Quality Improvement Plan
El Dorado Community
Health Centers
CY 2019

Section 1. Introduction

Mission
The mission of El Dorado Community Health Centers is to improve the health of our community through quality healing and preventive services.

El Dorado Community Health Centers (EDCHC) is a Federally Qualified Health Center located in El Dorado County, California. EDCHC provides quality, comprehensive health care to residents of El Dorado County, regardless of ability to pay. Services offered include: primary care, dental, pharmacy, integrated behavioral health, opioid addiction treatment, complex care management, immunizations, health coverage enrollment and preventive health services. The center’s focus is to provide exceptional health care for every age.

Purpose & Scope
Consistent with its mission, El Dorado Community Health Centers strives to enhance patient health and ensure services are provided in a safe, patient-centered, timely, equitable, and efficient manner:

- **Safe** – Services provided incorporate evidence based, effective practices and risks to patients, providers, staff, and others are eliminated or minimized.
- **Patient centered** – Services are responsive to individual patient needs and preferences and patients have the opportunity to participate in health care decisions.
- **Timely** – Services are provided in a timely manner.
- **Efficient** – Procedures, treatments, and services are conducted efficiently with appropriate coordination and continuity across all phases and providers of care.
- **Equitable** – Care provided is standard in both quality and access and care does not vary based upon any personal characteristics or biases.

This is accomplished through review of care quality, patient outcomes, peer chart review, patient experience, and adherence to quality and compliance guidelines outlined by the Bureau of Primary Health Care and the National Committee for Quality Assurance.

The Quality Improvement (QI) Plan serves as the foundation of El Dorado Community Health Centers’ commitment to continuously improve the quality of care and services provided. It helps guide the development, implementation, monitoring, and evaluation of department efforts that aim to improve patient outcomes and enhance the patient experience.

Quality improvement is an important component of El Dorado Community Health Center’s performance management, in which data is used for decision making and quality improvement tools and methods are applied to ensure adequate progress is made towards clinical and operational goals.
Quality Improvement Principles
Quality improvement is a systematic approach to assessing services and improving them on a priority basis. El Dorado Community Health Centers' (EDCHC) approach to quality improvement is based on the following principles:

- **Customer Focus.** High quality organizations focus on their internal and external customers and on meeting or exceeding needs and expectations.

- **Recovery-oriented.** Services are characterized by a commitment to promoting and preserving wellness and to expanding choice. This approach promotes maximum flexibility and choice to meet individually defined goals and to permit person-centered services.

- **Employee Empowerment.** Effective programs involve people at all levels of the organization in improving quality.

- **Leadership Involvement.** Strong leadership, direction and support of quality improvement activities by the governing body and Executive Director are key to performance improvement. This involvement of organizational leadership assures that quality improvement initiatives are consistent with both mission and strategic plan.

- **Data Informed Practice.** Successful QI processes create feedback loops, using data to inform practice and measure results. Fact-based decisions are likely to be correct decisions.

- **Statistical Tools.** For continuous improvement of care, tools and methods are needed that foster knowledge and understanding. Continuous quality improvement organizations use a defined set of analytic tools such as reports, tables, charts, and cause and effect diagrams in order to turn data into information.

- **Prevention Over-Correction.** Continuous quality improvement entities seek to design good processes to achieve excellent outcomes rather than fix processes after the fact.

- **Continuous Improvement.** Processes must be continually reviewed and improved. Small incremental changes do make an impact, and providers can usually find an opportunity to make things better.

Continuous Quality Improvement Activities
Quality improvement activities emerge from a systematic and organized framework for improvement. This framework is understood, accepted, and utilized throughout the organization, because of continuous education and involvement of staff (at all levels) in performance improvement. Quality Improvement involves two primary activities:

- Measuring and assessing the performance of EDCHC services through the collection and analysis of data.
- Conducting quality improvement initiatives and taking action where indicated, including the improvement of existing services and/or the design of new services.
Some of the tools used to conduct these activities are described in Appendix A.

Section 2. Leadership & Organization

Board of Directors
El Dorado Community Health Centers’ Board of Directors meets monthly and has overall responsibility to evaluate the performance of the health center and ensure health care services provided are accessible and meet quality and safety standards. The Board of Directors provides leadership for the quality improvement process by reviewing, evaluating and approving the Quality Improvement Plan annually.

Quality Assurance Committee
The Board of Directors meets its quality oversight responsibility through the Board Committee known as the Quality Assurance Committee (QAC). The QAC provides leadership for care quality and patient safety at El Dorado Community Health Centers (EDCHC). The committee meets at least quarterly and not less than four (4) times per year and consists of the following individuals:

Board Members (Committee Chair and min. 2 additional members)
Executive Director
Medical Director/Associate Medical Director
Clinical Director
Quality Improvement Manager
Executive Administrative Assistant (meeting documentation)

The responsibilities of the Quality Assurance Committee include:

- Reviewing and approving the annual Quality Improvement (QI) Plan.
- Monitoring QI Plan goals and indicators of care quality and patient safety.
- Periodically assessing objectives and reviewing actions taken by the Quality Improvement Committee (QIC) to address barriers to goals and objectives.
- Reporting to the Board of Directors on care quality and patient safety on a regular basis.

Quality Improvement Committee (QIC)
The Quality Improvement Committee provides ongoing operational leadership for care quality and patient safety at EDCCHC. The committee meets monthly and consists of the following individuals:

Executive Director
Chief Finance Officer (as needed)
Medical Director/Associate Medical Director
Clinical Director/Assistant Clinical Director
Development Director
Behavioral Health Director
QI Manager
EMR Specialist
Dental Representative (as needed)
Front Office Manager (as needed)
Consultants (as needed)
Executive Administrative Assistant (meeting documentation)
The Quality Improvement Committee (QIC) addresses all health center operational issues that relate to care quality and patient safety. The QIC is responsible for establishing goals and overseeing the implementation of objectives and activities related to care quality and patient safety throughout the organization.

The Quality Improvement Committee (QIC) identifies annual care quality and patient safety measures and sets goals and specific objectives to be accomplished each year. Specific responsibilities of the QIC are:

- Select and prioritize care quality and patient safety goals and indicators to monitor;
- Develop the annual Quality Improvement Plan;
- Assess goals and indicators, and taking action through quality improvement activities;
- Establish and support specific quality improvement activities;
- Include quality/performance improvement activities that are based on information from patients, staff and community stakeholders via the grievance and complaint process and patient satisfaction studies;
- Use standard practices to assess and conduct quality improvement (such as Plan-Do-Study-Act: PDSA);
- Coordinate quality improvement activities and documentation required by contract obligations and NCQA standards;
- Communicate quality improvement activities and results to staff, patients and other stakeholders as a means to engage and build a culture of quality
  Examples include:
  - Message boards and/or posters displayed in common areas
  - QIC reporting during the organization’s provider, staff, and leadership meetings
  - QIC reporting to various stakeholder groups
  - Sharing of the annual Quality Improvement Plan;
- Evaluate the annual QI Plan based on identified goals and quality indicators;
- Report to the QAC on quality improvement activities of the organization on a quarterly basis.

Section 3. Quality Improvement Goals

Goals & Objectives
The following are the ongoing long-term goals for El Dorado Community Health Centers’ Quality Improvement Program and the specific objectives for accomplishing these goals for the year 2019.

- To implement quantitative measurements to assess care quality and patient safety;
- To bring managers, EDCHC, and staff together to review quantitative data for care quality, patient safety and adverse events;
- To carefully prioritize care quality and patient safety needs and set goals for their resolution;
- To achieve measurable improvement in the highest priority areas;
- To meet internal and external reporting requirements;
• To develop or adopt necessary tools, such as policies, procedures, patient satisfaction/experience surveys, and quality indicators.

Patient Safety
El Dorado Community Health Centers’ (EDCHC) has a robust patient safety-monitoring program in place to improve patient safety, reduce risk and respect the dignity of those we serve by assuring a safe environment. Recognizing that effective medical/health care error reduction requires an integrated and coordinated approach, EDCHC employs a systematic methodology to minimize physical injury and accidents. Patient safety is the responsibility of all staff members and serious breaches are reported to the Quality Assurance Committee. The organization-wide safety program includes all activities contributing to the maintenance and improvement of patient safety. The following are engaged to monitor patient safety:

**Incident Reports:** Collect and trend data (quarterly) to monitor quality and safety.

**Equipment:** EDCHC has a formal process in place for ensuring equipment is maintained.

**Patient Complaints:** Collected, addressed, and trended quarterly to monitor quality and safety.

**Training:** EDCHC has a process for ensuring that its staff get regular training and updates in order to remain professionally competent.

**Peer Chart Review:** EDCHC has a formal process for providers to review/audit randomly selected charts quarterly to ensure care rendered is appropriate and safe.

**Patient Satisfaction Surveys:** EDCHC employs the use of the CG-CAHPS survey. This is available for patients to access on the El Dorado Community Health Centers website. The survey is open available for patients to access at any time. The EDCHC Marketing and Outreach Department is responsible for maintaining the administration of the survey, as well as the data collection/interpretation and reporting.

2019 Quality Improvement Goals:

Quality improvement at El Dorado Community Health Centers (EDCHC) has traditionally been championed by a group approach. In 2017, the EDCHC Board of Directors approved the position of Quality Improvement (QI) Manager. In December 2017, the position was filled. The QI Manager vacated her position in July 2018 and the position was again filled in October 2018. Quality improvement goals and objectives have been reassessed and 2019 will continue to be dedicated to ensuring the proper foundation and processes are in place for moving continuous quality improvement forward.
The table below outlines EDCHC 2019 goals* for quality improvement:

<table>
<thead>
<tr>
<th>Quality Improvement Goal</th>
<th>Commencement (date) of work</th>
<th>Anticipated Date of Completion</th>
</tr>
</thead>
<tbody>
<tr>
<td>Board Approval of 2019 QI Plan</td>
<td>2019 Q1</td>
<td>2019 Q1</td>
</tr>
<tr>
<td>Establish proactive monthly reporting process of key UDS &amp; HEDIS clinical measures for outreach/patient scheduling</td>
<td>2019 Q1</td>
<td>2019 Q2</td>
</tr>
<tr>
<td>Update uniform incident reporting process (including patient complaints) and conduct staff training</td>
<td>2019 Q1</td>
<td>2019 Q2</td>
</tr>
<tr>
<td>Peer Chart Review policy update and process improvement (include dental &amp; BH)</td>
<td>2019 Q1</td>
<td>2019 Q2</td>
</tr>
<tr>
<td>Credentialing &amp; Privileging policy update and process improvement (include dental &amp; BH)</td>
<td>2019 Q1</td>
<td>2019 Q2</td>
</tr>
<tr>
<td>Improve clinical referral process (Tracking &amp; follow up)</td>
<td>2019 Q1</td>
<td>2019 Q3</td>
</tr>
<tr>
<td>Analyze use of SBIRT and improve process</td>
<td>2019 Q2</td>
<td>2019 Q3</td>
</tr>
<tr>
<td>Diabetes program development</td>
<td>2019 Q2</td>
<td>2019 Q3</td>
</tr>
<tr>
<td>Patient satisfaction survey process improvement</td>
<td>2019 Q2</td>
<td>2019 Q3</td>
</tr>
<tr>
<td>Seek funding for program support of key quality measures</td>
<td>2019 Q3</td>
<td>2019 Q4</td>
</tr>
<tr>
<td>Establish proactive monthly reporting process of health plan new members for outreach/patient scheduling</td>
<td>2019 Q3</td>
<td>2019 Q4</td>
</tr>
</tbody>
</table>

*Goals are tentative and subject to change per business needs.
Section 4. Performance Measurement

Performance Measurement is the process of regularly assessing the results produced by the program. It involves identifying processes, systems, and outcomes that are integral to the performance of the service delivery system, selecting measures of these processes, systems and outcomes, and analyzing information related to these measures on a regular basis.

The Quality Improvement Committee (QIC) will review performance on all HRSA Uniform Data System (UDS) measures, with each measure reviewed biannually at minimum. The QIC may monitor additional measures based on relevance to the mission, strategic importance, contract requirements, and/or clinical importance (for example, areas that are high volume, problem prone or high risk).

The purpose of measurement and assessment is to:

- Assess the stability of processes or outcomes to determine whether there is an undesirable degree of variation or a failure to perform at an expected level.
- Identify problems and opportunities to improve the performance of processes.
- Assess the outcome of the care provided.
- Assess whether a new or improved process meets performance expectations.

Measurement and assessment involve:

- Selection of a process or outcome to be measured, on a priority basis.
- Identification and/or development of performance indicators for the selected process or outcome to be measured.
- Aggregating data so that it is summarized and quantified to measure a process or outcome.
- Assessment of indicator performance at planned and at regular intervals.
- Acting to address performance discrepancies when a process is not stable, is not performing at an expected level or represents an opportunity for quality improvement.
- Reporting within the organization on findings, conclusions and actions taken as a result of performance assessment.

Selection of a Performance Indicator

A performance indicator is a quantitative tool that provides information about the performance of processes, services, functions or outcomes. Selection of a Performance Indicator is based on the following considerations:

- Scientific Foundation: the relationship between the indicator and the process, system or facility’s outcome being measured.
- Validity: whether the indicator assesses what it purports to assess.
- Resource Availability: the relationship of the results of the indicator to the cost involved and the staffing resources that are available.
• Consumer Preferences: the extent to which the indicator takes into account individual or group (e.g., racial, ethnic, or cultural) preferences.

• Meaningfulness: whether the results of the indicator can be easily understood, the indicator measures a variable over which the program has some control, and the variable is likely to be changed by reasonable quality improvement efforts.

• Relevance to mission – whether the indicator addresses the population served.

• Whether it addresses the practice’s important process that is:
  o high volume
  o problem prone or
  o high risk

Assessment
Assessment is accomplished by comparing actual performance on an indicator with:
• Self over time
• Pre-established standards, goals or expected levels of performance
• Evidence-based practice
• Other Federally Qualified Health Centers (FQHCs), community clinics, or similar service providers

Clinical Performance Measures for 2019

The table below outlines the clinical performance measures (in orange) selected for prioritization and process improvement in 2019. Measures prioritized by the Quality Improvement Committee (QIC) will be reviewed at least quarterly during meetings with the goal of achieving improved performance.

QIC will offer consultation, training, facilitation and support to help drive improvement in these measures. QIC members may assess and do the following during process improvement:

• What are we trying to accomplish?
• Develop an Aim Statement that outlines what the team will accomplish
• Use the Plan-Do-Study-Act methodology, where appropriate
• Document key steps of the process
• Report results to the QAC
• Share documents, tools, lessons learned, etc. with others throughout the organization
<table>
<thead>
<tr>
<th>Measure</th>
<th>Current Performance</th>
<th>Goal</th>
<th>2017</th>
<th>HP 2020</th>
<th>CA 2017</th>
<th>2017 UDS Nation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diabetes – Poor Glucose Control (A1c &gt;9%) a lower % performance is better</td>
<td>35.01% 320/914</td>
<td>30%</td>
<td>31.47%</td>
<td>16%</td>
<td>33.75%</td>
<td>32.95%</td>
</tr>
<tr>
<td>Controlling High Blood Pressure (&lt;140/90 mmHg)</td>
<td>75.09% 1492/1987</td>
<td>75%</td>
<td>72.93%</td>
<td>61%</td>
<td>64.82%</td>
<td>62.71%</td>
</tr>
<tr>
<td>Screening for Clinical Depression and Follow-Up Plan</td>
<td>91.62% 5409/5904</td>
<td>91%</td>
<td>90.89%</td>
<td>X</td>
<td>63.81%</td>
<td>66.15%</td>
</tr>
<tr>
<td>Colorectal Cancer Screening</td>
<td>31.96% 928/2904</td>
<td>37%</td>
<td>37.21%</td>
<td>71%</td>
<td>44.91%</td>
<td>42.02%</td>
</tr>
<tr>
<td>Cervical Cancer Screening</td>
<td>54.11% 1343/2482</td>
<td>61%</td>
<td>61.10%</td>
<td>93%</td>
<td>59.23%</td>
<td>55.67%</td>
</tr>
<tr>
<td>Childhood Immunization Status</td>
<td>22.66% 29/128</td>
<td>25%</td>
<td>18.59%</td>
<td>X</td>
<td>43.04%</td>
<td>40.24%</td>
</tr>
<tr>
<td>Dental Sealants</td>
<td>84.40% 92/109</td>
<td>84%</td>
<td>50%</td>
<td>28%</td>
<td>54.53%</td>
<td>50.71%</td>
</tr>
<tr>
<td>Use of Appropriate Meds for Asthma</td>
<td>76.72% 76%</td>
<td>76%</td>
<td>87.13%</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Weight Assessment Children</td>
<td>94.26% 1969/2089</td>
<td>94%</td>
<td>95.48%</td>
<td>X</td>
<td>67.10%</td>
<td>65.85%</td>
</tr>
<tr>
<td>Adult BMI Screening</td>
<td>87.09% 5880/6752</td>
<td>87%</td>
<td>90.13%</td>
<td>X</td>
<td>65.16%</td>
<td>63.85%</td>
</tr>
<tr>
<td>Tobacco Use</td>
<td>95.89% 4809/5015</td>
<td>95%</td>
<td>95.35%</td>
<td>X</td>
<td>88.85%</td>
<td>87.50%</td>
</tr>
<tr>
<td>Coronary Artery Disease</td>
<td>78.93% 78%</td>
<td>78%</td>
<td>80.47%</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Ischemic Vascular Disease</td>
<td>78.40% 78%</td>
<td>78%</td>
<td>76.90%</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
</tbody>
</table>
Section 5. Quality Improvement Initiative/PDSA

Once the performance of a selected process has been measured, assessed and analyzed, the information gathered by the above performance indicator(s) is used to identify a continuous quality improvement initiative to be undertaken. The decision to undertake the initiative is based upon El Dorado Community Health Centers (EDCHC) priorities. The purpose of an initiative is to improve the performance of existing services or to design new ones. The model utilized at EDCHC is called Plan-Do-Study-Act (PDSA).

**Plan** - The first step involves identifying preliminary opportunities for improvement. The focus is to analyze data to identify concerns and to determine anticipated outcomes. Ideas for improving processes are identified. This step requires the most time and effort. Affected staff or people served are identified, data compiled, and solutions proposed. (For tools used during the planning stage, see sections “a” thru “k” in APPENDIX: A)

**Do** - This step involves using the proposed solution, and if it proves successful, as determined through measuring and assessing, implementing the solution usually on a trial basis as a new part of the process.

**Study** - At this stage, data is again collected to compare the results of the new process with those of the previous one.

**Act** - This stage involves making the changes a routine part of the targeted activity. It also means “Acting” to involve others (other staff, program components or consumers) - those who will be affected by the changes, those whose cooperation is needed to implement the changes on a larger scale, and those who may benefit from what has been learned. Finally, it means documenting and reporting findings and follow up.

Section 6. Evaluation

An annual evaluation of the Quality Improvement Plan will be conducted by El Dorado Community Health Centers (EDCHC) and kept on file, along with the annual Quality Improvement Plan.

The evaluation summarizes the goals of EDCHC’s annual Quality Improvement Plan, the quality improvement activities conducted during the past year, including the targeted process, systems and outcomes. It also includes the performance indicators utilized, the measurement findings, data aggregation, and the quality improvement initiatives taken in response to the findings:

1. Summarize the progress towards meeting the annual QI plan goals.
2. For each of the goals, include a brief summary of progress.
3. Provide a brief summary of the findings for each of the indicators used during the year. These summaries should include both the outcomes of the measurement process and the conclusions and actions taken in response to these outcomes.

4. Summarize process improvement progress, provide a brief description of what activities took place including the results on indicators. Include next steps and how measurement gains will be sustained.

5. Recommendations: Based upon the evaluation, state recommendations for the next year as well as any actions necessary to improve the effectiveness of the annual QI Plan.
APPENDIX A. Quality Improvement Tools

Following are some of the tools available to assist in the quality improvement process.

a. **Flow Charting:** Use of a diagram in which graphic symbols depict the nature and flow of the steps in a process. This tool is particularly useful in the early stages of a project to help the team understand how the process currently works. The "as-is" flow chart may be compared to how the process is intended to work. At the end of the project, the team may want to then re-plot the modified process to show how the redefined process should occur.
The benefits of a flow chart are that it:

1) Is a pictorial representation that promotes understanding of the process
2) Is a potential training tool for employees
3) Clearly shows where problem areas and processes for improvement are

b. **Brainstorming:** A tool used by teams to bring out the ideas of each individual and present them in an orderly fashion to the rest of the team. Essential to brainstorming is to provide an environment free of criticism. Team members generate issues and agree to “defer judgement” on the relative value of each idea. Brainstorming is used when one wants to generate a large number of ideas about issues to tackle, possible causes, approaches to use, or actions to take. The advantages of brainstorming are that it:

1) Encourages creativity
2) Rapidly produces many ideas
3) Equalizes involvement by all team members
4) Fosters a sense of ownership in the final decision as all members actively participate
5) Provides input to other tools: “brain stormed” ideas can be put into an affinity diagram or they can be reduced by multi-voting.

c. **Decision-making Tools:** While not all decisions are made by teams, two tools can be helpful when teams need to make decisions.

1) Multi-voting is a group decision-making technique used to reduce a long list of items to a manageable number by means of a structured series of votes. The result is a short list identifying what is important to the team. Multi-voting is used to reduce a long list of ideas and assign priorities quickly with a high degree of team agreement.
2) The Nominal Group technique is used to identify and rank issues in order of priority.
d. **Affinity Diagram:** The Affinity Diagram is often used to group ideas generated by brainstorming. It is a tool that gathers large amounts of language data (ideas, issues, opinions) and organizes them into groupings based on their natural relationship. The affinity process is a good way to get people who work on a creative level to address difficult, confusing, unknown or disorganized issues. The affinity process is formalized in a graphic representation called an affinity diagram. This process is useful to:

1) Sift through large volumes of data.
2) Encourage new patterns of thinking.

As a rule of thumb, if less than 15 items of information have been identified, the affinity process is not needed.

e. **Cause and Effect Diagram (also called a fishbone or Ishakawa diagram):** This is a tool that helps identify, sort, and display information. It is a graphic representation of the relationship between a given outcome and all the factors that influence the outcome. This tool helps to identify the basic root causes of a problem. The structure of the diagram helps team members think in a very systematic way. The benefits of a cause-and-effect diagram are that it:

1) Helps the team to determine the root causes of a problem or quality characteristic using a structured approach.
2) Encourages group participation and utilizes group knowledge of the process.
3) Uses an orderly, easy-to-read format to diagram cause-and-effect relationships.
4) Indicates possible causes of variation in a process.
5) Increases knowledge of the process.
6) Identifies areas where data should be collected for additional study.
f. **Histogram**: This is a vertical bar chart which depicts the distribution of a data set at a single point in time. A histogram facilitates the display of a large set of measurements presented in a table, showing where the majority of values fall in a measurement scale and the amount of variation. The histogram is used in the following situations:

1) To graphically represent a large data set by adding specification limits one can compare.
2) To process results and readily determine if a current process was able to produce positive results assist with decision-making.

**g. Pareto Chart**: Named after the Pareto Principle which indicates that 80% of the trouble comes from 20% of the problems. It is a series of bars on a graph, arranged in descending order of frequency. The height of each bar
reflects the frequency of an item. Pareto charts are useful throughout the performance improvement process - helping to identify which problems need further study, which causes to address first, and which are the “biggest problems.” Benefits and advantages include:

1) Focus on most important factors and help to build consensus.
2) Allows for allocation of limited resources.

The “Pareto Principle” says 20% of the source causes 80% of the problem. Pareto charts allow the team to graphically focus on the areas and issues where the greatest opportunities to improve performance exist.

h. Root Cause Analysis: A root cause analysis is a systematic process for identifying the most basic factors/causes that underlie variation in performance.

i. Run Chart: This is a basic tool to show how a process performs over time. Data points are plotted in temporal order on a line graph. Run charts are
most effectively used to assess and achieve process stability by graphically depicting signals of variation. A run chart can help to determine whether or not a process is stable, consistent, and predictable. Simple statistics such as median and range may also be displayed.

The run chart is most helpful in:

1) Understanding variation in process performance.
2) Monitoring process performance over time to detect signals of change.
3) Depicting how a process performed over time, including variation.

Run charts allows the team to see changes in performance over time. The diagram can include a trend line to identify possible changes in performance.

**j. Control Chart:** A control chart is a statistical tool used to distinguish between variation in a process resulting from common causes and variation resulting from special causes. It is noted that there is variation in every process. Some variation is the result of causes not normally present in the process (special cause variation). A common cause of variation is variation that results simply from the numerous, ever-present differences in the process. Control charts can help to maintain stability in a process by depicting when a process may be affected by special causes. The consistency of a process is usually characterized by showing if data fall within control
limits based on plus or minus specific standard deviations from the center line. Control charts are used to:

4) Monitor process variation over time.
5) Help to differentiate between special and common cause variation.
6) Assess the effectiveness of change on a process.
7) Illustrate how a process performed during a specific period.

Using upper control limits (UCLs) and lower control limits (LCLs) that are statistically computed, the team can identify statistically significant changes in performance. This information can be used to identify opportunities to improve performance or measure the effectiveness of a change in a process, procedure, or system.

**k. Benchmarking**: A benchmark is a point of reference by which something can be measured, compared, or judged. It can be an industry standard
against which a program indicator is monitored and found to be above, below or comparable to the benchmark.
Signatures of Approval

[Signature]
Medical Director
Date: 5/2/19

[Signature]
Executive Director
Date: 5/1/19

[Signature]
Board of Directors Chairperson
Date: 5/3/2019