

**PAIUTE INDIAN TRIBE OF UTAH  
HEALTH DEPARTMENT  
POLICY & PROCEDURE MANUAL**

<b>Policy Number:</b>	
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<b>Policy Title:</b>	<b>Quality Assurance and Improvement Plan</b>
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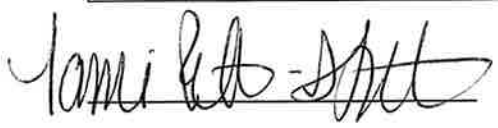
**POLICY STATEMENT:** The Paiute Indian Tribe of Utah (PITU) is committed to providing high quality, safe, cost effective healthcare. The Health Department will establish a Quality Assurance and Improvement (QAI) Plan that monitors the quality of services and identifies and acts on improvement opportunities that increase the value of services to our customers, reduce costs and eliminate errors.

The Council delegates the implementation of the plan to the Health Department Quality Assurance and Improvement (QAI) Committee. The Plan will be reviewed and updated at least every two (2) years. The Council delegates the authority to reprioritize and modify the plan to the QAI Committee in the event unexpected improvement opportunities are identified. The Quality Improvement Manager will lead the QAI committee. The Quality Improvement manager will provide quarterly reports to the Health Director and to the Council regarding the status of the QAI program.

**POLICY PURPOSE:** The QAI Plan provides a planned, systematic, approach for maintaining and improving the quality of services provided by the Health Centers.

**RESPONSIBILITY:** The Health Director is responsible for ensuring the QAI Plan is established and implemented. The Health Director delegates the responsibility for leading and overseeing the clinical quality to the Clinical Director and the Quality Improvement Manager.

<b>Date Approved by Tribal Council:</b>		<b>Effective Date:</b>	
<b>Dates Reviewed:</b>	None		
<b>Supersedes Policies :</b>	None		
<b>HRSA Program Requirement</b>	Program Requirement # 8, Quality Improvement/Assurance Plan		



Tami Borchardt-Slayton, Tribal Chairperson

6/15/17

Date

**THE PAIUTE INDIAN TRIBE OF UTAH HEALTH DEPARTMENT  
QUALITY ASSURANCE AND IMPROVEMENT PLAN**

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## I. SCOPE OF QAI PLAN

The Health Department QAI Plan provides a systematic, organization-wide approach to increasing the value of our services, by enhancing quality and strengthening our ability to deliver cost effective care. The scope of the plan encompasses all aspects of the management and clinical services delivery system. Activities are carried-out that ensure the Health Centers have effective processes to meet the needs of our patients which are consistent with the Health Center's Mission and Vision. The QAI Plan does not supersede other activities such as operational and strategic planning, but instead is designed to complement and align quality assurance and improvement activities across the organization. The important components of the plan include:

- A. The identification of improvement priorities where data collection and/or improvement work can be focused. Improvement priorities normally focuses on processes that are high volume, high risk and/or have proven to be problem prone. Priorities can also emerge from regulatory or other entities such as grant or payer requirements. Selecting priorities for improvement will also consider the results of the needs assessment identifying health and demographic trends within the customer base and communities.
- B. Ongoing collection of data to monitor the stability of existing processes, identify opportunities for improvement, identify changes that will lead to improvement, and sustain the gains realized from previous improvement work.
- C. Collected data is aggregated and analyzed to identify trends that will lead to improved process performance and error reduction.
- D. The plan puts in place systems to identify and prevent harm or injury for patients, visitors and staff. The plan addresses how the organization identifies, documents and investigates sentinel events and determines improvement mechanisms to remove potential for reoccurrence.
- E. There is an ongoing effort to educate leaders and staff regarding responsibilities and effective participation in performance improvement activities.

## II. IMPROVEMENT GOALS

The annual improvement goals are developed through a yearly needs assessment, and incorporation of key health indicators as suggested by Health Resources and Service Administration (HRSA) and Meaningful Use guidelines. The needs assessment includes demographic information and Bio-Psychosocial variables found in the user population. Other data is collected, aggregated and analyzed including a review of medical records and clinical indicator results. The goals are updated annually and they are approved by the Tribal Council. Progress towards achieving the improvement goals are reviewed each quarter at a Council meeting and new goals are added during the year as appropriate.

***Clinic Management*** focuses on ongoing quality improvement, patient safety, patient satisfaction, incident management, credentialing and privileging, and peer review. These efforts

are led by the Health Director, Clinical Director, and the QAI Committee. Goals are included in ADDENDUM 1 – MANAGEMENT GOALS

**Clinical Services** includes clinical best practice, ongoing quality of services provided, patient safety and patient satisfaction. These efforts are led by the Clinical Director, Quality Improvement Manager, and the QAI Committee with permanent subcommittees, ad hoc subcommittees, performance improvement teams or task forces. The current clinical goals are included in ADDENDUM 2 – CLINIC GOALS.

Clinic management/operations and clinical quality goals are set on a yearly basis. Clinic and management leadership is involved in the strategic planning process. These goals are reviewed at the committee level and approved by the Tribal Council. Goals are monitored through the committee process, and at the Council level. Improvement measures are discussed and accomplishments noted.

### III. QAI PROGRAM ORGANIZATION AND RESPONSIBILITIES:

#### F. Tribal Council:

The Tribal Council has the overall responsibility for ensuring the Health Centers provide high quality health care services. The Council approves the quality plan and annual goals and delegates the implementation of these goals to the Quality Assurance and Improvement (QAI) Committee. The Council's overarching goal is to improve the quality of care through improving key health indicators and managing chronic conditions. With these improved outcomes, we expect the overall health status of our patients to improve. The Council receives a quarterly report from the Quality Improvement Manager regarding the annual goals, any new concerns, QI goals or initiatives, and supports the accomplishments of these goals by providing ongoing resources. The governing Council assures that all patient and provider findings, recommendations and actions remain confidential.

#### G. Health Committee

The Health Committee will receive a monthly report regarding the status of the status of the QAI program. The Health Committee will provide guidance to the QAI committee in the identification and prioritization of improvement opportunities. The Committee conducts an annual review of the QAI Plan goals and makes recommendations to the Council.

#### H. Health Department QAI Committee:

A monthly QAI Committee meeting is held to coordinate all areas of quality improvement and risk management, and to assure action plans are in place, implemented and sustained. This

meeting includes the Health Director or designated representative, Clinical Director, Quality Improvement Manager, Mental Health Program representative and Dental Program representative. The Committee members are directly responsible for quality oversight and management of the clinical risk management program, including identifying and resolving areas of potential problems and improving identified suboptimal clinical and administrative services. This team reviews safety reports, incident reports, patient complaint summaries, and environment and operations reviews. Action plans for improvement are developed, implemented and monitored. High risk concerns are reported to the Council. Minutes of these meetings are filed for reference and summaries of the minutes are shared with the Health Committee monthly.

I. **Clinical Services/Staff Meetings:**

A multidisciplinary quality improvement Clinic Staff Meeting is conducted once a month. This meeting is used to discuss clinic functions, ensure that action plans are being implemented, and complete assigned tasks. The attendees discuss quality and risk issues as they arise, and address these in a timely manner. Minutes of these meetings are filed for reference. The minutes reflect the nature of the problem/risk, the action set to improve, and an action plan to address the problem/risk. Responsibility for addressing problems/risks is assigned to an appropriate staff member and follow up continues until resolution of the issue. The Clinical Director or Quality Improvement Manager provides a summary of clinical indicators, patient demographics and patient visit information on a regular basis. Clinic successes and areas for improvement are identified based on summary information and the review of QAI Committee meeting minutes. The clinic services/staff meeting is also a forum for introducing new or revised policies and procedures. All staff regularly communicates about quality issues and changes in clinic policies and procedures via direct verbal communication and through the clinic email system.

J. **Other Permanent and Ad hoc Subcommittees and/or Teams:**

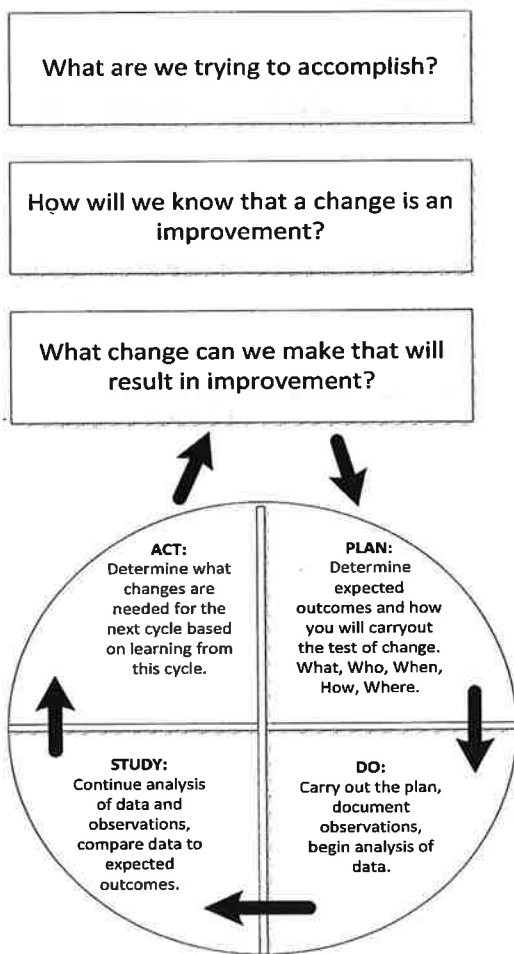
The QAI Committee can create permanent subcommittees, ad hoc subcommittees, performance improvement teams or task forces. The role of these committees and teams will be to conduct specialized studies in particular areas of concern and submit their findings to the QAI Committee. Ad hoc subcommittees and teams will be identified in the QAI Committee minutes and will include their charge, a time frame for completion, and suggested dissolution dates. Ad hoc committees and teams may be elevated to permanent status with their inclusion in the appropriate section of the Performance Improvement Plan.

#### IV. PERFORMANCE IMPROVEMENT METHODOLOGY

The PITU has chosen to use the Plan-Do-Study-Act (PDSA) model as the standard methodology for improvement. The use of a standard model creates a structure and common language for how improvement initiatives take place across the organization. The model will serve an additional purpose of communicating reports using a standardized format and areas for enquire.

#### PDSA MODEL FOR IMPROVEMENT JULY 26, 2014

**Improvement Model.** The improvement model consists of three fundamental questions and a Plan-Do-Act cycle to test and implement changes.



#### IMPORTANT MODEL CONCEPTS

A brief written "Aim Statement" clearly describes what you want to accomplish. It includes time specific measurable goals.

Determining if a change actually results in improvement requires a measure. The measure should be good enough, but not so complex that it slows the improvement work down.

All improvement requires change, but not all change is an improvement. The PDSA Cycle tests the change concept. The goal is to do many rapid cycle tests of change concepts until the aim is achieved.

FIGURE 2

## **V. COLLECTION AND CONTINUOUS MONITORING OF PERFORMANCE DATA**

The Health Centers have designed an on-going collection and monitoring program that covers a multitude of variables including clinical and operational, as well as patient and staff satisfaction. The selection of data to be collected is based on priorities set by the Tribal Council and Management. Leaders will consider the populations served by the centers as well as high risk, high volume and problem prone activities which occur. Requirements for data collection imposed by funding sources and legal/regulatory agencies will also be included, when appropriate.

The data collected will be used to monitor the stability of existing processes, identify opportunities for improvement, identify changes that lead to improvement, and/or to demonstrate sustained improvement.

## **VI. AGGREGATION AND ANALYSIS OF DATA**

Decision-making is based upon data collected. Data is aggregated and analyzed in such a way that current performance levels, patterns, or trends can be identified. The organization will utilize appropriate statistical tools and techniques to analyze and display data. When appropriate, data is trended and compared internally over time. In addition, external sources of information are used to benchmark the health centers performance when it is available and appropriate to identify opportunities for improvement. Analysis will be conducted when data indicates that levels of performance, patterns, or trends vary substantially from those expected and for those topics chosen by the organization as priorities for improvement.

## **VII. INCIDENT REDUCTION STRATEGIES**

### **Risk management procedures**

The QAI Committee identifies possible risk in the work place. Risk are identified from incidents (see ADDENDUM – 4), complaints (see ADDENDUM 3), employee suggestions (see ADDENDUM 3), malpractice cases, insurance claims, worker's compensation claims, injuries to patients or employees, federal rules and regulations (OSHA, HPAA, Red Flag), etc. Once the risk is identified, the QAI Committee develops policies and procedures to prevent the risk. These policies and procedures are reviewed annually. There may be an event or an occurrence through the year that could cause the policies and procedures to be updated.

### **Sentinel Event**

A sentinel event is defined in this organization as "An unexpected occurrence involving death or serious physical or psychological injury, or the risk thereof." Serious injury specifically includes the loss of limb or function. The phrase "or the risk thereof" includes any process variation for which a recurrence would carry a significant chance of a serious adverse outcome.

When a sentinel event occurs, or is thought to possibly have occurred, the event will be identified as a sentinel event. The Clinical Director will conduct an initial on-site evaluation, and if warranted, a comprehensive root cause analysis will be conducted (see ADDENDUM 7). The Clinical Director will notify the Health Director and Quality Improvement Manager of the incident in writing.

All sentinel events will be reported to the board of directors during their regularly scheduled meeting.

### **How Findings of the Process are Used to Improve Organizational Performance**

The QAI Committee review all findings of the committees and reports presented to analyze first whether all policies and procedures were followed in handling incidents, grievances, reviews, credentialing, etc.; second to determine if the procedures and policies are adequate to meet the present future problems, concerns, or adverse findings; and third, to make new policy and adjust existing policies and procedures to improve outcomes.

### **VIII. CONFIDENTIALITY OF RECORDS**

All documents and records that are shared through the Council and QAI Committees are confidential, following Title, 26, Chapter 25 of the Utah Code, Confidential Information Release (as amended in the 2008 Utah Legislative Session, and subsequent iterations). Records will be maintained under strict confidentiality, and references to specific providers and patients will be made by use of a code number or medical record number to assure privacy and confidentiality. Staff and Council members engaged in program activities are expected to maintain confidentiality of all information.

### **IX. REVIEW OF THE QAI PLAN**

This QAI plan will be reviewed at least every two years with the goals being reviewed annually by each committee and the Council. Goals are developed that align with the strategic plan, needs assessment and available data. This plan guides the Council, Health Department Management and staff to continuously strive for best practices in all areas of operations and patient care.



## **ADDENDUM 1 - MANAGEMENT GOALS**

- Ensure implementation of the QAI Plan
- Review and address consumer complaints through use of the Consumer Relations policy (see ADDENDUM 3 - CONSUMER RELATIONS POLICY)
- Oversee incident management and patient safety (see ADDENDUM 4 – INCIDENT MANAGEMENT)
- Monitor clinic locations to ensure a safe environment for the patients and staff
- Establish and maintain peer review records (see ADDENDUM 6 – PEER and CHART REVIEW)
- Monitor training records to ensure all staff are properly trained and competent in their respective duties
- Determine areas for clinical improvement through review of UDS and Meaningful Use data

## ADDENDUM 2 - CLINIC GOALS

<b>Objective</b>	<b>Specifics</b>	<b>Measurement</b>	<b>Time Line</b>
Ensure implementation of all UDS measures	Review each UDS measure and determine baseline data. Establish goals for method and measurement for improvement with timeframe for improvement	25% of UDS measures reviewed every three months	Ongoing 2014-2015
Maintain qualification for Meaningful use	Review Meaningful Use data each month to ensure measures are met	Satisfactorily meet all Meaningful Use requirements	Ongoing 2014-2015
Increase patient feedback and participation in organization	Review patient satisfaction surveys  Develop committee to address gaps in patient satisfaction	Identify a core set of survey measures to address	1 <sup>st</sup> Qtr

## **ADDENDUM 3 – CONSUMER RELATIONS POLICY**

### **Paiute Tribe of Utah Health Department Consumer Relations Policy**

The Tribal Council of the PITU will provide oversight for all Consumer Relations issues specifically relating to patient/client care and other community health-related issues. Personnel-related issues will be handled by Administration in accordance with approved PITU Personnel Policies and Procedures.

Consumer Suggestions and Concerns can either be in writing or provided over the phone. Your contact information should be provided for investigation and follow-up purposes. If you prefer to remain anonymous, please be advised we will not address your concerns, however we will consider your suggestions. Any PITU staff member can assist a consumer in documenting a specific concern or suggestion if needed. Consumer Issues should be sent to the PITU Tribal Council c/o the PITU Health Director. A Consumer Relations Form will be publicly available in each PITU clinic waiting area; however, as mentioned, you may also voice your comments verbally.

Written Consumer health-related issues will be addressed within a reasonable time period by the Health Department Director. A report, without specific patient/client identifying information (unless otherwise requested by the patient/client), will be provided to the Tribal Council if requested. Issues recommending specific policy changes by the Health Director will be referred to the Tribal Council for review and further action. Anonymous suggestions will be reviewed by the Health Committee at the discretion of the Health Director.

### **Consumer Relations Protocol**

Consumer health-related suggestions and concerns must be in documented form, either by the patient/consumer or as recorded by a PITU staff member receiving such suggestion or concern. Documentation must contain sufficient information to allow for an investigation and review as necessary, including patient/client name and contact information, date of service and primary concern or suggestion. Consumer Relations Forms will be made available at all clinic locations and on the PITU web site, although these forms are not necessary for communication of any consumer related issue. The Health Director will maintain a log recording the nature of the issue, date received, date issue was resolved and action taken. A summary report will be provided to the Tribal Council. Patient confidentiality will be strictly adhered to in this process.

Written consumer health-related suggestions and concerns should be addressed to the PITU Tribal Council c/o the Health Director. If not specifically addressed accordingly, the document should be forwarded as soon as possible to the Health Director. The document will be considered received when it is received by the office of the Health Director. A copy will automatically be forwarded to the Tribal Administrator.

Within three (3) working days of receiving the written suggestions or concern, the Health Director will acknowledge receipt of the document and will forward to the appropriate staff member for the follow-up review and action, as appropriate.

Within thirty (30) working days, any action taken will be reported via mail service to the affected parties. If the concern involves coordination with other agencies, action will be taken and reported within forty-five (45) working day to allow additional time required to adequately review and resolve the issue. Once resolved, the affected parties will be notified of such action and will be offered an opportunity to address their concern further by written request to the Tribal Administrator. The Tribal Council Chairperson will determine if such a request will be included on the next Council agenda . To protect patient confidentiality, all reviews of specific concerns shall be held in Executive Session.

## ADDENDUM 4 — INCIDENT MANAGEMENT

### Incident Management with Sample Report

**Key Performance Indicator1:** Number of incidents reported

**Key Performance Indicator 2:** Percentage of incidents that are completed within 28 business days from date reported

#### Definitions:

Incident: An occurrence that is inconsistent with routine facility operation or patient care.

Near Miss: Defined as an event or situation that could have resulted in an accident, injury, or illness but did not, either by chance or through timely intervention. Near misses are opportunities for learning and afford the chance to develop preventive strategies and actions. Near misses receive the same level of investigation as adverse incidents that result in actual injury.

Adverse Incident/Event: Defined as an undesired outcome or occurrence not expected within the normal course of care or treatment, disease process, condition of the patient, or delivery of service. Identifying something as an adverse incident does not imply "error," "negligence," or poor quality care. It simply indicates that an undesirable clinical outcome resulted from some aspect of diagnosis or therapy, not an underlying disease process.

#### Severity Levels:

Level 1: No adverse effect

Level 2: Minimal adverse effect

Level 3: Significant adverse effect

#### Performance Indicators and Goals:

Indicator #1: < 2/month

Indicator #2: 90% completed within 30 business days

#### Incident reporting form:

File ID	Incident Date	Date Reported	Incident Category	Date Initial Review Completed	Med Dir Review Completed Date	Incident Class	Severity Level	PI Recommend (Y or N)	PR Recommend (Y or N)	Case Closed	Was case closed within 14 business days?

Legend: NM = Near Miss, AE = Adverse Event, PI=Performance Improvement, PR=Peer Review

## **ADDENDUM 5 – QI AUDITS**

### **QI Routine Audits**

Quarterly audits will include the following areas:

Medical Records: 5 charts per provider will be reviewed each quarter by the staff checking accuracy of the following items:

- Pt name or ID number documented on each page
- Personal biographical data present and current
- All entries are signed and dated
- History form present and current
- Insurance information is present and current
- Correct placement of papers, forms with correct tabs
- If the element is present it is marked with “Y” if not it is marked with “N”. Comments are made on certain elements and trends noted.

Results of Medical Records audits will be forwarded to QI Coordinator for tabulation and analysis, then to QI Committee for review and recommendations.

Nursing chart review: 5 charts per medical assistant are reviewed each quarter with a focus on the following areas:

- Medication sheets—NKDA or allergies displayed, list up to date, reflects current regimen
- Vital signs: taken with each encounter, complete: Temp., pulse, respirations, BP, weight (Ht. and head circumference on peds)
- All entries signed with name and title and date.
- Immunizations—record reviewed and current

Results of Nursing Chart reviews will be forwarded to QI Coordinator for tabulation and analysis, then to QI Committee for review and recommendations.

### HIPAA Compliance review:

Review 50 charts each quarter for the “Privacy Notice Acknowledgement” form, placing a “Y” for yes, if the form is present and also noting if any other HIPAA forms: Authorization for release of PHI, etc. “N” is placed if no forms were found. Charts are selected from the scheduled appointments at each clinic site on the audit dates.

Results of HIPAA audits will be forwarded to QI Coordinator for tabulation and analysis, then to QI Committee for review and recommendations.

**HIPAA AUDIT**

<b>Clinic:</b>	<b>Patient initials or chart number</b>										<b>Comments</b>	<b>Total audit score</b>	
<b>Date:</b>												<b>Actual score</b>	
<b>Reviewer:</b>	<b>Enter Y if element is present</b>											<b>Max. score</b>	
<b>Acknowledgement of Privacy Practices present on chart</b>												<b>% Compliance</b>	
<b>Any other HIPAA form Present on chart (requests for release of info, etc)</b>													

## **ADDENDUM 6 — PEER and CHART REVIEW**

### **Medical provider peer review**

- A. Providers will be oriented to peer review process.
  - 1. The Clinical Director or designee will present peer review process at a provider meeting annually.
  - 2. New providers will be oriented to peer review process within one month of their start date.
- B. The Clinical Director or designee determines cases and topics for peer review.
  - 1. Cases may be selected at random.
  - 2. Cases that result in seriously undesirable patient outcome will be reviewed.
  - 3. Cases may be selected by being referred to the Clinical Director.
  - 4. Focus topics may be suggested to the Clinical Director for consideration for peer review.
  - 5. Focus topics may be submitted by the Quality Improvement Coordinator to the Clinical Director for consideration.
  - 6. Focus topics may be submitted to the Clinical Director by members of senior management for consideration for peer review.
  - 7. Any provider may request topics for peer review and submit them to the Clinical Director.
  - 8. In the event a case, in which the Clinical Director is the provider, is referred or otherwise identified for review, the next most senior physician shall review the case for appropriateness for peer review process.
- C. Peer review will be on the agenda of a provider meeting quarterly.
  - 1. The Clinical Director or his designee will notify the Clinical Director's assistant to include peer review on the provider meeting agenda quarterly.
  - 2. The Clinical Director will identify specific cases for review or the topic of focus to the assistant so she may provide applicable materials for the peer review process.
- D. Peer review is performed.
  - 1. In the case of individual case peer review the involved provider(s) is notified a minimum of three business days prior to the process so they may review the case in advance.
  - 2. Applicable record copies, minus patient identifying notations, are distributed three days prior to the provider meeting for review.
  - 3. The case is discussed in a professional, non-adversarial manner.
  - 4. Educational opportunities, policy revision, or other applicable improvements are identified.
  - 5. Focus topics may be performed individually or as a group of providers as determined by the Clinical Director.
  - 6. Focus topics peer review results will result in identifying educational opportunities, policy revision, or other applicable improvements.

- E. Peer review will be followed up as determined appropriate by the Clinical Director.
  1. The Clinical Director may randomly select cases for review.
  2. The Clinical Director may select specific cases for review.
  3. The Clinical Director may elect to repeat focus topic peer reviews for comparison.
- F. Confidentiality of peer review process shall be maintained.
  1. Peer reviews shall not be discussed outside of the process.
  2. Patient identifying notations (i.e. name, social security number, etc.) shall be obliterated on all copies.
  3. All copies of records shall be immediately returned to the Clinical Director.
  4. The Clinical Director shall destroy the copies.
  5. Peer review documentation shall not be entered into files which are legally discoverable.
  6. Focus topic peer review items may be saved or directed to PITU staff as required by regulatory agencies or as determined appropriate by the Clinical Director.

#### **Medical chart peer review**

##### **A. Chart Review Methodology**

1. Providers will review minimum of 5 medical records each quarter per provider, checking the following areas:
  - a. Was the assessment/diagnosis appropriate?
  - b. Was the physical examination appropriate for the problem or diagnosis?
  - c. Were appropriate diagnostic labs or tests ordered?
  - d. Were appropriate medication, dosage, and duration used and documented properly on medication list?
2. Clinical Director or designee will ask Medical Records Clerk or appropriate personnel to pull the following medical records for review each quarter:
  - a. 5 charts from each Provider.
3. Clinical Director or designee will forward copies to each provider at least three days in advance of the provider meeting where they are to be reviewed. A chart audit sheet will be attached to the copies.

##### **Examples of cases to consider for Medical peer review:**

- patient dies unexpectedly within two days of out-pt. visit
- patient is unexpectedly hospitalized within two days of visit
- patient formally or forcefully complains medical care was inadequate or incorrect
- patient has undiagnosed surgical abdomen or pelvic pain
- patient codes in clinic
- patient has anaphylactic reaction to medication administered at clinic
- has anaphylactic reaction to prescribed medication identified on chart as a drug allergy
- patient is transported to hospital from clinic via ambulance
- serious diagnosis not identified
- particularly interesting cases
- exceptionally well handled cases



Examples of focus topics for peer review:

- patients identified as smokers within past year were referred to smoking cessation classes
- patients identified as obese have documentation of diet and exercise instruction or education on progress notes within past year
- cancer screening appropriate for age and with agreed upon standards documented in chart, or documented as advised
- patients screened for hepatitis c when indicated

<b>Reviewer:</b>		
<b>Clinic site:</b>	<b>Patient initials or chart #</b>	<b>Provider being reviewed:</b>
<b>Date:</b>		<b>Comments</b>
Were chart entries legible?		
Was the assessment and/or diagnosis appropriate?		
Was the physical examination appropriate for the problem or diagnosis?		
Were appropriate diagnostic tests and labs ordered?		
Were appropriate medications, dosage, and duration used and documented properly?		
Were chronic problems documented properly on problem list?		

### **Mental health provider peer review**

- A. Providers will be oriented to peer review process.
  - 1. The Mental Health Coordinator or designee will present the peer review process to all Mental Health providers annually.
  - 2. New providers will be oriented to peer review process within one month of their start date.
  
- B. Peer review will be on the agenda of a Mental Health team meeting quarterly.
  - 1. The Mental Health Coordinator or designee will include peer review on the team meeting agenda quarterly.
  - 2. The Mental Health Coordinator or designee will identify specific cases or the topic of focus and provide applicable materials for the peer review process.
  
- c. The Mental Health Coordinator determines cases and topics for peer review.
  - 1. Cases may be selected at random.
  - 2. Cases that result in seriously undesirable patient outcome will be reviewed.
  - 3. Cases may be selected by being referred to the Mental Health Coordinator.
  - 4. Focus topics may be suggested by any provider to the Mental Health Coordinator for consideration for peer review.
  - 5. Focus topics may be submitted by the Quality Improvement Coordinator to the Mental Health Coordinator for consideration.
  - 6. Focus topics may be submitted to the Mental Health Coordinator by members of senior management for consideration for peer review.
  - 7. In the event of a case in which the Mental Health Coordinator is the provider, being referred or otherwise identified for review, the next most senior mental health provider shall review the case for appropriateness for peer review process.
  
- C. Peer review is performed.
  - 1. In the case of individual case peer review the involved provider(s) is notified a minimum of three business days prior to the process so they may review the case in advance.
  - 2. Applicable record copies, minus patient identifying notations, are distributed three days prior to the mental health team meeting for review.
  - 3. The case is discussed in a professional, non-adversarial manner.
  - 4. Educational opportunities, policy revision, or other applicable improvements are identified.
  - 5. Focus topics may be performed individually or as a group of providers as determined by the Mental Health Coordinator.
  - 6. Focus topics peer review results will result in identifying educational opportunities, policy revision, or other applicable improvements.
  
- D. Peer review will be followed up as determined appropriate by the Mental Health Coordinator.
  - 1. The Mental Health Coordinator may randomly select cases for review.

2. The Mental Health Coordinator may select specific cases for review.
  3. The Mental Health Coordinator may elect to repeat focus topic peer reviews for comparison.
- E. Confidentiality of peer review process shall be maintained.
1. Peer reviews shall not be discussed outside of the process.
  2. Patient identifying notations (i.e. name, social security number, etc.) shall be obliterated on all copies.
  3. All copies of records shall be immediately returned to the Mental Health Coordinator, who shall destroy the copies.
  5. Peer review documentation shall not be entered into files which are legally discoverable.
  6. Focus topic peer review items may be saved or directed to SWUCHC staff as required by regulatory agencies or as determined appropriate by the Mental Health Coordinator.

### **Mental health chart peer review**

#### **A. Chart Review Methodology**

1. Mental Health Coordinator or designee will forward copies to each provider at least three days in advance of the provider meeting where they are to be reviewed.
  - a. Is legible documentation present for the following:
    - Is there a signed release of information?
    - Documentation relating to limits of confidentiality?
    - Signed agreement to treat?
    - Discharge summary?
    - Documentation of presenting problem?
    - DSM IV diagnosis
    - Treatment plan
  - b. Do progress notes include:
    - Does progress note relate logically to the assessment?
    - Does progress note relate logically to the diagnosis?
    - Does progress note relate logically to the treatment plan?
    - Does progress note express the client concern/problem?
    - Does progress note express the therapist's interventions?
    - Does progress note express the client's response to interventions?
2. Mental Health Coordinator or designee will ask Medical Records Clerk or appropriate personnel to pull the medical records for review each quarter.

#### Examples of cases to consider for Mental Health peer review:

- patient commits or attempts suicide within one week of out-pt. visit
- patient is unexpectedly hospitalized for psychiatric reasons within two days of visit
- patient formally or forcefully complains mental health care was inadequate or incorrect

- patient is transported to hospital from clinic via ambulance
- serious diagnosis not identified
- particularly interesting cases
- exceptionally well handled cases

Examples of focus topics for peer review:

- Patients who are identified as having family or relationship difficulties are offered family therapy
- Patients with a diagnosis of Major Depressive Disorder have a record of tracking the gravity of their depression, (e.g. with the Beck Depression Inventory)
- Patients are appropriately screened for exposure to domestic violence, with results documented in the chart

**ADDENDUM 7 – FRAMEWORK FOR ROOT CAUSE ANNALYSIS**

**Framework for Root Cause Analysis  
in Response to a Sentinel Event**

Organization  
Name:  
Organization ID #:

Level of analysis	Possibilities	Questions	Findings		
<b>What happened?</b>	Sentinel event	What are the details of the event?			
		What area/service was impacted?			
				<b>Risk Reduction Strategies</b>	<b>Measurement Strategies</b>
<b>Why did it happen? --- What was the proximate cause(s)?</b>  (Typically a "special cause" variation)	Human error	What was the error?			
	Process deficiency	What was the missing or weak step?			
	Equipment breakdown	What broke?			
	Controllable environmental factors	What factors directly affected the outcome?			
	Uncontrollable external factors	Are they truly beyond the organization's control?			
	Other	Are there any other factors that have directly influenced this outcome?			
<b>Why did that happen? What processes were involved?</b>  (May involve "special cause" variation, "common cause" variation, or both)	Patient care process(es) ---- ---- (Specify)	What are the steps in the process?	Flow chart		
		What steps were involved in (contributed to) the event?	Cause-effect; Change analysis; Failure mode & effect analysis		
		What is currently done to prevent failure at this step?	Fault tree analysis	(Eg, simplification, redundancy)	
		What is currently done to protect against a bad outcome if there is a failure at this step?	Barrier analysis	(Eg, "fail-safe" design, redundancy)	
		What other areas or services are impacted?	Failure mode & effect analysis	(Generalize improvements to all applicable areas)	

### Framework for Root Cause Analysis (page 2)

Level of analysis	Possibilities	Questions	Findings	Risk Reduction Strategies	Measurement Strategies
<b>Why did that happen? What systems underlie those processes?</b>  (Common cause variation here may lead to special cause variation in dependent processes.)	Human resource issues	Are staff properly qualified and currently competent for their responsibilities?			
		Is staffing adequate?			
		Does planning account for contingencies that would tend to reduce effective staffing levels?			
		Is staff performance in the operant process(es) addressed?			
		Can orientation & in-service training be improved?			
	Information management issues	Is all necessary information available when needed? Accurate? complete? unambiguous?			
		Is communication among participants adequate?			
	Environmental management issues	Was the physical environment appropriate for the processes being carried out?			
		Are systems in place to identify environmental risks?			
		Are emergency and failure-mode responses adequately planned and tested?			
	Leadership issues: Corporate culture	Is the culture conducive to risk identification and reduction?			
	Encouragement of communication	Are there barriers to communication of potential risk factors?			
	Clear communication of priorities	Is the prevention of adverse outcomes adequately communicated as a high priority?			
	Uncontrollable factors	How can we protect against these?	Barrier analysis		