Rocking Horse Community Health Center is part of a caring community that encourages, supports, and empowers individuals and families to improve their overall health and emotional wellbeing. We are proud to be a Joint Commission Primary Care Medical Home.
The Rocking Horse Community Health Center’s (RHCHC) Quality Improvement Plan seeks to enhance the health of our patients and communities and enables us to achieve our vision and mission in all that we do by continuously improving the degree of excellence of our services, processes, provider and support staff performance, and decision-making skills. The organizational aim of this is two-fold: to systematically evaluate all aspects of care rendered using objective criteria and to implement strategies to improve the care based on objective findings throughout the entire organization.

Rocking Horse Community Health Center’s Quality Improvement program monitors quality through ongoing assessment of and response to measures of quality of care, patient safety and satisfaction, organizational efficiencies, and the financial bottom line. All departments within the organization will participate in monitoring and implementing quality management strategies to improve services.

**RHCHC Board of Directors**
RHCHC Board of Directors is ultimately accountable for the quality of care provided at the Health Center. The Board will review and approve the Quality Improvement Plan a minimum of every three years, receive and act upon reports related to the QI program, and assure the availability of resources and systems to support QI activities.

**RHCHC Board Quality Improvement Committee**
RHCHC Board Quality Improvement Committee, established by the Board of Directors has the responsibility for oversight of the QI activities of RHCHC. The Committee will develop, monitor, and recommend policies to the Board, the Committee Chair will report on the quality of health care provided by the organization, recommend approval of the health plan to the Board a minimum of every three years, and report on local, state, and national issues relating to the quality of health care provided by the organization. The committee meets 6 times per year at minimum and the Board President appoints the chairperson of the Committee.
**RHCHC Medical Director**
The Medical Director is accountable to the Board of Directors for ensuring that the directives of the Board regarding QI are carried out. The Medical Director supervises the Quality Assurance Coordinator. The Medical Director annually defines a set of metrics, to be managed by the Quality Assurance Coordinator, in the annual Health Plan.

**RHCHC Quality Assurance Coordinator**
The Quality Assurance Coordinator (QAC) is responsible for all quality improvement teams and will staff the Board Quality Improvement Committee. The QAC is responsible for reporting on all current quality measures and will synthesize performance data, identify opportunities for improvement, and present findings to appropriate departments, staff, Medical Director, and the Board of Directors. The QAC will supervise and delegate patient satisfaction surveys and analyze customer survey data to identify opportunities for improvement and present findings to appropriate departments and organization. The QAC will identify systems related problems and work collaboratively with staff to resolve, assuring forward momentum in achieving quality standards and maintenance of successes. The QAC will develop and maintain the Infection Control Plan and Environment of Care Plan and assure their implementation and follow up.

**RHCHC Internal Quality Improvement/Risk Management Committee**
RHCHC Internal QI/RM committee will consist of staff from a variety of departments. The committee will meet regularly to review Quality Metric Reports, Joint Commission items, Building Inspections, Satisfaction Survey results, and Incident Reports. The committee will support QI and RM work through discussion of trends, identification of improvement needs, and development of improvement cycles to address negative trends. The QIRM Committee meets on a monthly basis and is led by the Quality Assurance Coordinator. Internal QI/RM Committee members will support the integrity of QI and RM work that is done within their work departments.

**RHCHC Staff**
With the support of the Quality Assurance Coordinator, each department will identify and track ongoing quality indicators or projects in their clinical area. Staff will participate in improvement cycles; implement policies, procedures and processes as directed. All staff members will receive QI related education or training via annual competency, an online training program, and individualized trainings based on each department’s needs. New employees are oriented to the RHCHC QI program by the Quality Assurance Coordinator.
Clinical Standards of Care and Protocols
The Clinical Team Manager is responsible for the development and communication of clinical standards of care and system protocols. Each department maintains a directory of these protocols and implements a review schedule.

Clinical Performance
The Quality Assurance Coordinator will work with the clinical department directors to determine appropriate measures of and goals for clinical performance. These measures will be reported monthly to each clinical department director and will be made available to staff.

Performance Measures
RHCHC performance measures will be based on UDS and Meaningful Use measures for current year as well as evidence based best practices. Measure metrics will be reviewed quarterly and reported to Internal and Board QI Committees.

Peer Review
The Quality Assurance Coordinator and Clinical Nurse Manager work together to randomly select and distribute peer reviews to all Medical, Women’s Health, and Behavioral Health clinical staff. Each employee will complete 15 peer reviews within each quarter. The peer reviews are then collected and analyzed to create feedback for each staff member. All copies are provided to Management and the Chief Medical Officer to assist them with determining areas in need of quality improvement and to aid in the employee evaluation process. Peer review results will be reported to the Board Quality and Board of Directors on a quarterly basis and all patient information used during reviews are kept confidential.

Information Technology (IT)
RHCHC utilizes Information Technology (IT) to enhance the quality of patient care. The electronic medical record is used by all staff to advance the patient through the health-care delivery system, providing more accurate point of care information. IT is also used to extract trustworthy data for analytics and strategic planning in regards to quality improvement.
**Outside Reviews**
RHCHC regularly hosts outside reviewers and reviews to assure an independent assessment of quality of care and organizational effectiveness. These agencies include, but are not limited to:
- Joint Commission
- Fire equipment inspections
- BPHC through annual grant application and UDS data submissions
- Elevator Inspection
- Ohio Department of Health Immunization Review
- Annual financial audit

**Patient Satisfaction**
The formal assessment of patient satisfaction is the responsibility of the Quality Assurance Coordinator. At present, RHCHC uses the MidWest Clinicians Network survey tool on a quarterly basis and reports the results to the Internal and Board QI Committees.

**Staff Satisfaction**
The formal assessment of staff satisfaction is the responsibility of the Director of Human Resources. RHCHC will administer staff surveys a minimum of every two years. The results will be summarized, reviewed, and distributed to staff and to the Internal QI/RM and Board QI Committees. The results will also be reported to the Personnel Committee of the Board, along with a review at a monthly supervisor meeting. The Internal QI/RM Committee, Board QI Committee, the Personnel Committee and the supervisory team may identify improvement opportunities.

**Communication and Problem Solving Avenues**
Communication on issues, priorities, projects and initiatives is critical to creating a culture of continuous improvement. RHCHC is committed to fostering a culture of direct communication by conversation wherever possible. There are regularly scheduled all-staff meetings and weekly Leadership team meetings. Agendas, formal minutes or notes are taken at standing meetings, filed electronically and are reviewed to assure follow through and issue resolution.
**Process Improvement**
The Quality Assurance Coordinator will work with department directors and staff on process assessment in order to develop improvement cycles aimed at process efficiencies and outcome improvement. RHCHC utilizes the PDSA or Plan, Do, Study, Act Model to invoke change and bring about process improvement.

Equal Access to Patients with Limited English Proficiency
RHCHC is committed to providing equal access to all patients. As part of this commitment we will make every effort to provide interpreters to facilitate communication between staff and patients with special communication needs. RHCHC will access interpreter services for the hearing impaired and for those patients with limited English proficiency who present for services. Situations in which an interpreter is important include, but are not limited to:

A. Obtaining a medical, surgical, and social history  
B. Informed consent  
C. Explaining a diagnosis and plan for treatment  
D. Explaining any change in regimen, environment or condition  
E. Procedures in any of our departments  
F. Medication instructions and explanation of possible side effects  
G. Financial advice for payments/sliding fee scale
Primary Care Medical Home (PCMH)
Rocking Horse Community Health Care Center takes pride in our PCMH Accreditation through Joint Commission. Our QI/QA structure is built around this model and every decision made focuses on the patient first.
RHCHC QI/QA Model

Quality Assurance
- Data Analysis
- Medical Standards
- Equipment Safety
- Patient Satisfaction Surveys

Clinical QI Efforts
- Combined Professional Meetings
- SBIRT
- Clinical Protocols
- Provider Meetings

Peer Review
- Medical
- Behavioral Health
- Women's Health
- Provider Feedback

Committees
- Board Quality
- Internal Quality
- Safety
- Operations
- Trusteeship
- Finance
- Leadership

Human Resources
- Credentialing & Privleging
- New Hire Orientation
- Staff Satisfaction

Risk Management
- FTCA
- Incident Reporting
- Annual Finance Audits
- Hazard Vulnerability Assessment
- Safety Team

- 8 -

09/01/15
### Standing Meetings

<table>
<thead>
<tr>
<th>Meeting Type</th>
<th>Purpose</th>
<th>Time frame</th>
<th>Person Responsible</th>
</tr>
</thead>
<tbody>
<tr>
<td>Board of Directors</td>
<td>To support the vision and mission of the Health Center (2 hours)</td>
<td>Monthly</td>
<td>CEO &amp; Board President</td>
</tr>
<tr>
<td>Board Quality Improvement</td>
<td>Board of Directors standing committee (60 minutes)</td>
<td>6 or more meetings annually</td>
<td>QA Coordinator, Medical Director, Board Quality Chair</td>
</tr>
<tr>
<td>Finance</td>
<td>Finance Board of Directors standing committee (60 minutes)</td>
<td>Monthly</td>
<td>Chief Financial Officer</td>
</tr>
<tr>
<td>Internal Quality Improvement/Risk Management</td>
<td>Review event reports, department metrics, satisfaction survey results, and incident reports. Support QI &amp; RM work (60 minutes)</td>
<td>Monthly</td>
<td>Quality Assurance Coordinator</td>
</tr>
<tr>
<td>Leadership</td>
<td>Department updates, policy review, approvals, and oversight of all operations</td>
<td>Weekly</td>
<td>CEO</td>
</tr>
<tr>
<td>Behavioral Health Team Meeting</td>
<td>Unify the team, case management, peer review, provide updates</td>
<td>Weekly</td>
<td>Director of Behavioral Health</td>
</tr>
<tr>
<td>Safety Committee</td>
<td>To assess safety issues and develop action plans</td>
<td>Every Other Month</td>
<td>Clinical Team Manager</td>
</tr>
</tbody>
</table>

### QI Committee Reports & Reviews

<table>
<thead>
<tr>
<th>Report/review type</th>
<th>Time frame</th>
<th>Person Responsible</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provider Performance Reports</td>
<td>Monthly</td>
<td>Quality Assurance Coordinator</td>
</tr>
<tr>
<td>Building Inspections</td>
<td>Monthly</td>
<td>Quality Assurance Coordinator</td>
</tr>
<tr>
<td>Patient Satisfaction Surveys</td>
<td>Quarterly</td>
<td>Quality Assurance Coordinator</td>
</tr>
<tr>
<td>Incident Reports</td>
<td>Quarterly</td>
<td>Quality Assurance Coordinator</td>
</tr>
<tr>
<td>Peer Reviews</td>
<td>Quarterly</td>
<td>Quality Assurance Coordinator</td>
</tr>
<tr>
<td>Financial Reports</td>
<td>Quarterly</td>
<td>Accountant</td>
</tr>
<tr>
<td>UDS Measure Review</td>
<td>Quarterly</td>
<td>Quality Assurance Coordinator</td>
</tr>
<tr>
<td>Staff Satisfaction</td>
<td>Annually</td>
<td>Director of Human Resources</td>
</tr>
<tr>
<td>Review/Report type</td>
<td>Time frame</td>
<td>Person Responsible</td>
</tr>
<tr>
<td>-----------------------------------</td>
<td>------------------</td>
<td>---------------------------------------------</td>
</tr>
<tr>
<td>Financial Statements</td>
<td>Monthly</td>
<td>Chief Financial Officer</td>
</tr>
<tr>
<td>Personnel Issues</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Including but not limited to:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>o Employee turnover</td>
<td></td>
<td></td>
</tr>
<tr>
<td>o New staff orientation assessments</td>
<td></td>
<td></td>
</tr>
<tr>
<td>o Employee satisfaction survey</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Confidentiality/HIPAA</td>
<td>Annually</td>
<td>Director of Operations</td>
</tr>
<tr>
<td>Provider Productivity</td>
<td>Monthly</td>
<td>Director of Operations</td>
</tr>
<tr>
<td>Employee Health</td>
<td>Annually</td>
<td>Medical Director, QAC &amp; Clinical Team Manager</td>
</tr>
<tr>
<td>OSHA Update</td>
<td>Annually and/or ongoing</td>
<td>QAC &amp; Clinical Team Manager</td>
</tr>
<tr>
<td>Safety Training</td>
<td>Annually</td>
<td>QAC &amp; Clinical Team Manager</td>
</tr>
<tr>
<td>Including but not limited to:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>o OSHA</td>
<td></td>
<td></td>
</tr>
<tr>
<td>o Fire drills</td>
<td></td>
<td></td>
</tr>
<tr>
<td>o Tornado drills</td>
<td></td>
<td></td>
</tr>
<tr>
<td>o Patient and staff safety</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Activity</td>
<td>Frequency</td>
<td>Responsible Party</td>
</tr>
<tr>
<td>--------------------------</td>
<td>----------------------------</td>
<td>--------------------------------------------------------</td>
</tr>
<tr>
<td>Peer Review</td>
<td>Medical Behavioral Women’s Health</td>
<td>QAC, CMO, Clinical Team Manager, &amp; Director of Behavioral Health</td>
</tr>
<tr>
<td>Incidents, grievances,</td>
<td>Quarterly</td>
<td>Quality Assurance Coordinator</td>
</tr>
<tr>
<td>safety</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Clinical Skills</td>
<td>Annually &amp; Upon hire</td>
<td>Clinical Team Manager</td>
</tr>
<tr>
<td>Verification</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Provider Credentialing</td>
<td>Upon hire and then every 2 years</td>
<td>Administrative Assistant</td>
</tr>
</tbody>
</table>
Rocking Horse Community Health Center
Performance Measures
2015

Outreach / Quality of Care
- Percentage of pregnant women beginning prenatal care in the first trimester
- Percentage of children with third birthday during the measurement year with appropriate immunizations
- Percentage of women 21-64 years of age who received one or more pap tests during the measurement year or during the two years prior to the measurement year
- Percentage of child and adolescent patients with a calculated BMI recorded and weight management counseling documented within the calendar year
- Percentage of adults with a calculated BMI recorded and with appropriate follow-up if indicated every 6 months
- Percentage of patients aged 12 years and older screened for depression and if positive had a follow up plan documented

Health Outcomes / Disparities
- Percentage of diabetic patients whose HgbA1c levels are less than or equal to 9%
- Percentage of adult patients with diagnosed hypertension whose blood pressure was less than 140/90
- Percentage of births less than 2,500 grams to health center patients
- Percentage of known tobacco users who received tobacco use intervention and/or pharmacological intervention
- Percentage of patients with persistent asthma who received or were prescribed accepted pharmacological therapy (controller medication).
- Percentage of patients diagnosed with HIV by health center and received follow up treatment within 90 days
Behavioral Health
- Percentage of children from ages 6-12 with newly prescribed ADHD medication that had one follow-up visit with a practitioner during 30-day initiation phase and had at least two follow-up visits during the 270 day maintenance phase
- Behavioral Health Integration – Mental Health Service Expansion Percentage of patients 18 and up who are screened for substance or alcohol abuse and if found to be at risk, receive the appropriate intervention

Oral Health
- Percentage of children who received at least one fluoride varnish application with prevention counseling before age 3

Financial Viability / Costs
- Total cost per patient visit
- Medical cost per medical encounter
- Change in net assets to expense ratio
- Working capital to monthly expense ratio
- Long term debt to equity ratio