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POLICY & PROCEDURES MANUAL

RISK MANAGEMENT PLAN/CONTINUOUS QUALITY IMPROVEMENT PLAN 2018/3023

The purpose of the risk management program is to reduce Bullhook Community Health Center's exposure to loss (financial or otherwise). As part of its efforts to ensure the health, safety, and financial well-being of the clinic staff and patients, Bullhook Community Health Center will incorporate risk management principles and procedures into all operational activities. Bullhook Community Health Center staff members are expected to cooperate and participate in risk management efforts.

Incident Reports

Staff members are trained in when and how to complete incident reports. Report forms are available on the network drive – shared files/current policies/incident report policy. Incident reports are to be completed and turned into a supervisor with 24 hours of an occurrence that could result in loss of money, time, or legal liability.

Safety

The management assures that the building is maintained by the Northern Montana Hospital in an adequate manner. Sidewalks are kept free of snow in the winter and the parking lot is cleared of snow. All plumbing, lights, heating and air conditioning are maintained in good working order. Logs documenting equipment safety and operability, water temperature, refrigerator temperature will be maintained. Quarterly safety inspections will document fire extinguisher status, smoke detector status, safety log compliance, environmental hazard assessment, chemical safety and storage, MSDS availability, exit lighting and clearance, and compliance with hazardous waste requirements.

All staff members are instructed to report any safety concerns immediately to their supervisor or to the Safety Officer.

Policies and procedures are in place for proper biohazard waste disposal to protect both staff and patients within the facility.

Immunizations are available for all clinical direct patient care members in order to protect them from communicable diseases. Yearly influenza vaccinations are available and recommended for all health center staff. This in turn assures a higher level of protection for patients while dealing with staff in the clinic setting.

Safety training is provided to staff members during initial orientation and on-going throughout each year.

Patients
Productivity reports are compiled monthly and shared with providers, so that productivity levels of staff are monitored. Patient satisfaction surveys are completed at least annually by a formal questionnaire to our patients requesting their input on various aspects of the clinic services. Responses to these patient satisfaction surveys are compiled, shared with the staff, presented to the Board, and kept on file at the clinic site. Improvement opportunities are analyzed and incorporated into our Performance Improvement projects.

Staff
Management will verify all credentials and references before hiring new staff members. Staff members will be oriented to the organization and to their positions prior to working independently. All staff members will be required to maintain appropriate licensure and certification; and management will verify credentials biennially or sooner if there is a need.

All physicians and staff at the center are provided with continuing education in order to assure maximum knowledge and skill levels to deal with the patient population. BCHC is committed to helping staff in obtaining the necessary information to maintain knowledge levels to provide safe patient care.

Data
All QuickBooks data is backed up monthly and kept off-site. Data on individual PCs is backed up the network server daily.

Board of Directors
Board meetings are held monthly with presentations to members by BCHC staff. The Board has ongoing input into the management of the clinic. Visit encounter, patient data, and budget information is distributed to the Board at the monthly meetings. An orientation for new Board members outlining its purposes, goals and objectives, is provided. The goals and objectives as written in the grant are reviewed with the Board annually in order to update members on the progress being made. The Board is also involved in assisting staff to set goals and objectives for the clinic each year as the grant is being prepared and participates in strategic planning.

Meetings
BCHC management team meets on an as-needed basis. Continuous Quality Improvement Committee meets monthly. The whole staff meets monthly to discuss pressing issues, productivity, safety, risk management and ways to improve and refine services and to ensure that staff concerns are addressed promptly and appropriately. Each quarter ½ day is spent in staff training for facility-specific issues.

BULLHOOK COMMUNITY HEALTH CENTER

Risk Management Plan

	Responsibility	REPORTS TO
1. Performance Improvement Program:		
➢ Improvement Projects	All staff	CQI Team
➢ Patient & clinical data	All staff	Executive Director/Mgmt Team
➢ Financial data	Office Manager/Chief Financial Officer	Executive Director/Mgmt Team
➢ Operational data	OM/CFO	Executive Director/Mgmt Team
➢ Patient satisfaction	OM/CFO	Executive Director/Mgmt Team
➢ Diabetic Collaborative	Clinical Coordinator	Executive Director/Mgmt Team
➢ Medication survey	Clinical Coordinator	Executive Director/Mgmt Team
2. Safety Program:		
➢ Safety Committee	Health Information Coordinator	Executive Director
➢ Safety Reviews	All staff	Executive Director
➢ Biomedical Equipment Program	Nursing staff	Executive Director
➢ Facilities Maintenance Program	Northern MT Hosp	NMH Building & Grounds
➢ Incident reporting	Staff and Supervisors	Executive Director or supervisor & Operations Manager
3. Departmental Tracking and Preventive Maintenance Programs/Lifecycles		
➢ COM chart audits	Clinical Coordinator	Medical Director
4. Employee Training Sessions:		
➢ New Employee Orientation	Supervisors	Executive Director
➢ In-service/Continuing Education/Training	Supervisors	Executive Director
5. Accreditation Process –	Clinical Coordinator Office Manager All staff	Executive Director Medical Director
6. Provider Credentialing and Privileging	Office Manager	Medical Director Executive Director
7. Staff Competency	Supervisors	Executive Director

QUALITY IMPROVEMENT PLAN

PURPOSE:

The Quality Improvement Plan (QIP) of the Bullhook Community Health Center reflects a commitment to patient care excellence. It is designed to ensure that the patients receive quality care by continuous monitoring, evaluation, process improvement, and documentation of patient care activities. The QIP recognizes and encourages the participating of all Bullhook Community Health Center personnel for the achievement of excellence in patient care.

OBJECTIVES:

The primary objective of the Bullhook Community Health Center QIP is to encourage, organize and document continuously that all service are provided according to established protocol and current standards of quality.

1. To establish baselines and thresholds for acceptable outcomes of services provided.
2. To monitor changes and recognize trends that significantly affects patient care.
3. To enact and modify policies based on quality care data.
4. To develop criteria and indicators that are objective, measurable and based on current professional literature and experience.
5. To recommend activities and modification of existing activities to correct problems and avoid potential problems.
6. To share quality improvement information between department and personnel in order to prevent duplication of effort, provide support and streamline communication.
7. To recognize significant problems or potential problems that may affect Bullhook Community Health Center personnel.
8. To develop processes which will improve responses to significant individual occurrences.
9. To comply with policies, standards, regulations and laws set by State and Federal regulatory agencies as approved by the Board of Directors.

PLAN ELEMENTS:

The QIP will be performed in accordance with the following activities.

I. Authority and Responsibility
   The Quality Improvement Committee (QI Committee) is responsible for ensuring that the objective of the QIP are met. Each member will be responsible for assuring documentation and communication of QI activities in their area. Each member will also provide the QI Committee with information requested, reports as needed, clinic concerns and will act upon committee recommendations.

   The Chief Executive Officer and Board of Directors will be provided with regular information regarding committee activities.

II. Scope of Care

Bullhook Community Health Center provides primary health and dental care services to adults, adolescents, and pediatric patients. Bullhook Community Health Center provides mental health care through referral and financial assistance. The hours of operation will be voted on yearly and/or as needed by the Board of Directors.

III. Important Aspects of Care

The important aspects of medical care include, but are not limited to the following:

A. Assessment, intervention, coordination, planning, evaluation and documentation of care.
B. Providing and maintaining necessary equipment, including limited emergency equipment.
C. Maintaining patient and employee safety.
D. Maintaining infection control.
E. Assuring the accuracy of medication administration.
F. Assuring employee timeliness of license and/or certification when required.
G. Assuring clinical competence.
H. Prompt and courteous service to all patients.
I. Confidentiality of all patients' medical information.
J. Follow-up of abnormal test results.
K. Immunizations.
L. Incident reporting.
M. Patient instruction.
N. Staff education.

IV. Indicators and Thresholds for Evaluation

The QI Committee will identify indicators and thresholds for evaluation for the most important aspects of care. A schedule that reflects the methods and frequency of data collection and thresholds for each indicator will be maintained and serve as an appendix to this plan.

V. Data Sources

The data sources that will be used to identify problems and to monitor and evaluate the quality and appropriateness of care provided include, but are not limited to:

A. Patient records.
B. Incident reports.
C. Infection control findings.
D. Patient satisfaction survey results.
E. Substantiated patient complaints.
F. Substantiated personnel complaints.
G. Direct observation.
H. Equipment maintenance records.
I. Staff interviews.
J. Patient interviews.

VI. Summarization and Evaluation of Data

The QI committee will review and evaluate summaries of collected data. Tools which may assist in evaluating data include: committee or team members' expertise, professional organization's guidelines and standards, pertinent health care and related literature, and information from patients and families. All assessments, conclusions, recommendations, and rationales shall be recorded on worksheets or in meeting minutes. The evaluation usually includes searching for patterns or trends of care/service processes that cause delays, undesired variations in outcome and lack of continuity of care. The process of evaluating care involves breaking out the data in various ways to see how processes, services or other factors contribute to the rate of occurrences and how to improve the overall process. No action to improve care/service should be taken until the current processes are understood and evaluation indicates how the current processes can be improved.

VII. Corrective Action

Improving care/service is the purpose of monitoring and evaluation. Records shall be kept of what action is recommended, what action is finally decided on and approved, who is responsible for taking the action and when, and what action is taken. The Committee should determine appropriate actions. These actions will be recommended to the individual or group with the authority to act.

VIII. Assessment of Effectiveness of Correction Action

Monitoring and evaluation does not end when actions are taken. It must be determined when the actions result in improved care/service and whether the improvement is maintained. The findings from continued monitoring will provide evidence to determine whether actions were effective. It may be necessary to have data from more than one monitoring period to make the determination. If care/service does not improve within the expected time, then further evaluation should be done to determine further action. When feedback from outside the ongoing monitoring process triggers evaluation, then an appropriate method of follow-up shall be implemented. The important aspects of care/service chosen for the ongoing monitoring of indicators should be reviewed regularly to determine whether the overall priorities should be changed or whether the indicators should be revised.

IX. Communication and Integration of Quality Improvement

The QI Committee will report the conclusions, recommendations, actions and follow-up of monitoring and evaluation to the Chief Executive Officer and Board of Directors.

X. Confidentiality

All data and information acquired and prepared for quality improvement activities are strictly confidential and not considered discoverable or admissible in a court of law. This data will be effectively carry out quality improvement activities.

SCHEDULE OF REVIEW:

JANUARY:
- Patient Care – Diabetes
- Sliding Fee Scale (Updated paperwork for medical record and financial documentation)
- Patient Satisfaction Surveys

FEBRUARY:
- Patient Care – Diabetes
- Patient Satisfaction Surveys
- Policy Review by Board Committee
- Credentialing review
- Yearly employee evaluations

MARCH:
- Patient Care – Diabetes
- Patient Satisfaction Surveys
- Tobacco Screening & Education
- HIPAA Risk Assessment
- Quality of Care Indicators - Dyslipidemia

APRIL:
- Medical Records Peer Review (Including Pain Contracts and Financial)
- Care Management Peer Review
- Patient Care – Diabetes
- Quality of Care Indicators/Immunizations
- Sliding Fee Scale Review
- Revenue Cycle Review
- MAP
- Patient Satisfaction Surveys

MAY:
- Patient Care – Diabetes
- Safety Program Review
- Patient Satisfaction Surveys
- Quality of Care Indicators – Coronary Artery Disease (CAD)

JUNE:
- Patient Care – Diabetes
- Credentialing Review
- Patient Satisfaction Surveys
- Quality of Care Indicators – Ischemic Vascular Disease

JULY:
- Medical Records Peer Review (Including Pain Contracts and Financial)
- Care Management Peer Review
- Patient Care – Diabetes
- Patient Care – Hypertension
- Sliding Fee Scale Review
- MAP
- Revenue Cycle Review
- Patient Satisfaction Surveys

SCHEDULE OF REVIEW CONTINUED:

AUGUST:	Patient Care – Diabetes Substance Abuse Patient Satisfaction Surveys Quality of Care Indicators – Colorectal Cancer Screenings
SEPT:	Patient Care – Diabetes BMI Patient Satisfaction Surveys Quality of Care Indicators – Asthma Pharmacological Therapy
OCT:	Grant Update Patient Care – Diabetes Patient Care - HIV Patient Satisfaction Surveys
NOV:	Risk Management CQI Plan Update – Board Approval Medical Records Peer Review (Including Pain Contract and Financial) Care Management Peer Review MAP Quality of Care Indicators/PAPS Sliding Fee Scale Review Revenue Cycle Review Patient Care – Diabetes Patient Satisfaction Surveys
DEC:	Patient Care – Diabetes Patient Satisfaction Surveys

QUALITY IMPROVEMENT COMMITTEE INDICATORS

Indicators	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
Grant										X	X Board Approval	
Medical Records Peer Review Includes Pain Contracts, Financial			X				X				X	
Care Mgmt, MAP, and Revenue Cycle Review				X			X			X		
Patient Care – Diabetes	X	X	X	X	X	X	X	X	X	X	X	X
Quality of Care Indicators Includes updated paperwork for medical record, and financial documentation	X **Sliding Fee Scale**		Dyslipidemia	Immun. **Sliding Fee Scale**	CAD	IVD	HTN **Sliding Fee Scale**	CCS	APT	PAP **Sliding Fee Scale**		
Patient Satisfaction	X	X	X	X	X	X	X	X	X	X	X	X
Policies & Procedures		X										
HIPPA Risk Assessment			X									

CQI REPORTING FORM

Date:

Parties Involved:

Statement of Problem:

Baseline Data:

Root Cause Analysis:

Proposed Intervention:

Follow up Plan:

Post Intervention Data:

(Use additional pages as necessary)

QUALITY ASSURANCE

OVERVIEW

The purpose of quality assurance is to establish standards and policies for evaluating the quality and appropriateness of health care by the Bullhook Community Health Center. The progression of quality assurance is regarded as a kinetic process with staged development. In the initial stages, basic standards will be formulated and limited chart auditing implemented. As the process continues, standards will be reviewed and improved through revision, and the auditing process will be expanded.

All Bullhook Community Health Center staff will be responsible for implementing the quality assurance process. This includes involvement in setting standards, establishing and implementing audits, and improving the process through revisions and additions.

GENERAL

It is not the intent of the process of quality assurance to set procedural techniques for the practice of medicine. Standards and policies will be established to assist and improve the practice of general medicine at Bullhook Community Health Center. Standards of care will be determined and agreed upon by the practitioners responsible for individual treatment of patients. These standards will be reviewed and revised as necessary on a yearly basis or at the request of the staff providers.

PROCEDURE

Charts will be reviewed and audited on a regular basis. Findings of the chart audit will be documented, collated, reported, and retained in a quality assurance manual. It is the hope and intent of the Bullhook Community Health Center staff that quality assurance is viewed as a learning process, and that individual critiquing is informal.

QUALITY ASSURANCE COMMITTEE AUDITING

PURPOSE
To formulate, establish and maintain standards and policies, and evaluate the quality of medical treatment at Bullhook Community Health Center.

MEMBERSHIP
The committee, in its auditing function, will be comprised of all Management Team Members and designated employees.

PROCEDURE
The committee will review a random sampling consisting of 10% of charts per provider. This review process will be done quarterly.

EVALUATION
The goal of the committee will be to identify any problems and deficiencies in the provision of medical care at Bullhook Community Health Center, then to inform the providers and staff of these problems and deficiencies so that the department can improve their practice of medicine.
The random charts will be reviewed by the entire committee and critiqued using a pre-established list of standards as the evaluating criteria.

POLICY/PROCEDURE
MEDICAL CHART AUDITS

It is the policy of Bullhook Community Health Center, Inc. to ensure we are effectively providing and documenting care to our clients. To that end we will take a proactive approach in applying continuous quality improvement in the provision of clinical patient care services. Peer review and medical chart audits contribute to this goal by monitoring clinical treatments and medical record documentation. Medical chart audits also provide a source of information for performance evaluations and privileging.

During the month following each quarter, the Medical Director will select a diagnosis or set of diagnoses for an evidence-based medical review. The Risk Manager will randomly select from the past three months 5 of each provider's records for that diagnosis. These records will be pulled and an audit form attached to each record. A random 5 record review for each provider for patients with diagnosis to support controlled substance will assess for documentation of pain contracts for patients prescribed controlled substance. This assessment will take place during each review period.

Administrative Audit
The Risk Manager/Clinical Coordinator will audit the chosen records for HIPAA, financial, and completeness factors, annotating findings on the audit form. Financial includes the check to see if all documents are in place to qualify for the sliding fee scale as required by policy.

Peer Review
The Medical Director will select a protocol from an appropriate nationally recognized source for that diagnosis. Every effort will be made to utilize the same source for all protocols, in the interest of continuity. However, other sources may be utilized based on the discretion of the Medical Director. The Medical Director will select one clinic provider to conduct the review, based on the selected protocol. This provider will annotate findings on the audit form and return the forms to the Medical Director. Individual provider concerns will be addressed by the Medical Director with the individual provider. After review, the Medical Director will return the forms to the Risk Manager for preparation of an Audit Summary Report and data analysis.

Laboratory Review
The Management team will audit 10 random records of patients who were seen during the quarter to ensure that all lab procedures requested have been performed, reviewed and added to patient charts and that all appropriate documentation is present.

Performance Improvement
Audit summary results will be provided to the QI Committee, providers, and clinic staff. Appropriate action will be instituted and monitored through the PDSA Cycle and reported to the QI Committee. A summary of the findings will be reported to the Board of Directors through the monthly QI report.

Quarterly Chart Reviews

Instructions for Sliding Fee Scale Measures

1. Access list of self pay customers.
2. Pull a minimum of 75 charts to review for financial –sliding fee scale documents.
3. Review process to be reassessed when system utilizes electronic medical records.
4. To apply for the Sliding Fee Scale a patient must:
    a. Fill out and sign the SFS application
    b. Bring in Proof of entire household income.(one or more of the following)
        i. Paycheck stub
        ii. Social Security Check
        iii. Unemployment Checks
        iv. Notarized Letter Stating Monthly Income
        v. Alimony/child support
        vi. GA/TANF Check
        vii. Most Recent Income Taxes
        viii. Quarterly tax Statement
        ix. Letter from Employer
        x. Bank Statements showing Direct Deposit Type
5. Use attached measure sheet to document reviewer, review date, medical record number and/or name, dob, race, date of last visit, documentation up to date, and any notes pertinent to reviews.
6. Acceptable forms of income must be up to date within 6 months of the date of last visit.

Addendum A

Directors Compliance Committee Charter

1. Purpose. The Board of Directors (the "Board") shall establish a Compliance Committee of the Board ("Board Compliance Committee") to oversee and evaluate Health Center's Compliance Program and to make recommendations to assist the Board in approval and oversight of the development, maintenance, and implementation of Health Center's Compliance Program policies and activities.

2. Duties and Responsibilities. The Board Compliance Committee will work with Health Center's Compliance Officer and CEO, as appropriate, in coordinating and overseeing the development, maintenance, and implementation of Health Center's Compliance Program in a manner at least consistent with the recommendations of the Department of Health and Human Services, Office of Inspector General ("OIG"), as published in its Compliance Program Guidance for Individual and Small Group Physician Practices, 65 Fed. Reg. 59434 (Oct. 5, 2000).

- Identifying Areas of Risk. The Board Compliance Committee will be informed, through education and training, about the Federal and State statutory, regulatory, and policy requirements applicable to Health Center's activities as a basis for reviewing the risk priorities identified by the Compliance Officer and making recommendations for actions to be taken by the full Board of Directors, as may be appropriate.

- Oversight of Compliance Program Activities. The Board Compliance Committee will receive information, as appropriate, from the Compliance Officer on activities of the Compliance Program, including but not limited to, education and training, employee reporting mechanisms, and disciplinary guidelines.

- Monitoring, Audits, and Investigations. The Board Compliance Committee will review significant findings of, and trends identified through, internal and external audits and investigations, as presented by the Compliance Officer, for the purpose of identifying and responding to potential risk areas and reports of non-compliance and will receive information regarding any corrective and preventive actions taken.

- Policies and Procedures. The Board Compliance Committee will work with the Compliance Officer to review and obtain Board approval of Standards of Conduct and policies and procedures that address areas of risk and that promote compliance with Health Center's Compliance Program, laws, and regulations (including, as applicable, but not limited to, the laws authorizing and implementing Medicaid, Medicare, and other Federal and State health care programs, Section 6032 of the Deficit Reduction Act of 2005,[1] the requirements under Section 330 of the Public Health Service Act, and the requirements set forth in the Health Resources and Services Administration's Policy Information Notices and Program Assistance Letters) and contractual requirements imposed by third party payors.

[1] Authors' note: for more information regarding policy and procedure requirements related to the Deficit Reduction Act of 2005 see Introductory Guidance: Coding, Documentation, and Billing.

- Evaluation of Effectiveness. The Board Compliance Committee will review the Compliance Officer's evaluation of the Compliance Program. The review will evaluate the effectiveness of the Compliance Program as well as the extent to which the tasks in the Annual Compliance Program Work Plan have been completed.

- Developing Strategy. The Board Compliance Committee will analyze and, as needed, recommend to the full Board of Directors the development of new methods for promoting compliance and identifying potential violations and for soliciting, evaluating, and responding to complaints and reports of alleged non-compliance.

- Resources. The Board Compliance Committee will periodically review the resources assigned to Health Center's Compliance Program to ensure that such resources are adequate for maintaining an effective Compliance Program and will make recommendations for changes in the budgeting of resources to the full Board of Directors.

3. Committee Structure.

- The Board Compliance Committee shall consist of at least 4 Board members and be reviewed at each annual meeting:

- The Board Compliance Committee shall be subject to same requirements regarding quorum, attendance, and voting as are other committees of the Board.

- Minutes reflecting Board Compliance Committee recommendations, action plans (with time frames and responsible person(s) noted), and evaluation or follow-up shall be maintained for each Board Compliance Committee meeting and will be approved by the Board Compliance Committee at the following meeting.

4. Reporting. The Board Compliance Committee will report regularly (at least quarterly) to the full Board of Directors on the compliance activities undertaken as part of Health Center's Compliance Program.

Addendum B

Charges to Members of the Staff Compliance Committee

1. Authority. The Staff Compliance Committee is comprised of *Bullhook Community Health Center's* ("Health Center's") senior management who are representative of Health Center's major departments, such as billing, clinical, human resources, and operations. Members of the Compliance Committee serve to support the work of the Compliance Officer in implementing Health Center's Compliance Program.

2. Duties. As part of their duties, members of the Staff Compliance Committee will advise the Compliance Officer and assist in the implementation of the Compliance Program. The Staff Compliance Committee shall meet regularly (at least quarterly). The Staff Compliance Committee's functions will include, as directed by the Compliance Officer, and with due consideration for their other job responsibilities:

- **Policies and Procedures; Training and Educational Materials.** The Staff Compliance Committee will work with appropriate Health Center personnel to develop, maintain, implement, and disseminate Board-approved policies and procedures that address areas of risk and that promote compliance with Health Center's Compliance Program, all applicable laws (including, as applicable, the laws authorizing and implementing Medicaid, Medicare, and other Federal and State health care programs, and the requirements under Section 330 of the Public Health Service Act), and requirements imposed by commercial third party payors.

- **Open Lines of Communication.** The Staff Compliance Committee will assist in communicating to Health Center Board members, employees, contractors, agents, consultants, volunteers, and others who act on Health Center's behalf regarding the Health Center "open door" policy.

- **Identifying Areas of Risk**. The Staff Compliance Committee will assess (e.g., conduct audits of) Health Center's performance and activities to determine areas of risk and, if necessary, will identify measures to address such areas of risk. In addition, the Staff Compliance Committee will analyze issues affecting health centers (and the health care industry) generally and the legal requirements with which Health Center must comply.

- **Monitoring Audits and Investigations.** The Staff Compliance Committee will assist the Compliance Officer in recommending and monitoring internal systems and controls that seek to ensure compliance with Health Center's Standards of Conduct and policies and procedures. The Compliance Committee also will recommend internal and external audits and investigations for the purpose of identifying or responding to potential risk areas or reports of non-compliance and determining the sufficiency of measures taken to address risk.

- **Corrective Action.** As requested by the Compliance Officer, one or more members of the Staff Compliance Committee will recommend and supervise the implementation of appropriate corrective and preventive action based on reports and notifications received as well as audits and investigations.

- **Developing Strategy.** The Staff Compliance Committee will analyze and, as needed, develop new methods for promoting compliance and identifying potential violations and for soliciting, evaluating, and responding to complaints and reports of alleged non-compliance.

FLOW OF INFORMATION – EVENT REPORTING **Addendum C**

Report initiated by employee or patient concern who discovers, witnesses, or is notified of event*

Supervisor, Department Head

- Obtain medical attention
- Evaluate event
- Impound equipment, supplies (if applicable)
- Notify attending physician
- Review, sign report
- Notify family/responsible party (if applicable

Risk/Quality Management
Dental Coordinator
Clinical Coordinator

- Review and analyze report
- Assign severity index
- Obtain clinical, nursing, engineering expertise – interdisciplinary team
- Conduct investigation
- Conduct root cause analysis (if applicable)
- Determine if reportable under federal or state law
- Track, trend data
- Take corrective action/redesign systems
- Provide feedback to staff, administration, committees to prevent recurrence
- Monitor new systems
- Monitor event reporting program

Corporate Risk Management
Management QCI Committee

- Review report
- Track
- Trend with corporate data
- Report to insurer (if applicable)
- Participate in root cause analysis/system redesign
- Implement corporate-wide changes if necessary
- Communicate lessons learned throughout corporation

Corporate Risk Management
Policy/Compliancy Committee - Board

- Review
- Recommend policy changes or additions

Corporate Risk Management
Board of Directors

- Vote on policy changes

R:/Current Policies/Administration/2018 Risk Management/QI

Continuous Quality Improvement
Addendum to Policy 3023
for addition of Addiction Counseling Services
Bullhook Community Health Center, Inc.

The mission statement of Bullhook Community Health Center is: "We are committed to excellence in patient-centered accessible, cost-effective and timely primary healthcare for all." It is our overall goal to assist Montanan's to achieve optimum physical, mental and social well-being by providing access to health, mental health and addiction services and supports to meet the needs of adults and children to live, be educated, work and participate in their communities.

Bullhook Community Health Center will utilize NIATx in the continuous quality improvement program.

GOALS

- Increase completed treatment plans to 75%
- Coordinated treatment plans exist with medical team for greater than 50% of clients
- 100% retention rate of staff
- Competencies of staff are reviewed yearly and yearly training plan in place
- Quarterly peer review of charts
- Yearly peer review of overall clinical coordinator charts
- Program remains efficient and funding sources stable

Clients that cannot afford the service will be able to show proof of income and then will be able to go on the sliding fee scale. Clients can receive their ACT locally by community based on site counselor.

Quality Assurance Committee
The Continuous Quality Improvement (CQI) committee will review goals stated above in quarterly meetings to measure progress or lack of progress on listed goals. The committee members will offer suggestions based on resources and community needs.

____ Date: _________________________

CHIEF EXECUTIVE OFFICER

____ Date: _________________________

CHAIR, BOARD OF DIRECTORS

Date first adopted	09/24/2010
Date revised/QI	06/13/2013
New date adopted/Board	06/26/2013