Started</td>
<td>Final Report</td>
<td>Work Completed</td>
</tr>
<tr>
<td>---------------------</td>
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<td>----------------</td>
</tr>
<tr>
<td>and population health management (grant funded).</td>
<td></td>
<td>with Relevant. Data validation and mapping of UDS &amp; key HEDIS measures completed. Visit Planning module modification completed. Demonstrations given to leadership (6/29/22), primary care providers, and RNs (7/6/22); Access given to leadership, primary care providers, RNs, Site Managers, Front Office Manager, and Dental Director. <strong>Promotion of and additional access to Relevant needed in 2023 to improve staff utilization.</strong></td>
<td></td>
</tr>
<tr>
<td>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.”</td>
<td>2/1/22</td>
<td><strong>Complete.</strong> Primary care provider survey completed and data reviewed by Dr. Reina. A Controlled Substance Abuse (CSA) Committee consisting of providers and RNs established to begin implementing guidelines. CSA meetings are held regularly.</td>
<td>6/30/22</td>
</tr>
<tr>
<td>Develop proxy portal access training and workflows to comply with The Confidentiality of Medical Information Act (CMIA).</td>
<td>2/1/22</td>
<td><strong>Complete.</strong> Developed workflows and training guide. Moved eCW users to cloud application by 6/30/22. QI and HIT met with Clinical Leadership team on 8/25/22 to discuss reason for change and roll out plan. Patient notifications began in September and Proxy Portal access changes were effective in October. Parent/guardian letter created. Staff training on proxy access to patient portal and California Law completed at monthly staff meetings on 10/5/22. Proxy access changes implemented on 10/6/22.</td>
<td>10/6/22</td>
</tr>
<tr>
<td>Develop and implement a modified Social Determinants of Health (SDOH) screening tool in dental to assess SDOH barriers to care.</td>
<td>3/1/22</td>
<td><strong>Modified &amp; Complete.</strong> Modifications to PRAPARE survey reviewed to more easily engage patients in sharing sensitive information. RN Care Team started implementation during New Patient Orientations. Protocol developed. Dental patients who are also primary care patients currently being screened during primary care visits.</td>
<td>12/31/22</td>
</tr>
<tr>
<td>Create plan and workflow for RN flip visits designed to improve chronic disease management.</td>
<td>4/1/22</td>
<td><strong>Complete.</strong> RN Manager created a plan to identify ways to schedule with providers using Center for Care Innovations (CCI) flip visit model. Piloted RN flip visits.</td>
<td>7/31/22</td>
</tr>
<tr>
<td>Develop a Diabetes Prevention &amp; Management Program (DPMP) Sustainability Plan to</td>
<td>4/1/22</td>
<td><strong>Complete.</strong> DPMP Sustainability Plan completed and submitted to HRSA through the eHB on 6/1/2022. Key elements of DPMP model continued in a sustainable way after the DPMP</td>
<td>7/31/22</td>
</tr>
<tr>
<td>2022 QI &amp; RM Goals</td>
<td>Work Started</td>
<td>Final Report</td>
<td>Work Completed</td>
</tr>
<tr>
<td>----------------------------------------------------------------------------------</td>
<td>--------------</td>
<td>-----------------------------------------------------------------------------</td>
<td>----------------</td>
</tr>
<tr>
<td>continue program services after the end of the grant period (7/31/2022).</td>
<td></td>
<td>grant ended on 7/31/22. Key elements include RD services and lifestyle education through RN team. There was notable improvement in 2022 in the UDS measure for diabetes (HgA1c &gt;9).</td>
<td></td>
</tr>
<tr>
<td>Develop and implement a plan to educate patients and increase completion of patient Advance Directives.</td>
<td>4/1/22</td>
<td>Complete. Follow-Up Needed. Staff received Advance Directives training through MedTrainer and a protocol was developed to educate patients. Tracking of completion of Advance Directives will continue in 2023.</td>
<td>12/31/22</td>
</tr>
<tr>
<td>Implement workflows to comply with the 21st Century Cures Act information blocking rule that will encourage transparency around patient safety issues in Health IT.</td>
<td>5/1/22</td>
<td>Complete. The December eCW upgrade included system changes to meet the 21st Century Information Blocking Rule requirements.</td>
<td>12/31/22</td>
</tr>
<tr>
<td>Increase patient survey response rates through the implementation of a comprehensive, structured patient feedback model to improve patient services and overall patient experience.</td>
<td>3/1/22</td>
<td>Complete. Marketing Director revised patient satisfaction survey to improve ease of use as part of a comprehensive, structured patient feedback model designed to improve patient services. Survey is bilingual.</td>
<td>12/31/22</td>
</tr>
</tbody>
</table>

All 2022 Quality Improvement & Risk Management Goals were completed with three needing additional follow-up in 2023 and one modified to reflect organizational needs. The three goals needing additional follow-up are:

1. Revise and implement daily huddles to improve communication and promote team-based patient care for Tele-Video, Tele-Audio and in-person visits.
2. Secure contract with Relevant and implement services to improve patient outcomes through data and population health management (grant funded).
3. Develop and implement a plan to educate patients and increase completion of patient Advance Directives.

2023 follow-up for these goals will include:

1. Iterations will continue into 2023 to ensure Relevant Visit Planning module is effective and useful to care teams.
2. Promotion of and additional access to Relevant needed in 2023 to improve staff utilization.
3. Tracking of completion of Advance Directives.

2022 UDS Clinical Performance Goals
2022 UDS clinical measure performance goals were set by EDCHC based on the previous year’s performance, the impact COVID-19 had on clinical performance measures, and the 2021 national UDS average for each measure. UDS reporting was based on the 2022 calendar year.
and will be electronically reported to the Health Resources & Services Administration (HRSA) on February 15, 2023. It’s important to note that for new or modified UDS clinical measures, annual changes are not typically released by HRSA until June of the current measurement year. Historically, EDCHC has utilized BridgeIT, a data platform for eClinicalWorks (eCW), and has relied on mapping and reporting setup guides and training from Heckman Consulting. In the spring of 2022, EDCHC secured a contract with Relevant, a data analytics and visualization platform, and transitioned UDS reporting to the new system.

<table>
<thead>
<tr>
<th>2022 UDS Clinical Quality Measures</th>
<th>Source of Data</th>
<th>CMS eCQM ID</th>
<th>Numerator</th>
<th>Denominator</th>
<th>1/1/22-12/31/22</th>
<th>Overall % Change in 2022</th>
<th>2022 Goal (2021 UDS National Average)</th>
<th>% Difference From 2022 Goal</th>
<th>EDCHC 2022 Rate</th>
<th>EDCHC 2020 Rate</th>
<th>EDCHC 2019 Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Breast Cancer Screening (BCS)</td>
<td>Relevant</td>
<td>CMS123v10</td>
<td>967</td>
<td>1891</td>
<td>51.27%</td>
<td>2.69%</td>
<td>46.19%</td>
<td>4.98%</td>
<td>48.51%</td>
<td>46.42%</td>
<td>48.00%</td>
</tr>
<tr>
<td>Cervical Cancer Screening (CCS)</td>
<td>Relevant</td>
<td>CMS124v10</td>
<td>1423</td>
<td>2965</td>
<td>47.99%</td>
<td>1.73%</td>
<td>52.95%</td>
<td>4.96%</td>
<td>48.40%</td>
<td>46.10%</td>
<td>48.36%</td>
</tr>
<tr>
<td>Childhood Immunization Status (CHI)</td>
<td>Relevant</td>
<td>CMS117v10</td>
<td>5</td>
<td>27</td>
<td>11.11%</td>
<td>-9.09%</td>
<td>29.06%</td>
<td>-12.95%</td>
<td>25.37%</td>
<td>26.55%</td>
<td>24.32%</td>
</tr>
<tr>
<td>Colorectal Cancer Screening (CRS)</td>
<td>Relevant</td>
<td>CMS150v10</td>
<td>3138</td>
<td>3259</td>
<td>59.55%</td>
<td>3.01%</td>
<td>41.93%</td>
<td>1.18%</td>
<td>57.48%</td>
<td>54.41%</td>
<td>58.80%</td>
</tr>
<tr>
<td>Controlling High Blood Pressure</td>
<td>Relevant</td>
<td>CMS169v10</td>
<td>1144</td>
<td>2050</td>
<td>55.80%</td>
<td>7.69%</td>
<td>60.15%</td>
<td>-4.35%</td>
<td>66.90%</td>
<td>69.13%</td>
<td>77.61%</td>
</tr>
<tr>
<td>Depression Remission at 12 Months</td>
<td>Relevant</td>
<td>CMS159v10</td>
<td>34</td>
<td>462</td>
<td>7.36%</td>
<td>6.12%</td>
<td>13.84%</td>
<td>-6.48%</td>
<td>1.23%</td>
<td>0.00%</td>
<td>0.00%</td>
</tr>
<tr>
<td>Hemoglobin A1c (HbA1c) Poor Control (HbA1c)</td>
<td>Relevant</td>
<td>CMS122v10</td>
<td>759</td>
<td>1057</td>
<td>69.01%</td>
<td>3.84%</td>
<td>67.71%</td>
<td>2.22%</td>
<td>63.80%</td>
<td>59.48%</td>
<td>71.43%</td>
</tr>
<tr>
<td>HIV Screening</td>
<td>Relevant</td>
<td>CMS349v4</td>
<td>1196</td>
<td>6880</td>
<td>17.45%</td>
<td>0.93%</td>
<td>19.09%</td>
<td>20.68%</td>
<td>12.02%</td>
<td>12.98%</td>
<td>0.00%</td>
</tr>
<tr>
<td>Ischemic Vascular Disease (IVD) Use of Aspirin or Another antiplatelet</td>
<td>Relevant</td>
<td>CMS164v7</td>
<td>327</td>
<td>440</td>
<td>74.32%</td>
<td>-3.61%</td>
<td>78.25%</td>
<td>-3.93%</td>
<td>55.42%</td>
<td>55.88%</td>
<td>78.08%</td>
</tr>
<tr>
<td>Preventive Care &amp; Screening: (Adult) Body Mass Index (BMI) &amp; Follow-Up Plan</td>
<td>Relevant</td>
<td>CMS69v10</td>
<td>2696</td>
<td>6552</td>
<td>41.18%</td>
<td>-2.32%</td>
<td>61.22%</td>
<td>-20.14%</td>
<td>59.34%</td>
<td>77.88%</td>
<td>89.15%</td>
</tr>
<tr>
<td>Preventive Care &amp; Screening: Depression Screening with Follow-Up Plan</td>
<td>Relevant</td>
<td>CMS2v11</td>
<td>5519</td>
<td>6180</td>
<td>86.07%</td>
<td>2.52%</td>
<td>97.42%</td>
<td>-18.65%</td>
<td>89.18%</td>
<td>96.95%</td>
<td>83.30%</td>
</tr>
<tr>
<td>Preventive Care Screening: Tobacco Use: Screening &amp; Supervision</td>
<td>Relevant</td>
<td>CMS138v10</td>
<td>4717</td>
<td>5964</td>
<td>79.09%</td>
<td>-2.01%</td>
<td>82.34%</td>
<td>-5.25%</td>
<td>85.44%</td>
<td>91.68%</td>
<td>92.87%</td>
</tr>
<tr>
<td>Statin Therapy for the Prevention &amp; Treatment of Cardiovascular Disease</td>
<td>Relevant</td>
<td>CMS347v5</td>
<td>1190</td>
<td>1627</td>
<td>73.14%</td>
<td>6.59%</td>
<td>78.10%</td>
<td>0.04%</td>
<td>54.13%</td>
<td>54.09%</td>
<td>51.82%</td>
</tr>
<tr>
<td>Weight Assessment &amp; Counseling for Nutrition &amp; Physical Activity for Children &amp; Adolescents</td>
<td>Relevant</td>
<td>CMS155v10</td>
<td>1589</td>
<td>1789</td>
<td>88.82%</td>
<td>3.69%</td>
<td>68.72%</td>
<td>20.10%</td>
<td>84.01%</td>
<td>82.90%</td>
<td>95.61%</td>
</tr>
</tbody>
</table>

During 2022, EDCHC saw improvement in 9 of 14 clinical quality measures with five clinical quality measures exceeding the 2022 goal: Breast Cancer Screening, Hemoglobin A1c Poor Control, Depression Screening with Follow Up Plan, Statin Therapy for the Prevention & Treatment of Cardiovascular Disease and Weight Assessment & Counseling for Nutrition & Physical Activity for Children & Adolescents. Three clinical quality measures fell notably under goal: Childhood Immunization Status, HIV Screening, and Adult Body Mass Index (BMI) & Follow-Up Plan. EDCHC made notable efforts to address vaccine hesitancy with parents of children under two to improve the Childhood Immunization Status (CIS) clinical measure as soon as COVID-19 permitted. EDCHC did this by securing $5,000 in incentive funding to encourage parents to bring their children under two in for immunizations as part of the On Track By 2 Program. The Population Health Specialist also tracked and called parents to schedule and remind them of their child’s need for immunizations. Through data analysis and chart review, the Quality Improvement team identified two immunizations as primary barriers to meeting the CIS measure: Rotavirus and Influenza. The Quality Improvement team worked with clinical operations staff to ensure that the two-dose series of Rotavirus was made available to children who aged out of the three-dose series. Finally, the Quality Improvement team
conducted CIS measure training with providers and Medical Assistants. It is anticipated these efforts will help improve the measure in 2023. HIV screening was a new measure during COVID-19 and there has been some improvement during 2022. It is anticipated that EDCHC will implement an “opt-out” protocol for this measure in 2023. The “opt-out” protocol addresses HIV screening as part of normal routine care and gives patients the opportunity to “opt-out” of the screening instead of requesting permission to perform the screening. Finally, changes were made within eCW to stop the auto-population of a follow-up plan in the progress note when an adult patient’s BMI fell out of normal range during the primary care visit. Although this more accurately reflects clinical care and discussion between provider and patient, it negatively impacted the Adult BMI & Follow-Up Plan measure. Provider training in 2023 regarding the importance of documenting a follow-up plan when an adult patient’s BMI falls out of normal range will result in improvements to this measure.

EDCHC Quality Improvement & Risk Management 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 Quality Improvement & Risk Management 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 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 2023 QI & RM Plan

(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 Plan.
- Monitoring QI & RM plan goals and indicators of care quality and patient safety.
- Periodically assess objectives and reviewing actions taken by the organization’s internal 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
Site Managers
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
EDCHC 2023 QI & RM Plan

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 Plan.
   - Evaluate the annual Quality Improvement & Risk Management Plan based on identified goals and quality indicators.
   - Report quarterly to the QARMC organization quality improvement and risk management activities.
   - QIRMC reporting to various stakeholder groups.
   - QIRMC 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 2023.

- 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 & Risk Management Committee (QARMC). 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.

**2023 Quality Improvement & Risk Management Goals**

Working with key management staff, the Compliance & Quality Director is responsible for ensuring the implementation and updating of Quality Improvement & Risk Management operating procedures and related assessments and monitoring Quality Improvement & Risk Management outcomes. The Compliance & Quality Director works with the Quality Improvement & Risk Management Committee (QIRMC) to set annual quality improvement and risk management goals.
**EDCHC 2023 QI & RM Plan**

<table>
<thead>
<tr>
<th>2023 Quality Improvement &amp; Risk Management Goal</th>
<th>Responsible Person(s)</th>
<th>Work Begins</th>
<th>Work Completed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Development, review and Board approval of 2023 QI &amp; RM Plan.</td>
<td>Compliance &amp; Quality Director</td>
<td>January 1, 2023</td>
<td>March 1, 2023</td>
</tr>
<tr>
<td>Develop and implement a “Good Catch” program in Primary Care to better identify, report, and track near miss events.</td>
<td>RN Manager and Compliance &amp; Quality Director</td>
<td>March 1, 2023</td>
<td>September 30, 2023</td>
</tr>
<tr>
<td>Complete the CareQuality framework set-up to improve the exchange of clinical data between eCW and EPIC (UCD/Marshall and Kaiser). This will include the exchange of progress notes, visit summaries, lab, and DI results.</td>
<td>HIT Manager and HIT Team</td>
<td>March 1, 2023</td>
<td>September 30, 2023</td>
</tr>
<tr>
<td>Improve pediatric and adult immunization rates through focused outreach and immunization clinics. For adults, including offering Shingrix and Prevnar20 at no cost.</td>
<td>MA Supervisors</td>
<td>March 1, 2023</td>
<td>October 31, 2023</td>
</tr>
<tr>
<td>Prepare for and implement systems to ensure compliance with UDS+ reporting for 2023.</td>
<td>Compliance &amp; Quality Director and HIT Manager</td>
<td>April 1, 2023</td>
<td>December 31, 2023</td>
</tr>
<tr>
<td>Optimize care for patients at risk for heart disease and stroke by implementing the ABCS of cardiovascular disease prevention which are: 1) Appropriate aspirin and anticoagulant use, 2) Blood pressure control, 3) Cholesterol management, and 4) Smoking cessation.</td>
<td>Associate Medical Director and RN Manager</td>
<td>April 1, 2023</td>
<td>December 31, 2023</td>
</tr>
<tr>
<td>eCW Kiosk iPad set-up, for each pod/department in Cameron Park 1. This will allow patients to update their demographics and medical information, sign consents, and complete smart forms/questionnaires electronically.</td>
<td>HIT Manager, HIT Team, Site Manager, Front Office Manager, and Front Office Supervisor</td>
<td>June 1, 2023</td>
<td>October 31, 2023</td>
</tr>
<tr>
<td>Educate clinical staff on coding HEDIS Well Child Visit (WCV) requirements to improve performance in the patient population ages 18-21.</td>
<td>QI Analyst, Population Health Specialist and Billing Manager</td>
<td>June 1, 2023</td>
<td>August 31, 2023</td>
</tr>
<tr>
<td>Pilot improved tobacco screening, referral, prescriptions, counseling and follow-up for patients who use tobacco at Cameron Park 2 Clinic.</td>
<td>Compliance &amp; Quality Director, HIT Manager, Site Manager, MA Supervisor, and RN</td>
<td>July 1, 2023</td>
<td>October 31, 2023</td>
</tr>
<tr>
<td>Pilot Shared Medical Appointment model of care in Placerville for patients living with Diabetes to improve HgA1c.</td>
<td>Associate Medical Director and RN Manager</td>
<td>July 1, 2023</td>
<td>December 31, 2023</td>
</tr>
</tbody>
</table>

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 (QIRMC) 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 QIRMC 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 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 2023

The table below outlines the UDS clinical performance measures anticipated in 2023. Measures prioritized by the Quality Improvement & Risk Management Committee (QIRMC) will be reviewed quarterly during meetings with the goal of improved performance in select measures.

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.

<table>
<thead>
<tr>
<th>Measure</th>
<th>2023 EDCHC Goal</th>
<th>2022 EDCHC Rate</th>
<th>2022 EDCHC Goal</th>
<th>2021 EDCHC Rate</th>
<th>2020 EDCHC Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cervical Cancer Screening</td>
<td>53%</td>
<td>47.99%</td>
<td>52.95%</td>
<td>48.40%</td>
<td>46.10%</td>
</tr>
<tr>
<td>Breast Cancer Screening</td>
<td>52%</td>
<td>51.27%</td>
<td>46.29%</td>
<td>48.61%</td>
<td>46.42%</td>
</tr>
<tr>
<td>BMI Screening &amp; Follow-up Planning (Adult)</td>
<td>62%</td>
<td>41.18%</td>
<td>61.32%</td>
<td>59.34%</td>
<td>77.88%</td>
</tr>
<tr>
<td>Tobacco Use Screening</td>
<td>83%</td>
<td>79.09%</td>
<td>82.34%</td>
<td>85.44%</td>
<td>91.68%</td>
</tr>
<tr>
<td>Colorectal Cancer Screening</td>
<td>42%</td>
<td>39.95%</td>
<td>41.93%</td>
<td>37.46%</td>
<td>34.41%</td>
</tr>
<tr>
<td>HIV Screening</td>
<td>39%</td>
<td>17.43%</td>
<td>38.09%</td>
<td>12.02%</td>
<td>12.98%</td>
</tr>
<tr>
<td>Depression Screening &amp; Follow-Up Planning</td>
<td>87%</td>
<td>86.07%</td>
<td>67.42%</td>
<td>89.18%</td>
<td>86.95%</td>
</tr>
<tr>
<td>Childhood Immunization Status</td>
<td>39%</td>
<td>11.11%</td>
<td>38.06%</td>
<td>25.37%</td>
<td>26.32%</td>
</tr>
<tr>
<td>Weight Assessment &amp; Counseling for Nutrition &amp; Physical Activity (Children)</td>
<td>89%</td>
<td>88.82%</td>
<td>68.72%</td>
<td>84.01%</td>
<td>82.90%</td>
</tr>
<tr>
<td>Measure</td>
<td>2023 EDCHC Goal</td>
<td>2022 EDCHC Rate</td>
<td>2022 EDCHC Goal</td>
<td>2021 EDCHC Rate</td>
<td>2020 EDCHC Rate</td>
</tr>
<tr>
<td>------------------------------------------------------------------------</td>
<td>-----------------</td>
<td>-----------------</td>
<td>-----------------</td>
<td>-----------------</td>
<td>-----------------</td>
</tr>
<tr>
<td>Statin Therapy for the Prevention of Cardiovascular Disease</td>
<td>74%</td>
<td>73.14%</td>
<td>73.10%</td>
<td>54.13%</td>
<td>54.09%</td>
</tr>
<tr>
<td>Ischemic Vascular Disease: Use of Aspirin or Another Antiplatelet</td>
<td>79%</td>
<td>74.32%</td>
<td>78.25%</td>
<td>55.43%</td>
<td>55.88%</td>
</tr>
<tr>
<td>Depression Remission at 12 Months</td>
<td>14%</td>
<td>7.36%</td>
<td>13.84%</td>
<td>1.23%</td>
<td>-----</td>
</tr>
<tr>
<td>Controlling High Blood Pressure</td>
<td>61%</td>
<td>55.80%</td>
<td>60.15%</td>
<td>56.90%</td>
<td>69.13%</td>
</tr>
<tr>
<td>Diabetes – Poor Glucose Control (A1c &gt;9%)</td>
<td>70%</td>
<td>69.91%</td>
<td>67.71%</td>
<td>63.89%</td>
<td>59.48%</td>
</tr>
</tbody>
</table>

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) in conjunction with the annual Quality
EDCHC 2023 QI & RM Plan

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 goals 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**

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**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.

**Infection Rate - Ward 6 South**

**Definition of Rate:**
- **Numerator:** Number of Ward 6 South patients with an infection for month.
- **Denominator:** Number of patients discharged from Ward 6 South for month.

**System changes on ward**

**Median (centre line)**

**Stretch Goal**

**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. Benchmarking: 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

Veronica Velazquez Monif

__________________________
Chief Medical Officer

__________________________
Chief Executive Officer

__________________________
Board of Directors Chairperson

__________________________
Michael Ungheuer MN
RN PHN Board Chair

Digitally signed by Michael Ungheuer MN RN PHN Board Chair
Date: 2023.03.06 12:43:06 -08'00'

__________________________
Digitally signed by Caleb J Sandford
Date: 2023.03.06 12:43:06 -08'00'
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