



Hidalgo Medical Services Quality Improvement Policies and Procedures

**Complete Package was
Revised & Reviewed October 24, 2006**

Signed:

Mike Martin

HMS Board Chair

Date: 12/26/06

***Revisions or additions after the above date
will be reflected on the individual policies***

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Policy: # QI-010

Date Effective: 10/24/06

Revision Date: _____

Department: Quality Improvement

Title:

WHAT IS QUALITY IMPROVEMENT

Purpose: To define Quality Improvement as it applies to Hidalgo Medical Services and how it interacts with the various departments within HMS.

Policy: Hidalgo Medical Services is committed to continually developing its services to their full potential, increasing customer satisfaction, reducing costs, and eliminating errors. The Quality Improvement process at HMS will focus on increasing effectiveness and efficiency through a carefully planned and structured system to monitor, study, and improve all HMS systems, relying on quantitative measurement tools, pilot processes, and/or reengineering current processes.

The QI/A committee will also use information from various sources on deciding what to improve:

- Patient Satisfactory Surveys
- Compliance reports: PRP[Performance Review Protocol] or other regulatory requirements, results; licensing and certification reports; insurance reviews; audit reports; Medicare requirements; fire and safety standards etc.
- Formal improvement processes: chart reviews; chart audits; peer reviews; accreditation standard and mock surveys; UDS [Uniform Data System] report, etc.
- Contractual obligations—grant requirements, contract scopes of works
- Financial & Patient information/Utilization reports; accounts receivable, etc.
- Federal & State Regulations
- Standards of Care for Ambulatory & Behavioral Health from Joint Commission

Procedure: # QI-010.1

CORE FUNCTIONS

The core functions of the QI plan comes from Hidalgo Medical Services' compliance with State and Federal Regulatory agencies; Hidalgo Medical Services' policies & procedures and strategic plan; and all the scopes of work from contract grants that Hidalgo Medical Services is involved with.

- Primary Care Effectiveness Review (PCER) and Performance Reviews: peer reviews, mock codes, compliance with requirements of policies and procedures [includes medical records, financial, etc.], development and review of policies and procedures, and protocols for patient care.
- Federal: compliance with regulations [includes HIPAA (Health Insurance Portability and Accountability Act), OSHA (Occupational Safety & Health Administration), CLIA (Clinic Laboratory Improvement Advisory), Medicare]
- State: compliance with regulations [includes credentialing, licensures and RPHCA (Rural Primary Health Care Association) expectations]
- Grants & Contracts: compliance with scope of work, evaluations
- Hidalgo Medical Services Strategic Plan: compliance with Board goals, policies and procedures
- Standards of Care for Ambulatory and Behavioral Health

All of the above need to be monitored, studied and reviewed for compliance with set standards and established benchmarks.

Hidalgo Medical Services' priorities can be ever changing due to expansion, changing policies, changing regulations and development of new goals. Making sure HMS is on track and in compliance with the above requirements is the priority of the QI Plan.

Procedure: # QI-010.2

QI COMMITTEE STRUCTURE

A QI Committee is needed to review results of the various studies and reviews. It is also vital to help educate staff on the importance of QI processes and how QI works. The committee is to be represented by all departments and sites within the HMS organization. This would include:

Front office
Billing
Finance
Administration
Family Support
Clinical
Provider
Dental
Behavioral Health
Medical Records
Human Resources
Safety
Risk Management

At least one representative per department should be an active member. At least one representative from each site should also serve on the committee.

An active member's duties include:

- Reviewing departmental policies
- Performing studies [Deciding on what problem area is {this process can be done with aid of PDSA cycle}, what the indicators are, preparing study, summarizing results, presenting to committee]
- Returning to department to relay results and recommendations from committee
- Serve as a resource for departmental or site improvement PDSA teams and processes. Guide the PDSA through appropriate cycles, ensuring timeframes are maintained.
- Review other studies and policies

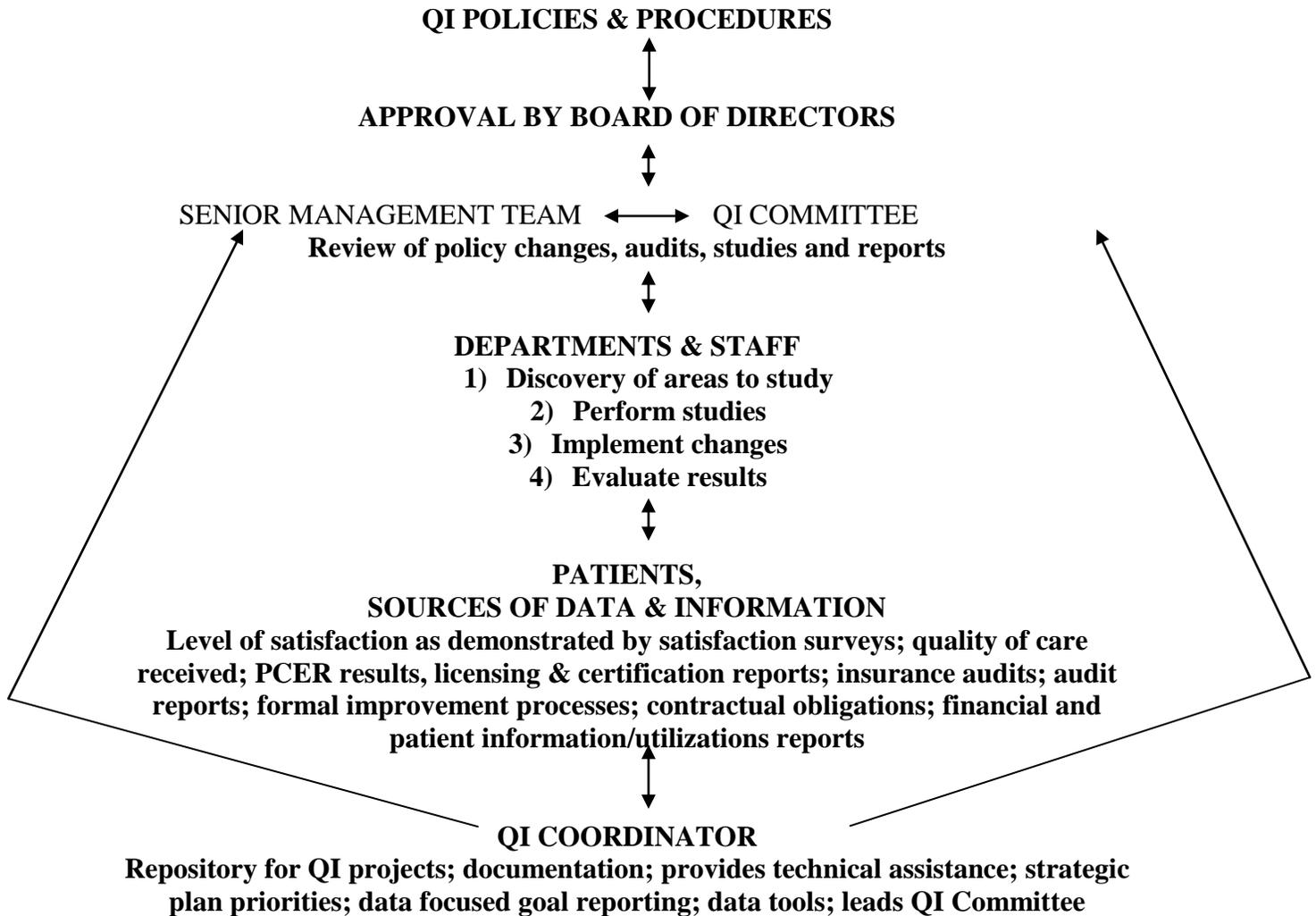
- Make recommendations; assure that departmental meetings take place and records of these meetings reflect progress are documented
- Attend the monthly QI meetings and be willing to volunteer for working subcommittees [occasional committees needed to complete a specific task for QI].

In the event that the regular member cannot attend, a designated employee from that department/site may attend. This person will have been briefed on what is expected of him/her by the regular member.

Procedure: # QI-010.3

QI ORGANIZATION FLOW CHART

The responsibility of the QI plan is as follows, with the ultimate responsibility for the leadership of HMS's QI activities belonging to the Quality Improvement Coordinator, QI Committee and HMS Board of Directors:



Procedure: # QI-010.4

QI IMPROVEMENT PROCESSES

While many quality improvement methods can be used to improve the process performance, the primary quality improvement methods used at HMS will be the FOCUS and PDSA models. The QI process begins with FOCUS:

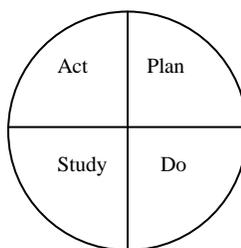
- F:** Find a process to improve
- O:** Organize a team
- C:** Clarify knowledge of the process
- U:** Understand variation in process
- S:** Select an improvement

(See Attachment A for FOCUS tool)

followed by the PDSA (Plan, Do, Study, Act) cycle:

Act: If it worked, standardize the change. If it didn't, try something else. Continue the cycle.

Study: Determine whether the plan worked. Study the results



Plan: Study the situation, determine what needs to be done, develop a plan and measurement process for what needs to be done.

Do: Implement the plan.

PLAN

- Study the improvement opportunity
 - Identify priorities through discussion to clarify issues, problems processes
 - Establish a method and identify resources for data collection
 - Determine a measurement tool
 - Determine a target or benchmark
 - Assign team role in collecting and collating data
 - Include feedback from sources other than ongoing monitoring, such as data from pt/staff surveys, complaints, suggestions, UDA report

DO

- Perform the task of data collection from either chart reviews, process results

- Keep within a time frame to collect the data
- Enter the data on a collection tool for measurement

STUDY

- Collate the data
- Compare to standards or benchmarks
- Review the results

ACT

- Implement changes to improve the results or processes
- If results are on the target, or meet the benchmark, standardize the process to ensure the target/benchmark is continuously being met
- Continue to study

(See Attachment B for PDSA tool)

Procedure: # QI-010.5

QI METHODOLOGY

Statistical Method

The causes of problems because of misunderstood facts are usually more difficult to discover and often more deep-rooted. Wrong judgments arise when facts are not correctly identified and knowledge is based on inaccurate or mistaken information.

Language is inherently imprecise, and it is extremely difficult to communicate information accurately with words alone. Formulas, drawings and numerical data are used to compensate for the imprecision of language, and as a way of expressing facts by means of numerical data, statistical method is part of this.

The statistical method is based on expressing phenomena in:

- Numerical terms
- Classifying them
- Stratifying them
- Observing their frequency of occurrence

This enables us to identify a situation precisely and communicate information about accurately.

The statistical method:

- Gives more importance to concrete facts than abstract concepts
- Expresses phenomena in terms of numerical data linked to specific observational procedures rather than in terms of sensory or conceptual language
- Accepts that observations are always performed only on part of a situation and that the results contain errors and fluctuations
- When a definite tendency is observed among large numbers of observations, it accepts this as reliable information for the time being

Statistical methods include:

- Spread sheets
- Tables
- Flow charts
- Pareto charts
- Cause and effect diagrams
- Scatter diagrams
- Control charts

Procedure: # QI-010.6

QI ROUTINE AUDITS

Quarterly audits will include the following areas:

Medical Records: 25 charts will be reviewed each quarter by the staff checking accuracy of the following items:

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

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

(See Attachment C)

Nursing chart review: 25 charts are reviewed each quarter with a focus on the following areas

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

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

(See Attachment D)

HIPAA Compliance review:

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

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

(See Attachment E)

Procedure: # QI-010.7 to 010.12

Date Effective: 10/24/06

Revision Date:

Department: Quality Improvement

Approved By:

PROVIDER PEER REVIEW

Purpose:

HMS is committed to quality health care; including medical , dental and mental health disciplines. Providers with similar training and experience will participate in peer review on a quarterly basis. Peer review is an evaluation, by practicing providers, of the quality and efficiency of care activities by other practicing providers. Peer review may be performed on an individual case basis or on general areas of focus. HMS established peer review shall be an opportunity for quality improvement and performed in a manner which encourages professional education opportunities and interactions.

Procedure: #QI-010.7

MEDICAL PROVIDER PEER REVIEW

- A. Providers will be oriented to peer review process.
 - 1. The Medical Director or designee will present peer review process at a provider meeting annually.
 - 2. New providers will be oriented to peer review process within one month of their start date.
- B. The Medical Director or designee determines cases and topics for peer review.
 - 1. Cases may be selected at random (see Appendix A for examples).
 - 2. Cases that result in seriously undesirable patient outcome will be reviewed.
 - 3. Cases may be selected by being referred to the Medical Director.
 - 4. Focus topics may be suggested to the Medical Director for consideration for peer review.

5. Focus topics may be submitted by the Quality Improvement Coordinator to the Medical Director for consideration.
 6. Focus topics may be submitted to the Medical Director by members of senior management for consideration for peer review.
 7. Any provider may request topics for peer review and submit them to the Medical Director.
 8. In the event a case, in which the medical director is the provider, is referred or otherwise identified for review, the next most senior physician shall review the case for appropriateness for peer review process.
- C. Peer review will be on the agenda of a provider meeting quarterly.
1. The Medical Director or his designee will notify the Medical Director's assistant to include peer review on the provider meeting agenda quarterly.
 2. The Medical Director will identify specific cases for review or the topic of focus to the assistant so she may provide applicable materials for the peer review process.
- D. Peer review is performed.
1. In the case of individual case peer review the involved provider(s) is notified a minimum of three business days prior to the process so they may review the case in advance.
 2. Applicable record copies, minus patient identifying notations, are distributed three days prior to the provider meeting for review.
 3. The case is discussed in a professional, non-adversarial manner.
 4. Educational opportunities, policy revision, or other applicable improvements are identified.
 5. Focus topics may be performed individually or as a group of providers as determined by the Medical Director.

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

Important:

Peer review is an educational process for all providers. If one of your cases is selected or referred for review, do not despair. In all likelihood every provider will have a case reviewed at some point. Remember, also, well handled cases are as likely to be reviewed as cases that may have had better assessment or treatment.

Peer review is an “open” process for providers. The cases must be discussed openly and professionally. Referring a case for review is not an opportunity to anonymously criticize another provider’s care.

Most often, bad patient outcomes are not a result of incorrect or inadequate care.

Procedure: #OI-010.8

MEDICAL CHART PEER REVIEW

A. Chart Review Methodology

1. Providers will review minimum of 28 medical records each quarter, checking the following areas:
 - a. Was the chart entry legible?
 - b. Was the assessment/diagnosis appropriate?
 - c. Was the physical examination appropriate for the problem or diagnosis?
 - d. Were appropriate diagnostic labs or tests ordered?
 - e. Were appropriate medication, dosage, and duration used and documented properly on medication list?
2. Medical Director or designee will ask Medical Records Clerk or appropriate personnel to pull the following medical records for review each quarter:
 - a. 5 charts from the Med Square Pediatric providers.
 - b. 5 charts from Med Square Family Practice providers.
 - c. 5 charts from Lordsburg Family Practice providers.
 - d. 4 charts from Cobre Family Practice providers.
 - e. 3 each from Cliff, Mimbres, and Silver High School.
 - f. At least one of the charts pulled from all Family Practice clinics should be for a patient under the age of 18 for pediatricians to review.
3. Medical records clerk or staff that pulls charts will copy the following items from the charts and forward copies to the Medical Director's office;
 - a. Last 3 physician's notes
 - b. Problem list
 - c. Medication list
 - d. Date relevant labs and x-rays.
4. Medical Director or designee will forward copies to each provider at least three days in advance of the provider meeting where they are to be reviewed. A chart audit sheet will be attached to the copies (see Appendix B)

Appendix A

Examples of cases to consider for Medical peer review:

- patient dies unexpectedly within two days of out-pt. visit

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

Examples of focus topics for peer review:

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

Appendix B

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

Procedure: #OI-010.9

DENTAL PROVIDER PEER REVIEW

- A. Dental providers will be oriented to peer review process.
 - 1. The Dental Director and his designee will present peer review process at a provider meeting annually.
 - 2. New providers will be oriented to peer review process within one month of their start date.

- B. Peer review will be on the agenda of a provider meeting quarterly.
 - 1. The Dental Director or designee will notify the Medical Director's assistant to include peer review on the provider meeting agenda quarterly.
 - 2. The Dental Director will identify specific cases for review or the topic of focus to the assistant so she may provide applicable materials for the peer review process.

- C. The Dental Director determines cases and topics for peer review.
 - 1. Cases may be selected at random.
 - 2. Cases that result in seriously undesirable patient outcome will be reviewed.
 - 3. Cases may be selected by being referred to the Dental Director.
 - 4. Focus topics may be suggested to the Dental Director for consideration for peer review.
 - 5. Focus topics may be submitted by the Quality Improvement Coordinator to the Dental Director for consideration.
 - 6. Focus topics may be submitted to the Dental Director by members of senior management for consideration for peer review.
 - 7. Any provider may request topics for peer review and submit them to the Dental Director.
 - 8. In the event a case, in which the dental director is the provider, is referred or otherwise identified for review, the next most senior dentist shall review the case for appropriateness for peer review process.

- D. Peer review is performed.
1. In the case of individual case peer review the involved provider(s) is notified a minimum of three business days prior to the process so they may review the case in advance.
 2. Applicable record copies, minus patient identifying notations, are distributed three days prior to the provider meeting for review.
 3. The case is discussed in a professional, non-adversarial manner.
 4. Educational opportunities, policy revision, or other applicable improvements are identified.
 5. Focus topics may be performed individually or as a group of providers as determined by the Dental Director.
 6. Focus topic peer review results will result in identifying educational opportunities, policy revision, or other applicable improvements.
- E. Peer review will be followed up as determined appropriate by the Dental Director.
1. The Dental Director may randomly select cases for review.
 2. The Dental Director may select specific cases for review.
 3. The Dental Director may elect to repeat focus topic peer reviews for comparison.
- F. Confidentiality of peer review process shall be maintained.
1. Peer reviews shall not be discussed outside of the process.
 2. Patient identifying notations (i.e. name, social security number, etc.) shall be obliterated on all copies.
 3. All copies of records shall be immediately returned to the Dental Director's assistant.
 4. The assistant shall destroy the copies.
 5. Peer review documentation shall not be entered into files which are legally discoverable.
 6. Focus topic peer review items may be saved or directed to HMS staff as required by regulatory agencies or as determined appropriate by the Dental Director.

Procedure: #QI-010.10

DENTAL CHART PEER REVIEW

A. Chart Review Methodology

1. Providers will review minimum of 20 medical records each quarter, checking the following areas:
 - e. Was the chart entry legible?
 - f. Did entry include date of service, medial history, and provider's signature?
 - g. Did new exams & emergencies include the following:
 - i. Subjective – what the patient says.
 - ii. Objective – what the provider sees.
 - iii. Assessment – differential diagnosis.
 - iv. Procedure – what was done & further treatment recommended.
 - h. Did procedure appointments include: the following:
 - i. Description of service.
 - ii. Materials used.
 - iii. Tooth number, quadrant, or arch worked on.
 - i. Check to see if all visits have been appropriately billed.
4. Dental Director or designee will ask Medical Records Clerk or appropriate personnel to pull the following medial records for review each quarter:
 - a. 3 charts from each the Med Square Dental providers.
 - b. 3 charts from Lordsburg Dental providers.
5. Dental records clerk or staff that pulls charts will copy the following items from the charts and forward copies to the Medical Director's office;
 - a. Medical history
 - b. treatment planning page
 - c. write up page(notes).
6. Dental Director or designee will forward copies to each provider at least three days in advance of the provider meeting where they are to be reviewed. A chart audit sheet will be attached to the copies (see Appendix B)

Important:

Peer review is an educational process for all providers. If one of your cases is selected or referred for review, do not despair. In all likelihood every provider will have a case reviewed at some point. Remember, also, well handled cases are as likely to be reviewed as cases that may have had better assessment or treatment.

Peer review is an “open” process for providers. The cases must be discussed openly and professionally. Referring a case for review is not an opportunity to anonymously criticize another provider's care.

Most often, bad patient outcomes are not a result of incorrect or inadequate care.

Appendix C

Examples of cases to consider for Dental peer review:

- Patient goes to hospital after a dental procedure
- Missed diagnosis
- Interesting and complicated cases
- Any case a staff dentist wants to discuss and review with other staff dentist
- particularly interesting cases
- exceptionally well handled cases

Examples of focus topics for peer review:

- Treatment of diabetic and medically compromised patients

Appendix D

Dental Providers' Chart Peer Review

Clinic site:	Patient initials or chart number					Comments
Date:						
Reviewer:	Y or N					
Were chart entries legible?						
Did entry include date of service, medical history, and provider signature?						
Did New Exams & emergency pt. include:						
Subjective (what pt says)						
Objective (what provider sees)						
Assessment (differential diagnosis)						
Procedure (what was done & further treatment recommended)						
Did procedure appointments include:						
Description of service						
Materials used						
Type & amt of anesthetic used						
Tooth #, quadrant or arch worked on						
Were chart entries legible?						
Did entry include date of service, medical history, and provider signature?						
Did New Exams & emergency pt. include:						
Subjective (what pt says)						
Objective (what provider sees)						
Assessment (differential diagnosis)						
Procedure (what was done & further treatment recommended)						
Did procedure appointments include:						
Description of service						
Materials used						
Type & amt of anesthetic used						
Tooth #, quadrant or arch worked on						

Procedure: #CLI-010.11

MENTAL HEALTH PROVIDER PEER REVIEW

- A. Providers will be oriented to peer review process.
 - 1. The Mental Health Coordinator or designee will present the peer review process to all Mental Health providers annually.
 - 2. New providers will be oriented to peer review process within one month of their start date.

- B. Peer review will be on the agenda of a Mental Health team meeting quarterly.
 - 1. The Mental Health Coordinator or designee will include peer review on the team meeting agenda quarterly.
 - 2. The Mental Health Coordinator or designee will identify specific cases or the topic of focus and provide applicable materials for the peer review process.

- B. The Mental Health Coordinator determines cases and topics for peer review.
 - 1. Cases may be selected at random.
 - 2. Cases that result in seriously undesirable patient outcome will be reviewed.
 - 3. Cases may be selected by being referred to the Mental Health Coordinator.
 - 4. Focus topics may be suggested by any provider to the Mental Health Coordinator for consideration for peer review.
 - 5. Focus topics may be submitted by the Quality Improvement Coordinator to the Mental Health Coordinator for consideration.
 - 6. Focus topics may be submitted to the Mental Health Coordinator by members of senior management for consideration for peer review.
 - 7. In the event of a case in which the Mental Health Coordinator is the provider, being referred or otherwise identified for review, the next most senior mental health provider shall review the case for appropriateness for peer review process.

- C. Peer review is performed.
 - 1. In the case of individual case peer review the involved provider(s) is notified

a minimum of three business days prior to the process so they may review the case in advance.

2. Applicable record copies, minus patient identifying notations, are distributed three days prior to the mental health team meeting for review.
3. The case is discussed in a professional, non-adversarial manner.
4. Educational opportunities, policy revision, or other applicable improvements are identified.
5. Focus topics may be performed individually or as a group of providers as determined by the Mental Health Coordinator.
6. Focus topic peer review results will result in identifying educational opportunities, policy revision, or other applicable improvements.

D. Peer review will be followed up as determined appropriate by the Mental Health Coordinator.

1. The Mental Health Coordinator may randomly select cases for review.
2. The Mental Health Coordinator may select specific cases for review.
3. The Mental Health Coordinator may elect to repeat focus topic peer reviews for comparison.

E. Confidentiality of peer review process shall be maintained.

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

Important:

Peer review is an educational process for all providers. If one of your cases is selected or referred for review, do not despair. In all likelihood every provider will have a case reviewed at some point. Remember, also, well handled cases are as likely to be reviewed as cases that may have had better assessment or treatment.

Peer review is an “open” process for providers. The cases must be discussed openly and professionally. Referring a case for review is not an opportunity to anonymously criticize another provider’s care.

Most often, bad patient outcomes are not a result of incorrect or inadequate care.

Procedure: #QI-010.12

MENTAL HEALTH CHART PEER REVIEW

A. Chart Review Methodology

1

. Mental Health Coordinator or designee will forward copies to each provider at least three days in advance of the provider meeting where they are to be reviewed. A chart audit sheet will be attached to the copies (see Appendix F)

- a. Is legible documentation present for the following:
 - Is there a signed release of information?
 - Documentation relating to limits of confidentiality?
 - Signed agreement to treat?
 - Discharge summary?
 - Documentation of presenting problem?
 - DSM IV diagnosis
 - Treatment plan
 - b. Do progress notes include:
 - Does progress note relate logically to the assessment?
 - Does progress note relate logically to the diagnosis?
 - Does progress note relate logically to the treatment plan?
 - Does progress note express the client concern/problem?
 - Does progress note express the therapist's interventions?
 - Does progress note express the client's response to interventions?
2. Mental Health Coordinator or designee will ask Medical Records Clerk or appropriate personnel to pull the following medial records for review each quarter:
- a. 10 charts from the Lordsburg Mental Health providers.
 - b. 6 charts from Silver High School providers.
 - c. 3 charts from Lordsburg High School providers.
 - d. 3 charts from Cobre High School providers.

Appendix E

Examples of cases to consider for Mental Health peer review:

- patient commits or attempts suicide within one week of out-pt. visit
- patient is unexpectedly hospitalized for psychiatric reasons within two days of visit
- patient formally or forcefully complains mental health care was inadequate or incorrect
- patient is transported to hospital from clinic via ambulance
- serious diagnosis not identified
- particularly interesting cases
- exceptionally well handled cases

Examples of focus topics for peer review:

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

Appendix F

**HIDALGO MEDICAL SERVICES
PROVIDER CHART REVIEW
MENTAL HEALTH**

PROVIDER:	Patient initials or chart number		Total Audit Scoring			
DATE:			Actual:			
REVIEWER:			% Compliance:			
Y: enter if element present N: enter if element not present			REVIEWER COMMENTS	Actual score	Max. Possible	% Compliance
Signed release of information						
Documentation relating to limits of confidentiality						
Agreement to treat						
Discharge summary						
Presenting problem						
Relevant history						
Reason for treatment						
Mental status						
Current medications						
<i>DSM IV Diagnosis</i>						
Treatment plan						
Does the progress note related logically to the assessment?						
Does the progress note relate logically to the diagnosis?						
Does the progress note relate logically to the treatment plan?						
Does the progress note express the client concern/problem?						
Does the progress note express the therapist's interventions?						
Does the progress note express the client's response to interventions?						
Totals						

Procedure: # QI-010.13

QI MOCK CODES

Mock codes will be conducted two times per year by the providers in their respective clinics. The following items shall be measured:

Identification of code and announcement
Nursing response & initiation of CPR
Notification of EMS and Providers
Provider response & initiation of ACSL
Medical records retrieval and response
Pt. registration and availability for directions
Social Services response/notification of family
Admin. Staff response and crowd control
Identification of code status
Initiation of CPR
Placement of devices: IV, Airway, ECG leads
Recording of data
Procedures: Defibrillation, intubation, medication
Equipment: Lg bore IV, bag, mask, ET blade
Well supplied crash cart
Functioning Defibrillator

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

(See Attachment F)

Procedure: # QI-010.14

QI PATIENT SATISFACTION SURVEYS

Patient Satisfaction Surveys shall be conducted twice per year to measure the impact HMS is having on the clients served. The following areas will be surveyed and tallied:

Clinic	DOB (age)	Gender	Insurance
Sliding Fee Offered	Co-pay required	Access to care	Staff Courtesy
Questions Answered	Area of Service	Provider name	Wait time
Rate provider	Rate nurse	Rate staff	Quality of Care
Statement Accuracy/clarity	Access by Phone	Recommend Clinic?	

Fifty surveys will be collected from each clinic and forwarded to the QI coordinator for tabulation and analysis. Comparisons will be made between clinics and HMS system, with the results and analysis reported to the QI Committee for discussion and recommendation. Recommendations will be forwarded to the Senior Management Team through the QI Coordinator.

Survey results will be shared with the NM Primary Care Association for comparison with other clinics in the state. NMPCA reports and results will be shared with QI Committee, SMT, Board of Directors and HMS system.

(See Attachment G)

Procedure: # QI-010.15

**FOCUS EMPLOYEE RECOGNITION
(First On Customer Service)**

Purpose:

To recognize those employees who go “above and beyond” the requirements of their job by providing exceptional customer service.

Procedure:

Individuals will be submitted for system-wide recognition through the FOCUS employee system using the following guidelines (FOCUS employees may be nominated for going above and beyond in areas other than Customer Service and may be nominated by ANY HMS employee. Nominating criteria is listed below) :

- A. Open to all HMS employees with the following exceptions:
 1. Members of Senior Management are not eligible
 2. Employed with HMS less than 6 months are not eligible
 3. Current position within HMS less than 3 months are not eligible
 4. Employees with current or pending disciplinary action are not eligible
 5. Employee selected within the last 12 months are not eligible
 6. Staff may nominate more than one employee- one form per employee
 7. Staff may nominate any employee from any site within HMS
 8. Nomination swill be submitted on the FOCUS Employee nomination form. (*See attachment D*)

- B. Employees may be nominated for one or more of the following reasons:
 1. Quality Improvement
 2. Customer Service: one or more of the following categories.
 - a. Patient satisfaction
 - b. Family Member satisfaction
 - c. Staff satisfaction
 - d. Vendor/contractor satisfaction
 - e. Other outside customer satisfaction
 - f. Improvement/increase of revenue for HMS
 - g. Cost reduction for HMS
 - h. Enhancement of HMS Image in the Community

- C. To aid the committee in the selection process the person making the nomination should cite specific examples for the category/reason.

- D. All nominations are due into the Human Resources Department by the 1st day of the month. Human Resources will “blind” the nominations by removing information that may indentify nominee, then submit the nominations to the QI committee for selection. This method will allow the QI committee to concentrate on the action rather than the person or location and ensure objectivity in the selection process.

- E. All nominees will be recognized in the HMS newsletter and those that were submitted specifically for Customer Service will receive a CS Star (emblem) to attach to their ID badge.
- F. Employees selected as FOCUS employee will be publicly recognized in the newsletter and will receive a \$250.00 gift certificate, their name added to the FOCUS plaque, and a CS Star to attach to their ID badge.
- G. FOCUS Employee will be a monthly recognitions except in January, April, July, and October when the “Exceptional Performance” employees are recognized.

Procedure: # QI-010.16

SUPER STAR AWARD

Purpose:

This incentive program is designed to recognize and reward consistently superior job performance and superior quality of interpersonal interactions. Recipients will be HMS employees nominated by their coworkers or supervisors.

Procedure:

This incentive program will provide a bonus of \$250 to each of four HMS employees on a quarterly basis (for a total commitment of \$4,000 per year). Employees may nominate each other by submitting the nomination form that includes a short narrative describing the nominee’s actions considered to be deserving of recognition, according to guidelines described below.

A. Guidelines for Nomination

This incentive program is designed to reward excellence in job performance and good customer service. Excellent job performance is generally considered to be that which goes beyond normal expectations or proficiencies of the individual’s position. Customer service is not intended to be defined too closely, but is considered to be those actions, activities and attitudes that engender respectful, considerate and professional treatment of the individuals with whom one interacts during the course of the workday.

The guidelines for nomination are not intended to be overly restrictive but to encourage specificity in the nominations. Individuals who nominate should be ready to describe the qualities, skills, proficiencies and/or innovations that characterize the nominee’s job performance, or to describe specific occurrences that stand out as instances of exceptional consideration of others. The guidelines are as follows (“Consistency” is the key):

1. In describing an individual who consistently performs beyond expectations, the person making the nomination will give specific examples or describe areas in which the individual particularly excels.

Example: "We have been understaffed for the last three months due to a chronic illness in one of our staff. Ms. Smith has taken up extra duties to make sure everything gets done on time, and her positive attitude encourages others to work cheerfully, too."

2. In describing a specific interaction between the nominee and another individual, the person making the nomination will briefly describe the characteristics of the nominee's action that impressed you.

Example: "On Tuesday, March 15, I observed Mr. Rodriguez talking on the phone with what appeared to be a very difficult patient. He is always good with patients, but in this particular instance, I was really impressed by his professional, courteous conduct when it sure sounded like the other person was out of hand. He was able to resolve this situation to the patient's satisfaction, but no matter what, he never lost his cool."

3. In describing an employee's efforts to improve work processes, procedures or systems, briefly describe the employee's ideas and the outcome of the idea.

Example: "We moved the filing cabinet when Robin ~~Mr. X~~ pointed out that having it right next to the door was a problem because people occasionally run into the open drawer when they come around the corner and can't see that it's open."

B. Nomination Process

Any employee may nominate another employee. If, for any reason, an employee does not feel comfortable nominating another employee, that individual may approach his/her supervisor to nominate. All nominations should be routed through the supervisor to ensure the nomination criteria is consistent with the employee's stated goals and expectations. Supervisors are encouraged to nominate their employees when excellent job performance is observed. Nomination forms will be available on Public Folders. Recipients of these bonuses must be employees in good standing with HMS, and must not have any disciplinary actions pending. Therefore, Human Resources will receive nominations and verify that nominees meet the basic requirements. The nominations will be presented to the HMS QI committee anonymously, that is, HR will edit the nominations to remove specific identifiers of personal identity, gender and location. All nominations received during the previous quarter will be evaluated at the regularly scheduled QI meetings in March, June, September and December. The QI committee will review the nominations and select four by consensus. Recipients will be notified by their supervisors and awards announced in the next HMS newsletter the month following their selection.

Procedure: # QI-010.17

QI - PDSA INCENTIVE PLAN

Purpose:

To reward ideas that have an extraordinarily positive impact on HMS services or the ability to provide services.

Procedure:

HMS is committed to rewarding ideas that have an extraordinary positive impact on HMS services or the ability to provide services. It is critical that incentives be fair, based on the efforts of the team developing the plan or process, and proportionate to the impact they have on the organization. Therefore, incentives will be standardized based on the effort involved and its impact on the organization. QI teams will be made up of members of the QI committee and other staff members interested in working on a QI project. The following chart will be used in determining the level of the QI measure proposed and the subsequent incentive to be provided.

QI Incentive Analysis	Impact	
Effort	Low Impact/ Low Effort	High Impact/ Low Effort
	Low Impact/ High Effort	High Impact/ High Effort

Definitions:

Impact (on the patient or organization):

1. Financial in nature: The QI project demonstrably improved the financial status of the organization in order to better serve patients/clients.

2. Operational in nature: The QI project demonstrates that it improves operational systems and efficiency and/or patient satisfaction. It can also improve HMS' regulatory evaluations and related processes.
3. Clinical in nature: The QI project measures a baseline in health status and demonstrates a positive change in the health of HMS patients and/or community.
4. Productive in nature: QI is used to increase access to patients for any HMS service and can demonstrate an increase in productivity.

Effort (of the QI team):

1. The effort is low, consistent with existing expectations of staff, job descriptions, self-improvement based, minor adjustment in process or minor improvement in system, relatively low cost to implement, easy to spread or disseminate.
2. The effort is high, requires major change in systems-thinking, cost a lot, difficult to understand and implement, unique to a location or setting, takes a long time to implement (more than 6 months).

*Determination of incentives:

Incentives will be provided to members of the QI project team upon successful completion of a QI Committee approved project based on goals set, baseline measures, and goal attainment. To qualify, team members must participate in 2/3^{rds} of the QI team meetings. Incentives will be provided upon receipt of a final report, approved by the QI Committee that includes recommendations of changes in Policies and Procedures along with a process for implementing the change to be reviewed by the Board. The emphasis is on developing high impact changes that require little effort or expense. The following incentives are based on those criteria:

Level 1:	Low Impact/High Effort	\$ 50.00
Level 2:	Low impact/Low Effort	\$100.00
Level 3:	High Impact/High Effort	\$150.00
Level 4:	High Impact/Low Effort	\$250.00

*The QI team leader will be responsible for presenting to the QI Committee the formal report and incentive recommendation which will include:

1. Final results and analysis of data collected.
2. The QI Team's perspective on the Impact/Effort of the project, detailing their reasons.
3. Amount of incentive requested.
4. Success of project. Was the goal met and if not, why? Were barriers identified and eliminated? Was the plan or timetables modified due to unexpected results or improper assumption at the outset?
5. Team members eligible for incentive. (Sign-in sheets for all team meetings should accompany this.)
6. Policy or procedure changes for QI committee approval.
7. Plan for system-wide dissemination.
8. Plan of periodic follow-up.

Procedure: # QI-010.18

QA SDCA PLAN

Standardize, Do, Check, Act

Standardization: Defined as an activity of establishing with regard to actual or potential problems, provisions for common and repeated use, aimed at the achievement of the optimum degree of order in a given context. Standards should be used to not only establish order but also to attain quality and work efficiency. A standard is the end of one improvement and the start of the next improvement.

If work is being done according to a standard, trouble can occur when the standard is not adequate. Improvement takes place and performance levels rise when standards are revised as a result of failures.

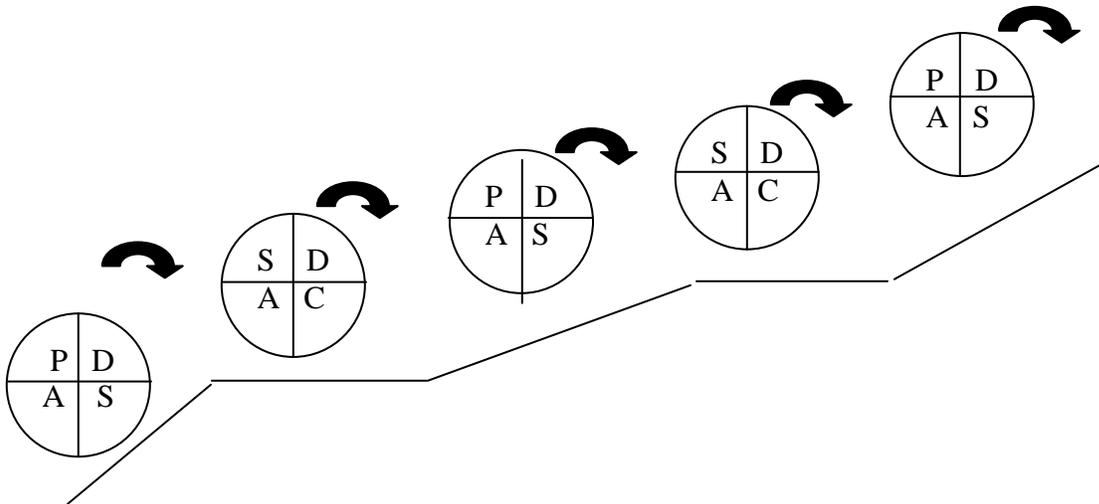
The results of work should always be checked, and if they are unsatisfactory, the following questions should be asked”

- Has a standard been established?
- Is the standard being observed?
- Is the standard adequate for the purpose?

Organizational activities that are not standardized cannot last.

Daily management activities consist of maintenance and improvement. Maintenance involves setting standards and working in accordance with them, and improvement involves setting targets above the present level and working to achieve those targets. This must be done in a well-balanced manner. All organizational activities are based on standards. Neglecting standards lowers efficiency. Progress and development are not held back by solid maintenance of the status quo. The elements of progress and development are always contained within the existing situation, and rigorous maintenance of the status quo highlights what needs to be improved and allows improvement activities to effectively progress.

When a new situation is created as a result of improvements, activities designed to maintain the new situation begin, and the next round of improvements start. The status quo is continually changing and accurately identifying those changes creating a driving force for improvement.



3) Correction, Corrective Action and Preventive action

If the present status is unsatisfactory, there are two ways to correct it: take action for what has occurred and take action regarding the cause.

Action taken for what has happened in order to make unsatisfactory results of work acceptable is generally called correction. Rework and repair are examples of correction.

In repeated activities, action taken to achieve the desired result does not lead to resolving problems, because similar problems may occur so long as the cause exists. Action taken for the result of what has occurred merely postpones solving problems to the future.

Improvements are obtained by eliminating the cause of defects. Improvements stem from actions aimed at processes.

Preventing the recurrence of problems is achieved by:

- Clarifying their cause
- Revising work methods and standards to eliminate that cause
- Training workers to use the new methods and standards.

SDCA and PDSA will be used conjunction with each other to ensure Quality is maintained in all areas.

Policy: # QI-020

Date Effective: 06/22/05

Revision Date: _____

Department: Quality Improvement

Approved By:

Title:

POLICY AND PROCEDURE REVIEW PROCESS

Purpose:

The purpose of this policy is: (1) to ensure that all policies and procedures are prepared using a standardized format and approval process, including a uniform numbering system. (2) To facilitate routine review and revision (as necessary) of all policies and procedures.

Policy:

The goal of this policy is to institute a process whereby HMS policies will be put into standardized format and be assigned a departmental number for use in cataloging and reviewing them on a routine basis. These numbers will be assigned by a team designated by the department head or manager. This team will review and assign appropriate numbers to all existing policies. Thereafter, all new policies will conform to this format and be assigned a number by a similar team when the policy and procedures are created. The review process will be on-going and will begin upon approval of this policy.

All policies and procedures will be reviewed and revised, if needed, on a bi-annual basis.

Procedure: #QI-020

Initial procedure: Teams will be created through the QI committee to number all policies. The numbering system will be departmental (NUR-001, IT-002, OP-003, etc) and each procedure will carry the same number as the policy to which it is attached (with a possible suffix if more than one procedure applies). This will enable changing procedures without having to revise the related policy.

Annual procedure: During the months of June, July, and August, policies and procedures will be reviewed, odd numbered policies on odd numbered years and even numbered policies in even numbered years. Any revisions will be recommended by the team, approved by the QI Committee, and forwarded to the Senior Management Team. Upon their approval, it will go to the Board for final approval if it is a policy revision. Procedure revisions will be approved by the CEO. A revision date will be assigned to the policy in the appropriate area of the policy form. Those policies and procedures requiring annotations to licensing requirements (7 NMAC 11.2 or other agencies) will also have that annotation included when revised.

Electronic copies of all updated policies and procedures will be placed on the main server in the appropriate departmental folder. Hard copies of the same policies and procedures will be placed in the binder located in the Administration Office. In addition, each HMS site will receive hardcopies policies that are pertinent to their respective site. These will be kept in a binder at the site and be available to any employee. The updates will replace existing policies and procedures in both formats.

ATTACHMENT A

FOCUS STATEMENT

Department: _____ **Location of Clinic:** _____

Category: Productivity Revenue Cost Other

Team Leader: _____ **Start Date:** _____

FOCUS

F: _____

O: _____

C: _____

U: _____

S: _____

ATTACHMENT B**PDSA FORM**

Date: _____ Initiated by: _____ Cycle # _____

*Purpose of this PDSA***PLAN the change, prediction(s) and data collection**

What change are we testing?

Who is testing the change?

When are we testing?

Where are we testing?

PREDICTION: What do we expect to happen?

DATA COLLECTION

What data do we need to collect?

Who will collect the data?

When will the data be collected?

Where will data be collected?

DO: Carry out the change/test, collect data, and begin analysis

What was actually tested?

What happened?

Unexpected Observations:

Problems:

STUDY: Complete analysis of data: Summarize what was learned and compare to prediction.**ACT**

What adjustments to the change or method of test should we make before the next cycle?

Are we ready to implement the change we tested?

What will the next test cycle be? (use back of form to elaborate)

ATTACHMENT C

MEDICAL RECORDS AUDIT

Clinic site:	Patient initials or chart number				Comments	Total audit score	
Date:						Actual score	
Reviewer:	Enter Y if element is present; N if element not present					Max. possible score	
						% compliance	
Patient name or ID number documented on each page							
Personal biographical data present: address, phone number and is current							
All entries are signed with name, title and date							
History form is present and current							
Insurance information is present and current [payer source]							
Correct placement of papers, forms with correct tab							

Reviewers: Medical records and front office staff cross-trained in Medical Records, Nursing, and QI Coordinator
 Pull 5 charts at random every [day, week], review using the selected criteria. Comment area is for notation of unusual findings within those criteria. Make sure all fields are completed. Leave shade area open. QI Coordinator will total scores for compliance. Please turn in completed form to QI Coordinator.

Standards being reviewed:

1. Every page of the patient record can be identified as belonging to that patient. Each page must have the patient's name of ID number on it. The reasoning is based on the premise that if the chart was dropped or came apart, the correct pages can be put back into the patient's chart.
2. Personal biographical data needs to be correct and up to date. This should be reviewed with the patient at each check in.
3. Systems should have a check and balance process in place. This is one area that medical records can assess along with Providers to make sure all entries that have been made into the medical record are signed and dated. This includes lab and other diagnostic reports. The medical record is a legal document and therefore should be kept accurately.
4. History form: this refers to the one that the patient fills out. It is recommended that it be up dated annually.
5. Insurance information: this is HMS's payer source. This information should be reviewed with the patient at every visit. Sufficient knowledge needs to exist with staff to ensure that all requirements set forth by the various insurance companies are met, as well as HMS policy on collections. This includes prior authorizations and co-pays. Make sure sliding fee is up to date, being current within the audit year.
6. Correct location of forms and papers within the correct tab of the chart. This ensures accuracy of the medical record.

ATTACHMENT D

NURSING CHART AUDIT

Clinic site:	Patient initials or chart number				Comments	Total audit score	
Date:						Actual score:	
Reviewer:	Enter Y if element is present, N if element not present, and N/A if it does not apply. (ie:LMP on male patients)					Max. possible score	
						% compliance	
Medication sheet: NKA or allergies displayed prominently, list up to date-reflects current regimen							
Vital signs: taken with each patient encounter, complete-temperature, blood pressure, pulse, respirations, weight [and height and head circumference if pediatric]							
All entries are signed with name and title and date.							
Immunizations: record reviewed at time of triage and record is current. [Notation in record made when record not up to date including measures to reconcile such as scheduling appointment for immunizations, referral to another agency for immunization and noting follow up]							
Peak flow, Oxygen saturation levels done on all patients with c/o breathing problems such as asthma, COPD, etc.							
LMP documented							

Reviewers: Nursing, QI Coordinator, and Providers

Pull five random charts each [day, week] and review. Comment section is for any unusual notations. Submit this completed form to the QI Coordinator. Make sure all fields are completed. Leave shaded columns open. QI Coordinator will figure totals.

Standards being reviewed:

7. Medication List: Allergies as well as NKA must be readily identifiable to help prevent any drug errors. This is also a check and balance system.
8. Vital Signs: All should be done at each visit. Methods of obtaining need to be consistent and the equipment be maintained and assured of accuracy.
9. Entries into the medical record must be signed and dated, as the medical record is a legal document.
10. Immunizations: important that this element is documented, as well as following up with efforts to obtain records from other agencies and efforts to assist parent in getting child current.
11. Peak flow and O2 sats: protocol of obtaining these elements important in care of the patient. Accuracy on performing peak flow is vital.
12. Last menstrual period: this is a key reference for assessment of gynecological indicators for the providers such as pregnancy, menopause, etc.

ATTACHMENT E

HIPAA AUDIT

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

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

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

Clinic:	Patient initials or chart number										Comments	Total audit score	
Date:												Actual score	
Reviewer:	Enter Y if element is present											Max. score	
Acknowledgement of Privacy Practices present on chart												% Compliance	
Any other HIPAA form Present on chart (requests													



MOCK CODE REVIEW

1-8 ASSESS THE TIMELINESS; 9-13 ASSESS APPROPRIATENESS AND 14-16 ASSESS THE EQUIPMENT

1. *IDENTIFICATION OF CODE AND ANNOUNCEMENT:* _____
2. *NURSING RESPONSE & INITIATION OF CPR:* _____
3. *NOTIFICATION OF EMS AND PROVIDERS:* _____
4. *PROVIDER RESPONSE & AND INITIATION OF ACLS:* _____
5. *MEDICAL RECORDS RETRIVAL AND RESPONSE:* _____
6. *PT. REGISTRATION AND AVAILABILITY FOR DIRECTIONS:* _____
7. *SOCIAL SERVICES RESPONSE/NOTIFICATION OF FAMILY:* _____
8. *ADMIN. STAFF RESPONSE AND CROWD CONTROL:* _____
9. *IDENTIFICATION OF CODE STATUS:* _____
10. *INITIATION OF CPR:* _____
11. *PLACEMENT OF DEVICES: IV; AIRWAY; ECG LEADS:* _____
12. *RECORDING OF DATA:* _____
13. *PROCEDURES: DEFIBRILLATION; INTUBATION; MEDICATIONS:* _____
14. *EQUIPMENT: LG BORE IV; BAG; MASK; ET BLADE:* _____
15. *WELL SUPLIED CRASH CART:* _____
16. *FUNCTIONING DEFIBRILLATOR:*

17. OTHER INFORMATION/COMMENTS: _____

ATTACHMENT G

Hidalgo Medical Services
SATISFACTION SURVEY

Date _____

You are important to us and we value your opinion. Please put an X in the box that best fits the care you feel you received. Please use the area provided for your comments. Your response is greatly appreciated. Please place completed survey in box. Thank you

Clinic: (Check the clinic you are currently at)

- | | | |
|--|--|---|
| <input type="checkbox"/> Lordsburg | <input type="checkbox"/> Med Square | <input type="checkbox"/> Silver High School |
| <input type="checkbox"/> Lordsburg-Dental | <input type="checkbox"/> Med Square Dental | <input type="checkbox"/> Cliff |
| <input type="checkbox"/> Lordsburg High School | <input type="checkbox"/> Bayard Community Clinic | <input type="checkbox"/> Mimbres |
| <input type="checkbox"/> Animas | <input type="checkbox"/> Cobre High School | |

- Do you have Insurance? Yes No Medicaid Medicare Other Insurance
- Your age: _____ Gender: Male Female
- Were you offered Sliding Fee at the time of your appointment? Yes No N/A
- Were you asked for your co-pay at the time of your visit? Yes No N/A

Please list the name of the provider you are here to see:

Please check all of the areas of service you came to our clinic for:

- | | | | |
|---|---|--|--------------------------------------|
| <input type="checkbox"/> Medical | <input type="checkbox"/> Dental | <input type="checkbox"/> Behavioral Health | <input type="checkbox"/> Lab/X-ray |
| <input type="checkbox"/> LaVida Classes | <input type="checkbox"/> Promotoras/CHW | <input type="checkbox"/> Medication Assistance Program | <input type="checkbox"/> Nurse Visit |

Access to Care

The number of days you had to wait for your appointment to receive care

- Same Day
 1-7 Days
 8-14 Days
 15-30 Days
 31 days or longer

Did you get appt time you requested?

- Yes No

Front Office Staff

The courtesy and respect shown to you by our reception staff was

- Excellent
 Very Good
 Average
 Poor
 Very Poor
 N/A

Billing Statement

Is statement understandable?

- Excellent
 Very Good
 Average
 Poor
 Very Poor
 N/A

Is statement accurate?

- Excellent
 Very Good
 Average
 Poor
 Very Poor
 N/A

Phone

If you called the clinic, were you able to talk to the person you called?

- Yes No N/A

If not, did the person return your call in a timely manner?

- Yes No N/A

Clinic Staff/Ancillary

The Provider's Explanations were:

- Excellent
 Very Good
 Average
 Poor
 Very Poor
 N/A

The Nursing staff explanations were:

- Excellent
 Very Good
 Average
 Poor
 Very Poor
 N/A

The other staff explanations were:

- Excellent
 Very Good
 Average
 Poor
 Very Poor
 N/A

Waiting Time

The amount of time you waited in the waiting room until you were seen was . .

- 10-15 minutes
 15-30 minutes
 30-45 minutes

Quality of Care

The care I received was . .

- Excellent
 Very Good
 Average

Would You Recommend
 Our Clinic To Your
 Family & Friends?

<input type="checkbox"/> 1 hour	<input type="checkbox"/> Poor	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<input type="checkbox"/> Over 1 hour	<input type="checkbox"/> Very Poor		

Comments: _____
