

JOINT QUALITY AND RISK MANAGEMENT PLAN

- I. Philosophy:** The _____ are committed to the coordinated provision of the highest quality of ambulatory healthcare possible for patients/clients by maintaining an active, integrated, organized, and peer-based quality improvement (QI) program.
- II. General Program Description:** An ongoing Joint Quality and Risk Management Plan (Q & R Plan) is necessary to fully implement the above philosophy. It will include all ambulatory services provided under the auspices of the _____. With two (2) separate administrative entities, common commitment, goals and objectives, joint participation in quality and risk management is vital for provision of quality, cost-effective, evidence-based care.
- III. Program Goals**
- A. Instill a common organizational culture of quality improvement and risk reduction.
 - B. Collect data to ensure ongoing quality and identify quality-related problems or concerns.
 - C. Provide a program designed to maintain and continuously improve the quality of care provided to patients/clients.
 - D. Provide services to patients/clients in a cost-effective manner utilizing the resources available.
 - E. Provide a program of risk management to protect the life and welfare of patients/clients, visitors, and employees and to promote anticipatory intervention.
- IV. Program Objectives**
- A. Identify oversight of quality improvement activities through Quality Improvement By-laws to be reviewed annually, which include:
 - B. Means whereby activities or events with potential adverse impact on quality of care may be reported, evaluated and undergo constructive action.
 - C. Monitoring aspects of care to identify potential problem areas and/or opportunities to make improvements in care.
 - D. A means for multidisciplinary review of quality improvement activities and risk management issues.
 - E. Coordination of quality improvement and risk management activities involving health care professionals, support services, and administrative staff of both
 - F. Providing an organizational structure whereby review of quality improvement activities and risk management issues can be completed in a systematic and transparent manner.
 - G. Facilitation of oversight responsibility for quality improvement and risk management activities by both the _____(with recommendation and review of the Board) and the Governing Body.
 - H. Assurance of patient/client and staff confidentiality in the collection and evaluation of data.
 - I. Promotion of patient/client advocacy to benefit the patient/client, care plan and/or treatment, and provide a process to address patient/client concerns and grievances. (Joint Patient Advocacy Committee Bylaws)
- V. Quality and Risk Management Plan:** _____ will maintain an active, integrated, organized, ongoing, data-driven, peer-based program of quality management and improvement linking peer review, quality improvement activities, and risk management in an organized, systematic way.
- A. All health care professionals will have the necessary and appropriate training and skills to deliver the services provided to patients/clients. (Joint Medical Professional Committee Bylaws)
 - B. Health care professionals will practice their professions in an ethical and legal manner.
 - C. All personnel assisting in the provision of healthcare services are appropriately qualified and supervised and are available in sufficient numbers for the care provided.

- D. Facilitation of the provision of high-quality care will be assured by:
1. Providing health care consistent with the current standard of care.
 2. Educating and effectively communicating with patients/clients regarding the diagnosis and treatment of their conditions, appropriate preventative measures and use of the health care system.
 3. Making appropriate and timely diagnosis based on findings of the current history and physical examination.
 4. Performing medication reconciliation.
 5. Providing treatment consistent with clinical impression or working diagnosis.
 6. Making appropriate and timely consultation and referrals.
 7. When clinically indicated, contacting patients/clients as quickly as possible for follow-up regarding significant problems and/or abnormal findings.
 8. Continuity of care and follow-up.
 9. Assessing patient/client satisfaction and taking corrective action, when indicated.
 - a. _____ will assess patient/client satisfaction quarterly.
 - b. _____ will assess patient/client satisfaction bi-annually.
 10. Using performance measures to improve outcomes.
- E. Health services will be available and accessible to patients/clients by providing information about access to services when the facilities are closed, and adequate and timely transfer of information to outside providers of shared patients/clients.
1. Transfer of care to an outside provider is available and referral is clearly outlined to the patient/client and arranged with the accepting provider.
- F. Policy and procedures will be maintained and followed regarding identification, storage, and transport of laboratory specimens and biological products, which include logging and tracking to ensure results from each specimen are obtained and reported to the ordering provider in a timely manner.
- G. Upon indication of emergent care/hospitalization:
1. A detailed written procedural plan for handling medical emergencies.
- H. Concern for the costs of care is present throughout the organization.

VI. Quality Improvement Program: The development and implementation of a quality improvement

program that is broad in scope to address clinical, administrative, and cost-of-care performance issues, as well as actual patient/client outcomes, i.e., results of care, including safety of patients/clients. There will be emphasis placed on actual patient/client outcomes resulting from delivery of services and process changes or modifications implemented through the QI program. Staff will understand, support, and participate in quality improvement activities.

A. Quality improvement activities generally include the following characteristics in the ten (10) steps to “closing the QI Loop”:

1. Purpose of the QI activity that includes a description of the problem, and an explanation of why it is significant to the organization.
2. Identify the measureable performance goal against which the organization will compare its current performance in the area of study. The goal must be stated in quantitative terms.
3. Description of the data that will be collected in order to determine the organization’s current performance in the area of study.
4. Evidence of data collection.
5. Data analysis that describes findings about the frequency, severity and source(s) of the problem(s).
6. A comparison of the organization’s current performance in the area of study against the previously identified performance goal.
7. Implementation of corrective action(s) to resolve identified problem(s).

This section meets the intent of **TC 07** The information explains the specific details of the tasks that must be completed in performance evaluation and closing the QI Loop.

8. Re-measurement (a second round of data collection and analysis) to objectively determine whether the corrective actions have achieved and sustained demonstrable improvement.
9. If the initial corrective action(s) did not achieve and/or sustain the desired improved performance, implementation of additional correction action(s) and continued re-measurement until the problem is resolved or is no longer relevant.
10. Communication of the findings of the QI activities to the governing body and throughout the organization, as appropriate, and incorporation of such findings into the organization's education activities ("closing the QI loop").
 - a. Each department or program provides ongoing monitoring of important aspects of service delivery. Key indicators will be reviewed and evaluated at least annually.
 - b. The QI Committee will review results of quality improvement projects. Presenters will utilize various media including charts to highlight important data.
- B. The Joint Quality Improvement Committee Chair will maintain a summary of QI activities, and subcommittee chairs will maintain records of all QI activities.
- C. Each department or program will determine its key indicators and provide reports to the Quality Improvement and Risk Management Subcommittee Chair who will forward to the Joint Quality Improvement Committee and share with governing bodies.
- D. The organizations participate in external and internal benchmarking activities that compare key performance measures with other similar organizations, with recognized best practices or with national or professional targets or goals.
 1. Performance Measure: A clearly defined statement or question describing information to be collected for purposes of improving processes and outcomes of care.
 2. Benchmarking: A systematic comparison of products, services or work processes of similar organization to identify best practices known to date for the purpose of continuous quality improvement.
 3. The organization's benchmarking activities include, but are not limited to:
 - a. The use of selected performance measures that are appropriate for improving the processes or outcomes of care relevant to the patients/clients served.
 - b. Systematically collecting and analyzing data related to the selected performance measures.
 - c. Using benchmarks that are based on valid and reliable local, state, national, or published data.
 - d. Measuring changes in the organization's performance improvement over time.
 4. Results of benchmarking activities must be incorporated into other quality improvement activities of the organization.
 5. Results of benchmarking activities must be reported to the organization's governing body and throughout the organization, as appropriate.

- VII. Risk Management Program:** Potential adverse impacts on the organization or delivery of services will be addressed, implemented, managed, and applied through the _____ Quality Improvement and Risk Management Subcommittees of the Joint Quality Improvement Committee.
- A. Development and documented staff training (appropriate to position duties within 30 days of hire and annually thereafter) on policies or processes for each respective organization addressing:
 1. Methods by which a patient/client may be dismissed from care or refused care.
 2. Methods for managing a situation in which a health care professional becomes incapacitated during a medical or surgical procedure.
 3. Methods for communicating concerns regarding an impaired healthcare professional.
 4. Establishment of responsibility for, and documentation of, coverage after normal working hours.
 5. Restricting observers in patient/client care areas.

6. Persons authorized to perform or assist in the procedure area.
 7. Requirements for evidence of patient/client consent for all persons admitted in patient/client care areas who are not authorized staff. Examples of unauthorized persons include students, interested providers, health care industry representatives, surveyors, etc.
- B. The organizations will address patient/client, visitor, and staff safety utilizing the following process:
1. Webcident and/or Incident reporting (which includes reports of any potential or actual adverse events) by patients/clients, visitors or staff. (Incident Report Form, and Joint Patient Rights & Responsibility Brochure)
 - a. Webcident and Incident reports will be reviewed and, when appropriate, acted upon by program manager, and Director and/or CEO.
 - b. Incident will be defined as any occurrence that is not consistent with routine care or operation of the organization and may involve patients/clients, visitors, and employees.
 - c. An adverse incident will be defined as:
 - i. An unexpected occurrence during a health care encounter involving patient/client death or serious physical or psychological injury or illness, including loss of limb or function, not related to the natural course of the patient's illness or underlying condition.
 - ii. Any process variation for which a recurrence carries a significant chance of a serious adverse outcome.
 - iii. Events such as actual breaches in medical care, administrative procedures, or other events resulting in an outcome that is not associated with the standard of care or acceptable risks associated with the provision of care and service for a patient/client.
 - iv. All events involving reactions to drugs and materials.
 - v. Circumstances or events that could have resulted in an adverse event (near-miss events).
 - d. The Joint Medical-Professional Staff will conduct periodic review of clinical records and clinical policies. If there is an abnormal finding meeting criteria of incident or adverse incident it will be reported to the Joint Quality Improvement Committee in the form of an Incident and/or Webcident report.
 2. The Joint Patient Advocacy Committee (PAC) receives and reviews all patient/client concerns and coordinates all investigations received by either _____ or programs/departments. (Joint Patient Advocacy Committee Bylaws, and PAC Patient Concern Report Form)

Everyone is expected to contribute to our QI activities, please see specifics on page 5.

VIII. Accountability & Responsibility

- A. **Departmental/Program Responsibilities:** Each department/program supervisor will be responsible for initiating and implementing quality improvement activities involving staff under his/her supervision. Risk Management issues arising in a particular department/program should initially be addressed by the department/program supervisor with the focus of "closing the Loop" at the lowest level. If not resolved at this level, to follow the process until issues are closed and/or resolved.

Joint _____ & _____ Committees: The following joint committees meet on a regular basis throughout the year and will be responsible for quality improvement activities pertinent to the purpose and scope of work of the committee:

1. Joint Case Management Committee
2. Joint Pharmacy & Therapeutics Committee
3. Joint Safety & Infection Control Committee
4. Joint Patient Advocacy Committee (PAC)

This highlighted section also meets the intent of

**Standard 2:
D. #9. And TC**

07 It describes

C. Joint Quality Improvement Committee: The committee will meet on a quarterly basis throughout the year to review/evaluate the following:

1. Quality improvement activities
2. Patient/Client Satisfaction Surveys
3. Joint _____ and _____ policies/procedures
4. Joint Quality and Risk Management Plan

D. THHS/FH-IHS Quality Improvement and Risk Management Subcommittees: The Risk Management Subcommittees (of the Joint Quality Improvement Committee) will meet on a regular basis throughout the year to receive reports from the subcommittee chairs, evaluate data derived from peer review activities that identify unacceptable trends or occurrences that affect patient/client outcome, and to review unresolved Incident Reports, Webcidents, and other risk management issues forwarded to the committee from departments, programs, committees or individuals.

E. Medical-Professional Staff: The Joint Medical-Professional Staff of the _____ and _____ under the leadership of the Chairperson will receive reports on clinical issues from the Joint and _____ Committees and will be responsible for:

1. Reviewing/evaluating _____ objectives.
2. Mortality and morbidity review.
3. Reviewing results from peer review activities when providers apply for re-appointment to the Joint Medical Professional Staff.
4. Credentialing/privileging off all Joint Medical-Professional Staff according to the Joint Medical-Professional Staff By-Laws.
5. Evaluating any incapacitation or impairment of a Joint Medical-Professional Staff provider according to the Joint Medical-Professional Staff By-Laws.

F. FH-IHS and THHS Executive Committees: These committees will be responsible for final review of quality improvement activities and risk management issues prior to presentation to the respective governing bodies.

G. Governing Bodies: The _____ and the _____ Governing Body will ultimately be jointly responsible for providing oversight for quality improvement and risk management programs at the _____ and satellite facilities.

This Joint Quality and Risk Management Plan is hereby adopted:

Chair, Joint Quality Improvement Committee

Date

Chair, Joint Medical-Professional Staff

Date

Chief Executive Officer

Date

Director,

Date

Chair, Fort Hall Business Council

Date

Chair, FH-IHS Governing Body

Date