Will County
Health Department &
Community Health Center

CONTINUOUS QUALITY IMPROVEMENT PLAN &
PERFORMANCE MANAGEMENT PLAN (CQIPM PLAN)

JANUARY 1, 2026 - DECEMBER 31, 2026

Governing Council Quality Committee:

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Jennifer Byrd, M.D., Chief Medical Officer
Carol Riken, Director of Operations
Sangita Garg, D.D.S., Chief Dental Officer
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CONTINUOUS QUALITY IMPROVEMENT PLAN &
PERFORMANCE MANAGEMENT PLAN (CQIPM PLAN)

The mission of the Will County Community Health Center is to improve the health of the residents of Will County by providing access to quality integrated medical, dental, & behavioral health care through community collaboration, service, and education.

Purpose: Fulfilling the Healthcare Needs of Individuals and Our Community

Core Values: Quality, Respect, Integrity, Dedication, and Professionalism

CONTINUOUS QUALITY IMPROVEMENT PRINCIPLES

1. Patients are our first priority.
2. Quality is achieved through people.
3. All work is part of a process.
4. Objective data is considered in decision making.
5. Quality requires continuous improvement.

I. INTRODUCTION AND STATEMENT OF PURPOSE

Will County Community Health Center (WCCHC) and its staff believe performance measurement and continuous quality improvement are critical elements for excellence in the health care industry. We believe that patients are our partners in their treatment plans and are entitled to exceptional health care services. Patient safety is a cornerstone of high-quality care and is a leadership priority.

The WCCHC strategic plan identifies strategic goals, objectives, and priorities. The Continuous Quality Improvement and Performance Management (CQIPM) plan encompasses both quality improvement and patient safety. It provides direction for developing, measuring, analyzing, and reporting all aspects of organizational performance and patient safety improvement activities. The CQIPM plan guides the Center in setting performance improvement priorities and identifying needed adjustments in response to unusual or urgent events. This process helps the health center address high risk, high cost, high frequency, and problem-prone indicators identified through data collection and assessment.

WCCHC recognizes that providing safe patient care requires significant coordination and collaboration. The optimal approach to patient safety involves multiple departments and disciplines to establish and effectively implement the plans, processes and mechanisms that comprise the CQIPM plan.

WCCHC's authority for peer review is found in the Illinois Medical Studies Act, 735 ILCS 5/8-2101. Peer review is intended to promote confidential and systematic processes that contribute to the quality improvement efforts at the individual provider level, within a non-punitive context.

II. QUALITY ASSURANCE/QUALITY IMPROVEMENT INFRASTRUCTURE.

To ensure the care provided by the WCCHC is evidence based, well-coordinated, safe, and patient centered, the CQIPM plan creates a dynamic integrated system of activities that coordinate multiple function areas that have a direct impact on the quality of patient care and ultimately the health of the individuals and the communities we serve. The Quality Improvement and Quality Assurance (QI/QA) program creates a mechanism to improve clinical quality measures, ensure effective risk management, monitor the environment of care, and ensure a stable and competent work force. The CQIPM plan outlines a data driven mechanism for making improvements to the system that will ultimately result in improved patient outcomes. Additionally, the plan will provide guidance to health center leadership to identify and monitor their department's performance and guide them through staff level process improvements.



III. SCOPE

Will County Community Health Center's QI/QA Plan applies to all clinical and operational activities. The scope of the QI/QA Plan is overarching and meant to serve as a guide to all QI/QA work across the organization. This document focuses on the following:

- Identifying improvement activities that are consistent with and support the annual strategic plan.
- Setting guidelines for the quality structure within the organization.
- Addressing quality assurance requirements from governing regulatory or accrediting entities.
- Reporting on quality data as required by contracts (example: managed care organizations).
- Describing key initiatives.
- Addressing findings identified through audits and assessments.

The scope of all quality improvement and assurance activities shall promote the mission, purpose, core values and continuous quality improvement principles of WCCHC:

Mission: The mission of the Will County Community Health Center is to improve the health of the residents of Will County by providing access to quality integrated medical, behavioral health, and dental care through community collaboration, service, and education.

Purpose: Fulfilling the healthcare needs of individuals and the community

Core Values: Respect, Integrity, Professionalism, Quality, and Dedication

Continuous Quality Improvement Principles

1. Patients are our priority.
2. Quality is achieved through people.
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IV. OBJECTIVES

The purpose of the overall Continuous Quality Improvement Plan (CQI Plan) is to provide the health center direction for:

- Identifying improvement activities that are consistent with and support the annual strategic plan.

- Defining responsibilities for performance improvement patient and risk-management activities to address the quality and utilization of health center activities, patient satisfaction and patient grievance processes and patient safety (including adverse events).

- Assuring a systematic, collaborative, facility-wide approach is in place for collecting and evaluating data and to identify and prioritize opportunities for improvement.

- Providing a means of integrating performance improvement and quality control data from multidisciplinary efforts such as clinical safety, infection control, and utilization management into the CQI Plan.

- Reporting performance improvement and patient safety activities to the Quality Committee and Governing Council.

- Identifying mechanisms and designing new processes for improving performance.

- Measuring the stability of existing processes.

- Demonstrating compliance with regulatory, licensure and accreditation requirements.

V. AUTHORITY, ACCOUNTABILITY AND RESPONSIBILITY

Governing Council

The Governing Council oversees and ensures the quality of clinical care, patient safety and patient satisfaction throughout the health center. The Governing Council acknowledges its accountability through approval of the comprehensive approach to continuous quality improvement, patient safety and risk management activities as outlined in the CQI Plan and have authority and responsibility for compliance as follows:

- Reviews and approves center-wide performance indicators on a routine basis to track results of overall system performance.

- Reviews and approves the health center's audits of quality activities and Unified Data System (UDS) submission.

- Oversee the medical staff credentialing processes.

- Communicates strategies and recommendations to health center management related to performance improvement and patient safety activities.

- Annually reviews and approves the CQI Plan.

- Annually approved the Clinical Competency Summation Report of individual staff members.

Governing Council Quality Committee

The Quality Committee includes a minimum of three council members (two with health care expertise), Chief Executive Officer (CEO), Chief Medical Officer (CMO), Chief Dental Officer, Director of Operations, Director of Nursing, Quality Improvement /Risk Management Program Manager, the Director of Compliance and other management team members. The committee meets, at a minimum, quarterly.

Health Center Leadership identifies quality issues to be addressed by electronic health record (EHR) data, peer review and proactive risk assessment to the Quality Committee.

The Quality Committee recommends the approval of the annual QA/QI plan to the full Council, monitors the plans implementation and results, and reports its findings and observations to the Governing Council.

The Quality Committee also reviews specific case studies (incident reports), patient satisfaction surveys and patient complaints/grievances and reports these items to the Governing Council.

Continuous Quality Improvement Committee (CQI)

CQI is an organization-wide cross-functional committee that includes clinical and administrative departments representing Medical, Dental, Optical, Operations, Mental Health, and Compliance. Other staff may be called upon as subject matter experts on an ad-hoc basis. CQI serves as the umbrella committee for quality across the organization's services and programs. CQI compiles a list of topics and defines organizational priorities, and continually assesses the health center's needs for quality improvement activities. CQI provides input on the overall QA/QI Plan, which is approved by the Governing Council. CQI is chaired by the Chief Medical Officer and staffed by the Quality Improvement and Risk Management Coordinator

The Staff-CQI Committee includes the following permanent members:

- Chief Executive Officer/CEO (ex officio)
- Chief Medical Officer (chair)
- Chief Dental Officer
- Director of Nursing
- Director of Compliance
- Behavior Health Clinic Manager
- Quality Improvement/Risk Management Coordinator
- Director of Operations
- Brook Middle School representative
- A clinical provider
- Administrative Assistant to the CMO (to keep minutes)

The Staff-CQI Committee also includes staff members serving a one-year term. Members are nominated by the management team and approved for appointment after reviewing the individual nominees' commitment,

participation, and performance in the Committee for the first 3 months. Reflecting a broad representation of staff, these members may include, but are not limited to the following:

- Clinical Support Staff Representative
- Ancillary Staff Representative, Medical Records, Outreach, and Other Ancillary Services
- Billing and Registration Representative
- Dental Clinic Representative
- BH Staff Representative
- School Based Health Center Representative

The CQI Committee focuses on 1) Federal Tort Claims Act (FTCA) Risk Assessment; 2) safety and risk management: 3) quality improvement; 4) tracking improvement activity; and 5) monitoring and reporting effectiveness of the CQI Plan. Individually, each member is responsible for assuring documentation and communication of the quality improvement and quality assurance activities in their area, providing the CQI Committee with information requested, and acting upon committee recommendations.

In addition, the CQI Committee is responsible for oversight of the following function areas:

- Medication Management
- Environment of Care
- Infection Control
- Risk Management

The CEO, an ex officio member of the CQI Committee, facilitates the implementation of approved changes or actions. The CMO oversees the clinical aspects of the CQIPM Plan and leads the CQI Committee. The CMO assures the plan functions as intended, and those members operationalize all approved changes or recommendations. It is also the CMO's responsibility to integrate improvement activities into clinical care and maintain close coordination with the Quality Improvement and Risk Management Coordinator.

The CQI Committee submits reports and recommendations to the Quality Committee of the Governing Council when it is convened quarterly. The Chair of the Quality Committee of the Governing Council informs the Governing Council via reports and verbal presentations, as to the organization's full CQI results based on the CQI Plan, including quality improvement activities, and recommendations.

Functions of the Staff-CQI Committee include but are not limited to the following:

- Meets monthly.
- Documents, by means of minutes and supporting documents, all meetings, actions, and recommendations.
- Establishes a secure repository for reports and related activities.
- Documents all identified risks in the FTCA Risk Assessment tool at least quarterly and report on the risks to the Quality Committee quarterly. Risk assessment will also be approved by the Governing Council quarterly.
- Identifies actual or potential problems related to patient care and clinical performance.

- Forms ad hoc committees to address concerns highlighted during quality assessments through the Plan-Do-Study-Act (PDSA) model. The CQI Committee will:
    - Develop a PDSA as determined by members of the CQI Committee
    - Implement and monitor the PDSA's progress
    - Evaluate the process and effectiveness

- Submits reports and recommendations to the Quality Committee of the Governing Council.

Chief Executive Officer

- Accepts full responsibility from the Governing Council for ensuring implementation of the CQI plan.

- Delegates to the Chief Medical Officer the authority, accountability, and responsibility for assuring adequate resources, support, and educational opportunities exist for quality performance improvement and patient safety for leaders, medical staff, and other employees.

- Designates the Quality Improvement and Risk Management Coordinator to oversee the CQIPM Plan that addresses the following but not be limited to ensuring implementation of QI/QA operating procedures and related assessments, monitoring QI/QA outcomes and updating QI/QA operating procedures.

- Assures the Center's continuous improvement, especially in areas of service, finance, patient satisfaction, and growth.

- Demonstrates commitment to the CQI principles.

- Reviews and approves reports of performance and system indicators to assess activities that improve organizational performance and patient safety.

- Assures compliance with regulatory, licensure and accreditation requirements.

- Reviews the bylaws, policies, and regulatory rules and regulations, to ensure compliance with current laws and accreditation standards.

- Reviews and approves medical staff applications, credentialing, and disciplinary actions.

Leadership (includes Chief Medical Officer, Chief Dental Officer, Director of Operations, Director of Nursing, Director of Compliance, Quality Improvement/Risk Management Program Coordinator, Behavior Health Clinic Manager, Billing Supervisor, Community Outreach & Marketing Coordinator, Patient Registration Supervisor, Clinic Managers and Governing Council)

- Demonstrates commitment to the CQI principles.

- Sets measurable objectives for improving organizational performance and patient safety.
- Communicates the CQI Plan and Strategic Plan to department leaders and staff for use in establishing performance improvement and patient safety activities.
- Allocates adequate resources (including time, staff, data systems, methods, and tools) for measuring, assessing, and implementing performance improvement and patient safety initiatives.
- Develops mechanisms to measure, analyze and manage variation in the performance of high-risk processes that affect patient safety.
- Fosters a culture that supports proactive, effective responses to reducing actual occurrences, and minimizes individual blame or retribution for reporting of and involvement in variances and occurrences.
- Develops methods and structures that increase communication and coordination among individuals and departments.
- Identifies risks within their specific area to be included in the FTCA Risk Assessment. Establishes policies and processes that identify and reduce risks and occurrences. Ensure the risk assessment is submitted and reviewed by the quality committee and approved by the Governing Council.
- Focuses on improvements to practices, processes and systems that contribute to variances and occurrences.
- Supports sharing knowledge and data that can affect behavioral change.
- Serves as champions for action plans to achieve strategic goals; provides support and facilitates progress
- Reviews strategic plan and indicators to measure, monitor and analyze performance and identify priorities for improvement.
- Oversees and reviews progress of the performance improvement teams.
- Approves and facilitates the implementation of team recommendations based on best practices.
- Participate in the annual evaluation of the CQIPM plan.
- Assures compliance with accreditation, regulatory and licensure requirements.

Providers & Support Staff

- Demonstrates a commitment to the CQI principles.

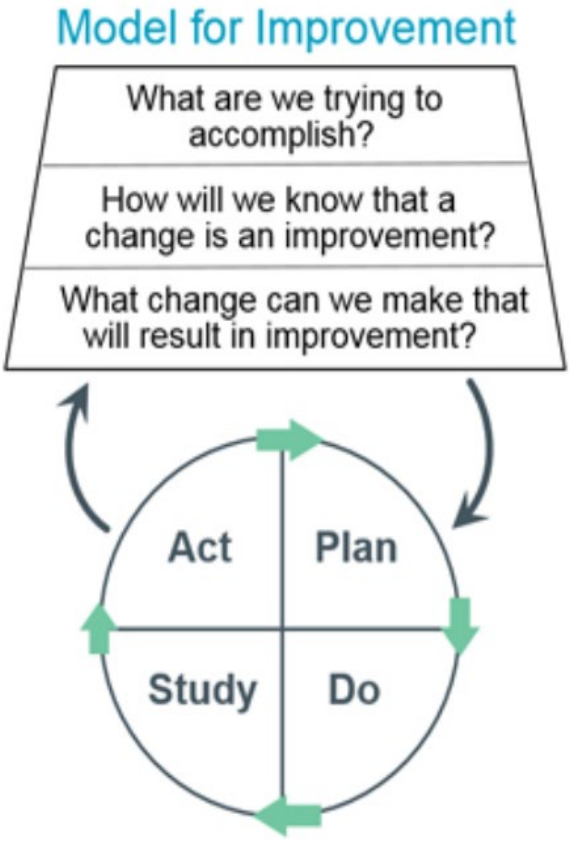
- Focuses on improvements to practices, processes and systems that contribute to variances.
- Fosters a culture that supports proactive, effective responses to reducing actual occurrences and minimizes individual blame or retribution for reporting of and involvement in variances.
- Develops methods and structures that increase communication and coordination among individuals and departments.
- Supports sharing knowledge and data that can affect behavioral change.
- Reviews performance and patient safety data, to prioritize processes for improvement and assure department alliance with the strategic plan.
- Performs quality activities to measure the performance of the department.
- Participates in multidisciplinary performance improvement and patient safety activities to improve organizational performance.
- Performs follow-up monitoring of implemented processes to ensure actions taken contribute to sustained results.
- Participate in orientation, ongoing training, and continuing education of staff within the department to assure consistent or continuous competency.
- Adheres to departmental compliance with regulatory, licensure and accreditation requirements.
- Identifies risks in their position to share and discuss as well as determine if risks need to be included in the FTCA Risk Assessment.

VI. IMPLEMENTATION OF THE QA/QI Program

The primary responsibility for implementing, managing and monitoring WCCHC Quality Assurance and Quality Improvement efforts is assigned to the Chief Medical Officer with operational support from health center leadership including Chief Dental Officer, Director of Operations, Director of Nursing, Director of Compliance, Quality Improvement/Risk Management Coordinator, Behavior Health Clinic Manager, Billing Supervisor, Community Outreach & Marketing Coordinator, Patient Registration Supervisor, and Clinic Managers**.** These staff, along with leaders at each clinical site, are tasked with implementing the quality improvement initiatives for each of the areas outlined in the Quality Assurance/Quality Improvement infrastructure outlined above. The CMO and/or designees will report QA/QI efforts and identified issues directly to the Chief Executive Officer, Quality Improvement Committee of the Governing Council, and relevant CQI committee as applicable.

The Model for Improvement serves as the basis of all quality improvement activities. The model consists of two core components: the first is defining the focus of the improvement project based on the three fundamental

questions outlined below. The second is the use of the Plan-Do-Study-Act (PDSA) cycle to test and implement changes in real work settings. The PDSA cycle guides the test of a change to determine if the change is an actual improvement.



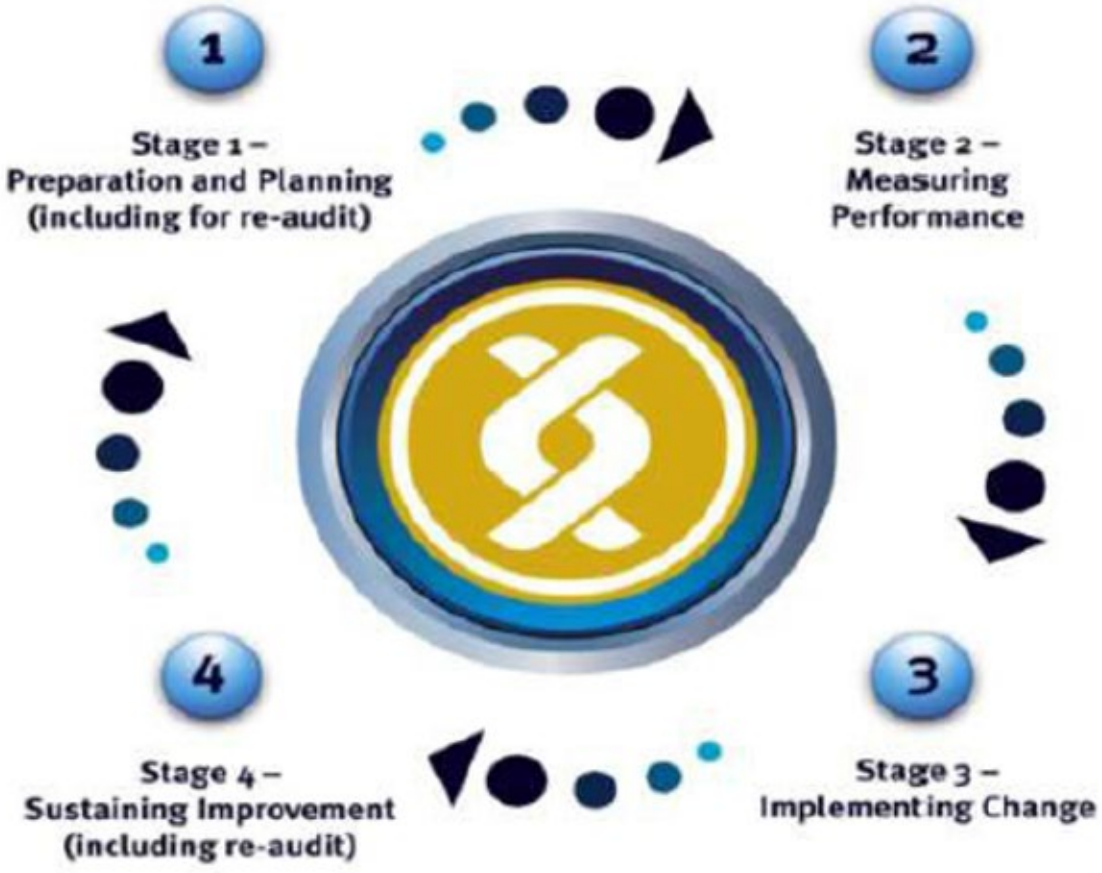
This model will be used to improve elements in each of the areas that are part of the QA/QI program including clinical indicators.

VII. ACTIVITIES THAT SUPPORT THE QUALITY IMPROVEMENT INFRASTRUCTURE

Clinical and Non-Clinical Audits

A Clinical Audit is one of many activities focused on improving patient care. It is a quality improvement process that seeks to improve patient care and outcomes through systematic review of care against explicit criteria and the implementation of change. Aspects of the structure, processes, and outcomes of care are selected and systematically evaluated against explicit criteria. Where indicated, changes are implemented at an individual, team, or service level and further monitoring is used to confirm improvement.

AUDIT CYCLE



Types of Audits

Outcome Audit queries the result of the care delivered. This type of audit is used to assess if patients get the appropriate outcome e.g., blood pressure control of diabetic patients.

Process Audit queries the care that was delivered. This audit refers to decisions and actions taken e.g., do patients get the right treatment at the right time.

Structure Audit queries how care is delivered. This audit looks at items required for clinical practice e.g., equipment, materials.

Selecting a Topic

The criteria for choosing a topic which encompasses as many of the following as possible:

- It is a priority
- It is of concern to service users and has potential to improve service user outcomes
- It is of clinical concern e.g., an acknowledged variation in clinical practice, high risk procedure
- It is financially important e.g., very common, very expensive
- It is of local, national, funding, and/or regulatory importance
- It is practically viable e.g., can be measured and you will be able to implement change or effect the implementation of change
- There is new research evidence available

Roles and Responsibilities

The Quality Improvement/Risk Management Coordinator is responsible for the statutory duty of quality and takes overall responsibility for this strategy and policy. The coordinator ensures that systems are in place to facilitate the delivery of safe and effective patient care and for the effective prioritization of participation in federal, state, and local clinical audits.

The Clinical Audit Sub-Committee (a subgroup of the CQIPM Committee) is responsible for ensuring there are robust processes in place for the effective management of clinical audits that meet mandatory regulatory standards and provides independent assurance to the validity of the audit.

The Clinical Audit Team is responsible to undertake the work of the Clinical Audit Sub-Committee, including the development of the clinical audit annual plan in collaboration with service audit leads, monitoring delivery of service audit work plans, providing support and advice at team meetings (where required), and advise on developing agendas for the WCCHC Clinical Audit Meetings to encourage the effective dissemination of audit outcomes, recommendations, and process improvements.

Managers and Service Leads are responsible for ensuring that service development and delivery is underpinned by clinical audit findings and to ensure the timely completion of the clinical audits to WCCHC standards.

Clinical Audit Leads are responsible for coordinating audit activity within their service area and ensuring action plans are developed to address any identified deficiencies, changes implemented, and services re-audited as appropriate.

All Clinical Staff are responsible for ensuring they audit their own practice in accordance with their professional codes of conduct and conducting clinical audits in accordance with the CQIPM Plan.

Risk Management

The Office of the Chief Medical Officer has been tasked to lead risk management activities, but efforts are made in every service line. The Office of the CMO works with various clinicians to discuss actual, potential, and alleged risk management cases and potential system improvements to improve care at all medical sites. WCCHC risk management process stresses timely, constructive educational dialogues between involved parties in a continuous effort to improve the quality of patient care. WCCHC has malpractice insurance through the Federal Tort Claim Act (FTCA) and additional wraparound insurance through a private insurance carrier. WCCHC works closely with FTCA and our insurance carrier around potential malpractice issues.

Incident Reporting

WCCHC has a specific policy and procedure related to Critical Incident Reporting. An incident is defined as any occurrence at any site or department that has produced an actual, perceived, or potential injury, or any practice or product that could potentially cause an injury. According to the policy, the employee who witnessed or experienced the incident must immediately complete an Incident Reporting Form online. The Critical Incident Report captures the nature of the incident, date, time, findings of fact, timeframe, and other pertinent information related to the incident. All additional reports (police, pictures, etc.) can be attached and uploaded. The Critical Incident Report is directly sent to the Director of Compliance at the Health Department. The Director of Compliance reviews the incident and forwards it to the Quality Improvement and Risk Management Coordinator at the Community Health Center who will follow up with the investigating manager to complete the investigation and action steps taken to resolve the incident. The Coordinator shares the critical incident reports with the CEO immediately, and with the managers weekly, and the continuous quality improvement committee monthly. Trends are identified, discussed and rectified within the continuous quality improvement committee. A quarterly report of the critical incident reports is shared with the Quality Improvement Committee within the Governing Council.

Patient Satisfaction Survey

WCCHC's primary care medical sites participate in an ongoing patient satisfaction survey. A one-page survey may be given to all patients in person, or the patient can complete a survey electronically at the health center. Surveys are also completed electronically through a link or an iPad tool provided in the health center. The survey measures satisfaction with access to care and staff/provider interactions. Patient satisfaction results are compiled

and analyzed by the Quality Improvement/Risk Manager Coordinator The survey results are presented at CQI, and the Quality Improvement Committee. Areas for improvement based on response rates are addressed by the CQI Committee.

Privilege and Credentialing

The Governing Council is responsible for oversight of all Privileging and Credentialing activities. All Will County Community Health Center providers go through credentialing at the time of hire and are re-credentialed every two years. We follow all state, health plan and hospital regulations for credentialing. All medical providers must be either Board certified or Board eligible in their field of practice.

Will County Community Health Center is dedicated to assessing and verifying the credentials of all licensed, registered, or certified health care practitioners including employed, contracted, volunteer, and locum tenens practitioners. This assessment will be done at the time of hire and every two years thereafter, in accordance with HRSA guidelines and the Peer Review Policy. Investigation, review, and ongoing evaluation of providers skills, education, and experience can safeguard patients, improve quality of care, and minimize liability.

The purpose is to define the health center's standards for determining the level of training, experience, and competence required of its clinical staff: To define and delineate responsibilities of personnel authorized to recommend and approve credentials and privileges of clinical staff: To evaluate a practitioner's eligibility to provide clinical services at the health center and evaluate the provider's competency for specific clinical privileges: To avoid potential liability for negligent hiring or retention of a provider: and To avoid denial of payment or reimbursement for services for failure to credential providers in a timely manner.

WCCHC's policy is at the time of hire, all credentialing and verification will be completed before the individual provides patient care and every two years thereafter. The Chief Medical Officer conducts a phone interview with the practitioner prior to commencement of the credentialing and privileging process to ascertain minimum criteria are met. Once on-site interview is complete, the candidate receives a credentialing and privileging packet, and the process is set in motion. Each provider is responsible for assisting in and supporting successful credentialing and privileging.

Competency Assessment

All clinical staff will participate in a clinical skills assessment to ensure that basic clinical skills are being performed appropriately and give leadership the opportunity to address deficiencies. If clinical skills gaps are identified, a plan is developed to train and complete a repeat demonstration of each identified skill.

Peer Review

Peer Review promotes collegial confidential quality review of care rendered by WCCHC's Provider staff. To comply with the legal requirement of Peer Review, thereby providing immunity from liability and protecting quality review from legal discovery.

Policies and Procedures

Will County Community Health Center completes a thorough review and update of the organization's administrative Policies and Procedures, to ensure consistency with Health Resource and Service Administration (HRSA) and other applicable requirements. This process is ongoing. Currently, policies and procedures are approved by the Chief Medical Officer, Chief Executive Officer, and Director of Operations as appropriate.

Patient Grievance Procedures

WCCHC has a Patient Grievance policy and procedure that describes how patients may file formal grievances. According to the policy, the staff person who learns of the complaint/grievance has the patient complete a complaint/grievance form. It is forwarded to the appropriate Supervisor or Manager. The Supervisor or Quality Improvement and Risk Management Coordinator has thirty days to investigate and/or resolve the grievance, communicating with the patient if appropriate, and informing them of the resolution. A grievance log is compiled and sent to the Chief Medical Officer and Quality Improvement/Risk Manager Coordinator. A summary of trends related to patient grievances is reviewed by the Quality Improvement Committee of the Governing Council in summary form on an annual basis.

VIII. Confidentiality of Patient Records

WCCHC policy on Confidentiality of Medical Records states that medical records are protected under both Illinois and federal law. It is the policy of WCCHC to protect patient health information in accordance with Federal and State privacy and security regulations. All information shall be confidential and shall be disclosed only to authorized persons in accordance with Illinois and federal law. All charts must be kept in locked file cabinets or a locked medical records room. Patient's family and friends will not be informed of the medical visit or whether a medical chart exists unless the patient agrees in writing. Any patient requests to have the medical record transferred, copied, or inspected must have a written request. A family member or friend may deliver the written request, but they should be informed that a 'contact' number for the patient or a call from the patient is needed to verify the request prior to releasing medical records. Only WCCHC staff involved in caring for the patient will have access to the medical record. Under Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule, all possible measures within reason to protect against 'accidental disclosures' should be implemented. All clinic staff working with medical records will periodically receive training on confidentiality and sign a Confidentiality Statement. All WCCHC employees sign confidentiality statements.

IX. Review and Revision to the CQIPM Plan

This CQIPM Plan is intended to be flexible and readily adaptable to changes in current initiatives, regulatory requirements and in the healthcare system as a whole. The CQI Plan will be reviewed annually by the CMO, CEO, DO and Quality Improvement/Risk Manager Coordinator and CQI Committee, to assess the viability of the plan and the inclusion of all appropriate WCCHC QI and QA activities. The CQI Plan will be revised as experience demonstrates that a certain approach is not effective or suggests a better alternative. WCCHC CQI Committee will have the authority to revise or amend the plan with the approval of the Quality Improvement Committee of the Governing Council, and the Chief Executive Officer.

X. Key Initiatives for 2023 - 2027

WCCHC quality improvement program will focus on the following key developments:

Priority UDS Clinical Measures:

Clinical effectiveness measures the disease specific and general health results of provider (individual and organizational) diagnoses, treatments, procedures, and patient education. Quality-related performance measures that place emphasis on health outcomes and demonstrate the value of care delivered by the health center are selected to provide a balanced and comprehensive representation of health center services, clinically prevalent conditions among underserved communities, and the population across life cycles.

The Clinical performance measures are performance improvement tools that provide a summary of progress towards the goals identified in the most recently approved Service Area Competition (SAC) / Budget Period Renewal (BPR) submissions. Performance measures are defined and reported in the UDS (Uniform Data System) report.

Performance Indicators FY23 – 27 Target Goals

- **Immunizations:** Percentage of children 2 years of age who had four diphtheria, tetanus and acellular pertussis (DTaP); three polio (IPV), one measles, mumps and rubella (MMR); three H influenza type B (Hiba); three Hepatitis B (Hep B); one chicken pox (VZV); four pneumococcal conjugates (PCV); one Hepatitis A (Hep A); two or three rotaviruses (RV); and two influenza (flu) vaccines by their second birthday.

Goal: 40% (HRSA Goal)

- **Diabetes:** Percentage of patients 18–75 years of age with diabetes who had hemoglobin A1c (HbA1c) greater than 9.0 percent during the measurement period.

  Goal: 34% (Poor Control; HRSA Goal)

- **Hypertension:** Percentage of patients 18-85 years of age who had a diagnosis of hypertension (HTN) and whose blood pressure (BP) was adequately controlled (less than 140/90 mmHg) during the measurement period

  Goal: 67% (HRSA Goal)

- **Prenatal Health:** Pregnant women will receive prenatal care in the first trimester either at the health center or with another provider. Initiation of care means the first visit with a clinical provider (MD or NP) where the initial physical exam was done and does not include a visit at which pregnancy was diagnosed or one where initial test were done, or vitamins were prescribed.

  Goal: 80% (HRSA Goal)

- **Cervical Cancer:** Female patients 21-64 years of age as of measurement year who were seen for a medical encounter at least once during the measurement year and were first seen by the grantee before their 65th birthday will receive one or more Pap tests during the measurement year or during the two years prior to the measurement year.

  Goal: 65% (HRSA Goal)

- **Weight Assessment and Counseling for Children and Adolescents:** Child and adolescent patients ages 3 to 17 years as of the measurement year, who have been seen in the clinic at least once during the measurement year will have Body Mass Index (BMI) Percentile documentation, counseling for nutrition, and counseling for physical activity.

  Goal: 65% (HRSA Goal)

- **Adult Weight Screening and Follow Up:** Patients aged 18 years or older who have been seen in the clinic at least once will have their Body Mass Index (BMI) calculated at the last visit or within the last six months and, if they were overweight or underweight, will have a follow-up plan documented.

  Goal: 80% (HRSA Goal)

- **Tobacco Use Screening and Cessation Intervention:** Patients aged 18 years and older with 2 or more medical visits (ever, although at least one must be during measurement year) will be assessed for tobacco use at least once within 24 months of their last visit in the measurement year and if identified as tobacco user, will receive cessation counseling and/or pharmacotherapy

  Goal: 85% (HRSA Goal)

- **Coronary Artery Disease (CAD) and Lipid Lowering Therapy:** Patients aged 18 years and older with a diagnosis of CAD or who have had cardiac surgery (with at least one medical visit during the

- reporting period or two medical visits ever) will be prescribed or will take a lipid-lowering therapy if not contraindicated (based on current ACC/AHA guidelines).

  Goal: 81% (HRSA Goal)

- **Ischemic Vascular Disease (VID) and Aspirin or Other Anti-thrombotic Therapy:** Patients 18 years of age and older (with at least one visit during the reporting period) who were discharged alive for acute myocardial infraction (AMI), coronary artery bypass graft (CABG) or percutaneous transluminal coronary angioplasty (PTCA) (during January 1 to November 1 of the year prior to the measurement year), or who had a diagnosis of Ischemic Vascular Disease (IVD) during the current or prior year will have documentation of use of aspirin or another antithrombotic.

  Goal: 70% (HRSA Goal)

- **Colorectal Cancer Screening:** Adults aged 51 to 75 years who had at least one medical visit during the reporting period will have appropriate screening for colorectal cancer (includes colonoscopy ≤ 10 years, flexible sigmoidoscopy ≤ 5 years, annual fecal occult blood test (FOBT), Fecal immunochemical test (FIT)-deoxyribonucleic acid (DNA) ≤ 3years, Computerized tomography (CT) colonography ≤ 5 years)

  Goal: 31% (HRSA Goal)

- **HIV Linkage to care:** Patients whose first ever HIV diagnosis was made by health center staff during specified period of the prior year and the measurement year will be seen for follow-up treatment (medical visit with health center provider or visit with a referral source who initiates treatment within 90 days of that first ever diagnosis).

  Goal 85% (HRSA Goal)

- **Behavioral Health (Depression Screening):** Patients aged 12 years or older will have a result recorded from depression screening using a validated structured screening tool document within the last 12 months and a follow-up plan is documented.

  Goal: 97% (HRSA Goal)

- **Oral Health (Sealants to First Molars)** Dental patients ages 6-9, at moderate to high risk for caries will receive a sealant on a first permanent molar during the reporting period.

  Goal: 97% (HRSA Goal)

- **Low Birth Weight:** Decrease the percentage of pediatric patients born to health center patients with a birthweight of below normal (less than 2500 grams*)* to 7% or less.

  Goal: 7% (Inverse Measure; HRSA Goal)

- **HIV Screening Measure**: Patients aged 15–65 on January 1 with an outpatient medical visit. Who have had a recorded HIV test on or after their 15th birthday and before their 66th birthday?

  Goal 60% (HRSA Goal)

- **Breast Cancer Screening**: Women aged 51–73 on January 1 with a medical visit. Women with one or more mammograms during the 27 months prior to the end of the measurement period.

  Goal 25% (HRSA Goal)

- **Depression Remission at Twelve Months Measure**: Patients aged 12 and older, who received a diagnosis of major depression or dysthymia with a Patient Health Questionnaire, PHQ-9 or PHQ-9 modified for teens (PHQ-9M) score greater than 9 during the index event and at least one medical visit during the measurement period. Who at 12 months (+/-60 days) had a PHQ-9 or PHQ-9M of 4 or less?

  Goal 20% (HRSA Goal)

- **Diabetes Eye Exam**

  Goal 50% (HRSA Goal)

- **Closing Referral Loop**

  Goal 50% (HRSA Goal)

- **Documentation of Current Medications in the Medical Record**

  Goal 50% (HRSA Goal)

- **Chlamydia Screening for Women**

  Goal 50% (HRSA Goal)

Illinois Ryan White Program

Funded agencies are required to develop and adhere to a comprehensive quality management plan assessing the adequacy, appropriateness, and effectiveness of services. WCCHC through an analysis of quarterly reporting submissions, satisfaction survey analysis, site visits and audit of case files, fiscal reports and other administrative/ programmatic frameworks will submit its current quality management plan to the Aids Foundation of Chicago and a report of activities aligned with the plan.

Performance improvement for the 2026 year will focus on key indicators for medical case management services to include:

- Four face-to-face visits per client during the review year (one documented face-to-face visit every three months).
- Two case conferences per client during the review year (one case conference is documented every six months).
- Three documented client contacts during each quarter (every three months) of the review year.

Family Planning

The Grantee must provide medical services, either directly or through referral, in compliance with 77III. Admin. Code 641 to students who have obtained written parental consent or are otherwise allowed by law to give their own consent to receive health center services and who are enrolled in designated schools. The Grantee must also institute corrective action approved by the Department within twenty (20) days of notification by the Department of noncompliance.

Performance Measures and Standards:

Funded grantees are required to ensure performance reports are submitted quarterly. The grantee must also ensure the grant objectives and accomplishments are compared, quantifying accomplishments, computing the cost, program trends and analysis are required, reasons why goals were not met and a narrative and why objectives were not achieved.

Other information requested by the Department includes:

1) Annual patient demographic and encounter data via the format required and outlined by the Department;
2) Outreach Report detailing activities to reach client visits/goals. The report will include the date of activity, a brief description, and the number of attendees;
3) Third party Biling report; and
4) Complete operating costs (budget) of the center via the format required and outlined by the Department.

Staff Development:

Training and Onboarding: A new hire's onboarding experience should be unique, exciting, and engaging. Since it starts well before Day 1 and continues far past the first week on the job, the WCCHC onboarding process must be thorough. The Onboarding Checklist details a list of agency and department information and documents of the skills or tasks required for each employee’s scope of practice.

Supporting employee development is a critical priority in WCCHC. Developing a highly skilled workforce ensures that employees are trained and ready to help achieve the organization's mission and strategic plan. Just as importantly, it helps to drive employee engagement and retention.

This process begins by diagnosing the development needs of each staff member to identify appropriate learning activities. These learning activities occur monthly and are monitored by the department supervisor/manager. Also provided, is the annual skills day to give staff the opportunity to demonstrate skills and show appropriate techniques and processes from the duties assigned within their scope of practice. Each employee will complete a return demonstration, offering their precision in skill, technique, and process. As the improvement opportunities are realized, a remediation plan is created for each employee's individualized career development plans. Then we take steps to ensure employees and the organization benefit from the clinical audit's development opportunities.

Career development plans are an essential step in this process. When you help shape employees' careers for the future, employees become more dedicated to WCCHC, more engaged, and contributors to business success. Additionally, employees who are on a career development path develop positive feelings about their brand and WCCHC, which helps with future recruitment.

School Health Center

Objectives:

1) Medical Services/ Treatment - Improve the health of Brooks students and their siblings and the Bolingbrook community through increased access to care including necessary treatment or referrals, promotion of healthy behaviors, and early identification of child and adolescent risk factors.
2) Reproductive Health - Improve reproductive health and provide Resources
3) Immunizations - improve access to immunizations
4) Mental and Behavioral Health - Improve access to behavioral health resources and care.
5) Emerging Health Issues - Identify and respond to emerging health issues.
6) SDOH - Improve health equity and address social determinants of health

QUALITY IMPROVEMENT COMMITTEE CHARTER

PURPOSE

The Quality Improvement Committee (the “Staff Quality Committee”) provides assistance to the Governing Council of Will County Community Health Center in its oversight of organizational quality and safety of the Health Center’s services. It is the Committee’s responsibility to carry out the activities described in the agency’s CQIPM Plan, to actively monitor quality management activity, and to report on this activity to the Governing Board’s Quality Improvement Committee.

MEMBERS

The Staff Quality Committee members shall consist of a broad representation of the front-line staff members who do not have leadership or management responsibility, or are supervisors, and can also include clinical providers. The members of the Committee are appointed by the Quality Improvement and Risk Management Coordinator and serve one or more one-year terms.

The Chief Medical Officer will serve as the Committee Chairperson, and the Quality Improvement and Risk Management Coordinator will serve as the facilitator co-chair.

DELEGATION

The Committee may, at its discretion, form and delegate authority to sub-committees, including a single member, when appropriate and consistent with Will County Community Health Center policies. Any actions taken by a sub-committee will be reported to the full Committee at its next meeting.