

SILETZ COMMUNITY HEALTH CLINIC POLICY



QUALITY IMPROVEMENT

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PART 2A
Quality Improvement Plan

I. PURPOSE

The purpose of this policy is to create a program to ensure the Siletz Community Health Clinic: demonstrates high-quality health care services in accordance with the principles of professional practice and ethical conduct; continually seeks to provide more effective and efficient utilization of facilities and services; and works toward improving the community’s health status.

II. POLICY

It is the policy of the Siletz Community Health Clinic (SCHC) to maintain a Quality Improvement Program (QI Program) to implement the core standards set forth by SCHC.

III. CORE STANDARDS

The core standards of the QI Program are as follows:

- A. The Siletz Tribal Council establishes policy and assumes full responsibility for the operation and performance of SCHC.
- B. Administration ensures the provision of high-quality health services and fulfills the mission, goals, and objectives of the Confederated Tribes of Siletz Indians.
- C. The basic human rights of patients are recognized and patients are treated with respect, consideration, and dignity.
- D. The provision of high-quality health care services is demonstrated through planning, hiring, training, review, and monitoring processes.
- E. The improvement of professional competence, skill, and quality of performance of all professional personnel is promoted.
- F. An electronic records system:
 - 1. allows for prompt data retrieval, and
 - 2. protects data from loss, tampering, alteration, destruction, or unauthorized or inadvertent disclosure.
- G. A functionally safe and sanitary environment is provided for patients, personnel, and visitors.

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- H. An active, integrated, organized, peer-based program of quality management and improvement links peer review, quality improvement activities, and risk management and infection prevention and control in a systematic way.

IV. ORGANIZATION RESPONSIBILITIES

A. Governing Body

1. The Siletz Tribal Council is empowered to act on behalf of the Confederated Tribes of Siletz Indians of Oregon (CTSI) pursuant to Article IV, Section 1 of the Tribe's constitution approved on June 13, 1979.
2. The Siletz Tribal Council is comprised of nine members duly elected by the enrolled members of CTSI. The Tribal Council conducts regular monthly meetings. Decisions are embodied in a resolution or ordinance depending on the intended purpose of the decision.
3. Quality Improvement Responsibilities of the Siletz Tribal Council

The Siletz Tribal Council:

- a. ensures the quality of care provided by SCHC is evaluated and problems are addressed;
- b. reviews the responsibilities delegated to the Health Committee, in the Quality Improvement Plan, on an annual basis;
- c. reviews and approves the Quality Improvement Plan on an annual basis;
- d. reviews and approves all major contracts or arrangements affecting health care; and
- e. approves initial appointment, reappointment, and assignment or curtailment of clinical privileges of active, temporary, and visiting medical staff upon evaluation of the applicant's current qualifications; including education, training, experience, competence, and recommendation by the Executive Committee.

B. Health Committee

1. The Health Committee is a Standing Committee that is established by the Siletz Tribal Council to provide advice and assistance and includes at least one Tribal Council representative. The Health Committee complies with laws, regulations, and policies set by the Tribal Council. The role of the Health Committee is to

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provide guidance and assistance to the Executive Health Director regarding implementation of tribal policy as it relates to the delivery of health care.

2. Quality Improvement Responsibilities Delegated to the Health Committee

The Health Committee:

- a. establishes organizational goals to improve the quality of health care;
- b. recommends approval of policies that affect the delivery of health care; and
- c. reports to the Siletz Tribal Council, annually, about the activities and results of the QI Program.

C. Executive Health Director

The Executive Health Director ensures administrative policies, procedures, and controls are established and implemented for the orderly and efficient management of SCHC. The Executive Health Director reports to the Chief Executive Officer and is an ex-officio member of the Health Committee. The Executive Health Director is responsible for the appropriate and timely communication and reporting of quality management and improvement activities and concerns between the Health Committee and SCHC staff.

V. COMMITTEES

A. Executive Committee

The Executive Committee grants temporary privileges and recommends to the Siletz Tribal Council the appointment, re-appointment, and assignment or curtailment of clinical privileges for health care practitioners.

B. Standing and Ad Hoc Committees

Standing and ad hoc committees may be established by the Executive Health Director and Medical Director to conduct monitoring and quality improvement activities, or provide information that may lead to the development of such activities.

VI. ADMINISTRATIVE/QUALITY IMPROVEMENT (QI) COORDINATOR

The Administrative/ QI Coordinator performs the following functions:

- A. Coordinates all quality improvement activities, including the provision of technical assistance to staff to implement the Quality Improvement Plan. The Coordinator strives to link peer review, quality improvement activities, and risk management in an organized, systematic way.

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- B. Tracks monitoring and quality improvement activities including issues and problems identified by these activities.
- C. Establishes program and committee reporting schedules.
- D. Prepares and distributes agendas and minutes for the Planning/QI Committee meetings.
- E. Prepares reports for the Health Committee.
- F. Supports the medical staff appointment, reappointment, and credentialing process.

VII. SCOPE OF QI ACTIVITIES

A. Sources

Sources that identify problems or concerns in patient care include, but are not limited to:

1. Unacceptable or unexpected results of ongoing monitoring, such as complications or unplanned hospital admissions.
2. Clinical performance and practice patterns of health care providers.
3. Medical record review for quality of care and completeness of entries.
4. Quality controls for use of x-ray, laboratory, and pharmacy.
5. Assessment of patient satisfaction.
6. Staff concerns
7. Accessibility
8. Medical or legal issues
9. Wasteful practices

B. Monitoring and Evaluation

Monitoring and evaluation of activities that include aspects of care most important to the health and safety of the patients include but are not limited to activities that:

1. occur frequently or affect large numbers of patients;

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2. place patients at risk of serious consequences or of deprivation of substantial benefits; or
3. tends to produce problems for patients or staff.

VIII. QI PROGRAM

The QI Program is composed of three components: peer review, risk management, and programs. The QI Program addresses clinical, administrative cost-of care issues, and actual patient outcomes. The Administrative/QI Coordinator manages the program.

A. Peer Review

Peer review is the ongoing monitoring of important aspects of care and is coordinated by the Medical Director or designee, Dental Director or designee, and clinic administration.

B. Risk Management and Infection Prevention and Control

Risk management is under the direction of the Executive Health Director and includes continuous review of the following:

1. Collection of unpaid accounts.
2. Incident reports, potential litigation, and patient complaints.
3. Adverse patient events.
4. Methods for managing unplanned events (i.e. after hour coverage or coverage for incapacitated health care provider).
5. Compliance with government regulations and contractual agreements.
6. Environmental, safety, and infection control inspections.
7. Conditions under which a patient may be refused care and methods of informing the patient.

C. Programs

1. The Executive Health Director designates a person from each clinical discipline to initiate and report quality improvement activities to the Administrative/QI Coordinator.

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2. Reports must include the following six steps:
 - a. State the Purpose: Quality the gap and explain why it is important.
 - b. Set the Goal: Define what your organization is trying to achieve.
 - c. Identify the Gap: Identify reasons for the performance gap; explain "why" the gap exists.
 - d. Corrective Action (Define and Do): Describe your correction action and implement them.
 - e. Remeasure: Remeasure to ensure improvement and sustainment.
 - f. Communicate: Share your study widely before, during and after: to the governing body; and throughout the organization, as appropriate.

3. Quality improvement activities are reported to the Executive Health Director, Administrative/QI Coordinator, employees, Health Committee, and Siletz Tribal Council.

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**PART 2B
Program Evaluation and Review**

I. PURPOSE

The purpose of this policy is to ensure compliance with the core standards set forth in the Quality Improvement Plan.

II. POLICY

It is the policy of SCHC to assess each clinic and department regularly to ensure the core standards are satisfied.

III. CONTENT OF REVIEW

A. Policies

Policies are reviewed annually by staff, Health Committee, and Siletz Tribal Council.

B. Procedures

Procedures are reviewed annually by staff and Health Committee.

C. Quality Improvement Activities

1. The Planning/QI Committee recommends revision, addition, or deletion of quality improvement activities.
2. The results of quality improvement activities are reviewed by the Executive Health Director, Planning/QI Committee, Health Committee, and Siletz Tribal Council.
3. The Administrative/QI Coordinator and Planning/QI Committee ensure implementation of corrective measures after review of quality improvement activities.

D. Staffing and Budgets

Budgets and staffing are reviewed on an annual basis by the clinic directors or program supervisors and the Executive Health Director.

E. Facility Issues

The Safety/Infection Control Committee conducts quarterly inspections of the clinic and facilitates mitigation of issues in a timely manner.

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F. Continuing Education

1. General

Staff are provided continuing education opportunities in accordance with license, certification, appointment, credentialing, and other requirements.

2. In-Service Training

Staff are required to participate in mandatory in-service training specified in the Administration Policy.

3. ACLS, CPR, BLS, and PALS Training

- a. ACLS, BLS, CPR, and PALS training is required in accordance with the job description, unless stated otherwise in this section.
- b. Contract employees are required to obtain an ACLS, CPR, BLS, or PALS card if it is required by a commensurate job description, unless stated otherwise in this section.
- c. ACLS training is required for at least one dentist and may be required for the nursing supervisor or nurse.
- d. PALS training is required for a pediatrician and at least one dentist and one nurse and may be required for family practice providers and other nursing staff.
- e. The dental assistants are required to obtain a BLS.
- f. The medical social workers for the behavioral health and MAT program are required to obtain a CPR.
- g. The massage therapist is required to obtain a BLS.

G. Goals and objectives

Goals and objectives are reviewed by clinic directors or program supervisors and the Executive Health Director during the budget process and status reports are provided to the Siletz Tribal Council on a quarterly basis.

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H. Fraud, Waste, and Abuse

1. Excluded Individuals and Entities
 - a. The Office of Inspector General (OIG) List of Excluded Individuals and Entities (LEIE) and General Services Administration (GSA) System for Awards Management (SAM) exclusion list are reviewed on a monthly basis.
 - b. The Administrative/QI Coordinator is subscribed to the OIG LISTSERVE via the OIG website and receives immediate notice of updates to the LEIE.
 - c. The clinic will promptly remove employees from the performance of services in support of government funded healthcare programs, including but not limited to Medicare Part D services, if the employee's name appears on the OIG or SAM exclusion list
2. Training
 - a. All staff obtain fraud, waste, and abuse training during orientation and on an annual basis.
 - b. Covered staff participate in compliance, fraud, waste, and abuse training provided by the Medicare Learning Network, within 90 days of hire and on an annual basis, if the training is available.
3. Code of Conduct

All staff are required to review the CTSI code of conduct during orientation.
4. Record Retention

Training records, copies of training material, including the date of the training, attendance, certificates of completion, test scores, and a copy of the training materials are retained for 10 years.
5. Conflict of Interest

The Chief Executive Officer, Executive Health Director, Medical Director, and Pharmacist-In-Charge are required to sign a statement, on an annual basis, indicating they are free from any conflict of interest in administering or delivering Medicare Part D benefits.

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PART 2C
QI Coordinator Responsibilities

I. PURPOSE

The purpose of this policy is to enumerate the responsibilities of the Administrative/QI Coordinator in ensuring the activities referenced in the Quality Improvement Plan are satisfied.

II. POLICY

It is the policy of SCHC to maintain a position that assists with coordination of an active, integrated, organized, peer-based quality improvement program

III. RESPONSIBILITIES AND ACTIVITIES

The responsibilities and activities of the Administrative/QI Coordinator are varied and include the below.

A. Communications

1. Refers information to the appropriate staff and committees.
2. Notifies staff when the following is completed and ready for viewing:
 - a. New and revised policies and procedures
 - b. Patient satisfaction survey results
 - c. Quality improvement studies
 - d. Quarterly reports
3. Notifies staff about all staff trainings
4. Submits web page updates to the IS Department.

B. Quality Improvement and Accreditation Expertise

Maintains awareness of current accreditation requirements through networking, continuing education, research, and publication of quality improvement standards. Serves as a resource to staff.

C. Clinical Technical Resource

1. Provides consultation to programs in developing quality improvement activities.

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2. Serves as a resource in data presentation through the use of Excel, Word, Access, and PowerPoint.
3. Participates in problem solving meetings and assists with development of process oriented approaches.

D. Staff Orientation

Facilitates orientation of new staff, higher education students, locum tenens, WEX, high school students, volunteers, and visitors.

E. Planning/QI Committee

Prepares the Planning/QI Committee agenda in consultation with the Executive Health Director and prepares or procures reports to be reviewed by the committee.

F. Safety/Infection Control Committee

1. Serves as chair of the Safety/Infection Control Committee.
2. Prepares the Safety/Infection Control Committee agenda and prepares or procures reports to be reviewed by the committee.

G. Executive Committee

1. Prepares the credentialing packet to be reviewed by the Executive Committee for staff requesting appointment and privileges.
2. Schedules meetings of the Executive Committee to discuss 90-day privileges, one-year appointments, three-year appointments, and curtailment of privileges for credentialed staff.

H. Health Committee

Prepares policies and procedures for review, and the quarterly report, for the Health Committee.

I. All-Staff Training

Facilitates staff training in the following areas: Computer Security, Cultural Competency, Emergency Preparedness, Fire Extinguisher, Fire Safety, Fraud, Waste, and Abuse, HIPAA, and Infection Control.

J. CPR, BLS, ACLS, and PALS

Facilitates CPR, BLS, ACLS, and PALS training for relevant staff.

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K. Medical Staff Credentials and Privileges

1. Requests credentialed staff complete a credentialing packet; conducts verification of documents; and requests approval of the appointment request.
2. Reviews credentialing file on a monthly basis to ensure licenses, certificates, and registrations are current.

L. Quarterly Reports

Requests information from all program areas for the quarterly report, reviews NextGen data, and prepares the report for the Executive Health Director's review.

M. Patient Satisfaction Surveys

1. Conducts patient satisfaction surveys on an annual basis for behavioral health, dental, hand hygiene, medical, optometry, pharmacy, and transportation
2. Ensures a patient satisfaction survey, regarding the entire clinic, is available at all times.

N. Risk Management

1. Facilitates investigation of patient complaints in a timely manner.
2. Submits a summary of incidents and patient complaints to the Planning/QI Committee on a monthly basis and the Siletz Tribal Council on a quarterly basis.
3. Works with maintenance and the Safety/Infection Control Committee on facility concerns and issues.
4. Schedules or facilitates the calibration, inspection, maintenance, or testing of the following: audiological instruments, backflow preventer, bio-medical equipment, dryer, elevator, fire alarm and system, fire extinguisher, fire sprinkler, generator, HVAC, septic system, and x-ray equipment.
5. Schedules the three-year facility inspection with the State Fire Marshal.
6. Facilitates quarterly safety drills.
7. Conducts monthly searches of the federal exclusion databases for relevant staff; tracks training of staff regarding fraud, waste, and abuse; and processes the conflict free certification.
8. Maintains registration of the radiation machines with the Oregon Health Authority.

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O. Patient Accounts

Facilitates negotiation of insurance contracts; maintains the contracts; and notifies the executive health director, clinic director, and business office manager about requested amendment to the contracts.

P. Standing Orders

Processes standing orders for therapeutic equivalent of existing prescriptions on an annual basis.