The County of Santa Cruz
Integrated Community Health Center Commission
MEETING AGENDA

July 10, 2024 @ 4:00pm - 5:00pm

MEETING LOCATION: In-Person – 150 Westridge, Suite 101, Watsonville, Ca 95076 and 1080 Emeline Ave., Bldg. D, Admin Conference Room, Santa Cruz, CA 95060 will connect through Microsoft Teams Meeting or call in (audio only) +1 831-454-2222,191727602# United States, Salinas Phone Conference ID: **191 727 602#**

ORAL COMMUNICATIONS - Any person may address the Commission during its Oral Communications period. Presentations must not exceed three (3) minutes in length, and individuals may speak only once during Oral Communications. All Oral Communications must be directed to an item not listed on today's Agenda and must be within the jurisdiction of the Commission. Commission members will not take actions or respond immediately to any Oral Communications presented but may choose to follow up at a later time, either individually, or on a subsequent Commission Agenda.

1. Welcome/Introductions
2. Oral Communications
3. June 5, 2024, Meeting Minutes – Action Required
4. Sliding Fee Discount Schedule - Ability to Pay Policy – Action Required
5. Grant Applications – Action Required
6. Quality Management Plan - Action Required
7. Revise bylaws regarding the executive committee – Action Required
8. Seek a Third Member of Executive Committee – Action Required
9. Mental Health Protocols (for Maximus to present as requested)
10. Quality Management Update
11. Financial Update/340B Presentation
12. CEO Update

Action Items from Previous Meetings: Action Item	Person(s) Responsible	Date Completed	Comments

Next meeting: Wednesday, August 7, 2024, 4:00pm - 5:00pm **Meeting Location: In-Person** - 150 Westridge, Suite 101, Watsonville, Ca 95076 and 1080 Emeline Ave., Bldg. D, Admin Conference Room, Santa Cruz,

CA 95060. Commission will connect through Microsoft Teams Meeting or call in (audio only) +1 831-454-2222,191727602# United States, Salinas Phone Conference ID: **191 727 602#**

The County of Santa Cruz Integrated Community Health Center Commission

Minute Taker: Mary Olivares

Minutes of the meeting held July 10, 2024

TELECOMMUNICATION MEETING: Microsoft Teams Meeting - or call-in number +1 916-318-9542 -- PIN# 500021492#

Attendance	
Christina Berberich	Executive Board - Chair
Len Finocchio	Executive Board - Co-Chair
Rahn Garcia	Member
Dinah Phillips	Member
Marco Martinez-Galarce	Member
Maximus Grisso	Member
Tammi Rose	Member
Miku Sodhi	County of Santa Cruz, Assistant Director HSA
Amy Peeler	County of Santa Cruz, Chief of Clinics
Raquel Ruiz	County of Santa Cruz, Acting Chief of Clinics
Julian Wren	County of Santa Cruz, Admin Services Manager
Mary Olivares	County of Santa Cruz, Admin Aide
Meeting Commenced at 4:01 pm and concluded at 5:03 pm	

Excused/Absent:

Excused: Michael Angulo
Absent: Gidget Martinez
Absent: Michelle Morton

1. Welcome/Introductions

2. Oral Communications:

3. June 5, 2024, Meeting Minutes – Action Required

Review of June 5, 2024, Meeting Minutes – Recommended for Approval. One correction to the meeting minutes Dinah Philips was excused from this meeting. With that one correction Marco moved to accept the minutes as corrected and submitted. Rahn second, and the rest of the members present were all in favor.

4. Sliding Fee Discount Schedule - Ability to Pay Policy – Action Required

Amy presented on behalf of Julian, Amy reviewed updates with commissioners. Rahn recommended approving revised Sliding Fee Discount Schedule. Len second, and the rest of the members present were all in favor.

5. Grant Applications – Action Required

Amy presented three grant applications for approval from commissioners.

- **HRSA Behavioral Health Service Expansion -**
  Application Due Date: 6/21/2024, Term: 9/1/2024-8/31/2026, Award Amount: $600K year 1; $500K year 2
  This funding will increase access to behavioral health services through expanding mental health services and substance use disorder services, adding a Behavioral Health Manager to focus on quality improvement and a Nurse Practitioner/Physician Assistant.
- **Central California Alliance for Health -**
  Application Due Date: 7/16/2024, Term: 9/13/2024, Award Amount: $250,000
  This funding is to recruit and hire new health care professionals who will serve the Medi-Cal population in the Alliance service areas.
  First year salary, relocation expenses, liability insurance, recruitment agency, and sign on bonus.
- **HRSA Expanded Hours -**
  Application Due Date: 7/23/2024, Term: 12/1/2024-11/30/2026, Award Amount: $500K per year
  This funding will expand access to health center services at HPHP by increasing health center operating hours to meet identified patient and community needs. And to hire a NP/PA, and a PHNIII.

Dinah made a motion to accept grant applications as presented. Len second, and the rest of the members present were all in favor.

6. Quality Management Plan - Action Required
Amy presented on behalf of Raquel the Quality Management Plan. Amy reviewed edits and additions with commissioners, only very minor edits were done. Dinah made a motion to accept quality management plan as presented. Marco second, and the rest of the members present were all in favor.
7. Revise bylaws regarding the executive committee – Action Required
This item to be removed from agenda.
8. Seek a Third Member of Executive Committee – Action Required
It was asked if any commissioners were interested in taking on the role as a third member of the executive committee. There was a short discussion and Tami volunteered. Dinah made a motion to appoint Tami to the executive committee. Marco second, and the rest of the members present were all in favor.
9. Mental Health Protocols
This topic was brough to by a commission member who wanted to get a better understanding of the staff training on mental health protocols. Recommendation was to make sure all clinicians have crisis training as well as placing suggestion boxes in clinics that are accessible to patients and letting patients know that they can always go directly to the Health Center Manager or Amy for any grievances.
10. Quality Management Update
Amy reported on behalf of Raquel on the quality management committee. Amy reported on the following, quality management finalized the quality management plan, which was on today's agenda, CCAH Quarter 1- Care Based Incentive Data, she stated they did good this year and HPHP reported on their quarterly quality improvement presentation which was: **Improvement Project Title: Double Booking Establish Care visits to replace no-shows with Office Visits & Walk-ins** **OUTCOME MEASURE:** Increased accessibility for walk-in patients and triage nurse to provider appts when converting OVL no-shows to walk-ins. **BALANCING MEASURE:** *Possible that double booking results in both appts showing up, which may impact clinic workflow and result in longer patient wait times.* **PROCESS MEASURE**: The Health Center Manager will collect # double booked appts, result appts made, show rate, replacement rate, impact on wait times, feedback from providers and support staff. **Long-Term Sustainability Plan:** Schedulers, template builders, MAs will all implement with their providers. Amy also gave an update on the Peer Review and Risk Management Committee. She reported on mortality data 8 charts were reviewed, 2 had substance use disorders, appropriate care was given to all.
11. Financial Update
Amy reported on behalf of Julian, item 340b presentation tabled for next month's meeting. Amy stated we will not know what the budget outcome is until September, and it was not looking good. Amy reported that clinics are looking at accounts receivable, no shows, clinician templates and asking physicians to see more patients. Amy stated each division director will be going to the CAO giving updates on what their divisions are doing next month. Lastly Amy reported that the Watsonville Clinic had hired two bilingual providers and that she was doing final interviews Medical Director, for the Emeline Clinic.
12. CEO Update
Given during financial update.

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☐ Minutes approved _____ ___/___/____
(Signature of Board Chair or Co-Chair) (Date)

SUBJECT: Billing Department Ability to Pay (Sliding Fee Scale Program) Policies and Procedures SERIES: 100 Administration APPROVED BY: Amy Peeler, Chief of Clinic Services	POLICY NO.: 100.04 PAGE: 1 OF 4 EFFECTIVE DATE: March 2020 REVISED: June 2024 May 2024 February 2022	COUNTY OF SANTA CRUZ HEALTH SERVICES AGENCY Clinics and Ancillary Services

PURPOSE:

The purpose of this policy is to reduce or eliminate financial barriers to patients who qualify for the Ability to Pay (ATP) (Sliding Fee Discount Program) to ensure access to services regardless of the patient's ability to pay. At no time will a patient be denied services because of an inability to pay.

The ATP applies to the full scope services provided by Health Services Agency's (HSA) Clinic Services Division, which includes Primary Care, Integrated Behavioral Health, Acupuncture, and Dental Services.

POLICY STATEMENT:

The Health Services Agency (HSA) Clinic Services Division operates county-run community health centers. The purpose of this policy is to describe all billing policies and procedures currently in use for ensuring assets are safeguarded, guidelines of grantors are complied with, and finances are managed with accuracy, efficiency, and transparency.

It is the policy of County of Santa Cruz Health Services Agency (HSA) to comply with government regulations. HSA is a Federally Qualified Health Center (FQHC) and received federal funding under the Health Center Program authorized by Section 330 of the Public Health Services (PHS) Act (42 U.S.C. 254b) ("section 330"), as amended (including sections 330C and (h)). The program is administered by the federal Health Resources and Services Administration (HRSA)

HSA staff with a role in the management of billing operations are expected to comply with the policies and procedures in this manual.

These policies will be reviewed annually and revised as needed by the staff and approved by the Integrated Community Health Center Commission, the Chief of Clinic Services, and HSA Director.

PROCEDURE:

A. Billing Overview: Clinic Services Division will provide methods for appropriate and sensitive evaluation of each patient's ability to pay for services rendered.

   1. Financial screening of each patient shall not impact health care delivery.

2. The screening will include exploration of the patient's possible qualification for specialized payer programs. Staff will encourage patients to apply for appropriate funding programs and facilitate an application when appropriate.

    a. The Business Office Manager and Health Center Managers are authorized to waive patient fees due to expressed financial hardship or disputes, as described in the HSA Billing FO Policy and Procedures 100.3 (Section A, #4).

3. The Health Services Agency (HSA) will ensure access to health care services by families and individuals regardless of the patient's ability to pay. At no time will a patient be denied services because of an inability to pay.

B. Sliding Fee Discount Program (Ability To Pay: ATP)

1. Definition of Income: Income is defined as earnings, unemployment compensation, workers' compensation, Social Security, Supplemental Security Income, public assistance, veterans' payments, survivor benefits, pension or retirement income, alimony, child support, or any other sources that typically become available. Noncash benefits, such as food stamps and housing subsidies, do not count.

2. A family is a group of individuals who share a common residence, are related by blood, marriage, adoption, or otherwise present themselves as related, and share the costs and responsibility of the support and livelihood of the group. Children of said individuals under the age of 19 or if the child is a full-time student, under the age of 21 who do not share a common residence with said individuals but are supported financially and are the responsibility of said individuals will be counted as part of the family.

3. The Sliding Fee Discount Program incorporates the most recent Federal Poverty Level Guidelines published by the Federal Health and Human Services.

4. Eligibility is based on income and family size only.

5. All patients are eligible to apply for the program.

6. Eligibility will be honored for 12 months.

7. Ability to Pay (ATP) is a sliding fee program available to all patients who qualify according to family size and income (individuals/families living at or below 200% of the Federal Poverty Level (FPL). Partial discounts or a nominal fee are provided for individuals and families with incomes above 100% of the current FPL and at or below 200% of the current FPG (see attachment 1).

8. Patients will self-report income and family size on the ATP self-declaration/provisional application if the individual or family does not have the proof of income at the time of the visit. The self-declaration/provisional application period expires after 30 calendar days. Patients applying for the ATP program are re-assessed if income or family size changes, as self-reported or the ATP eligibility period expires, and a new application is received.

9. Patients must first be screened for third-party insurance. Nominal fee charges apply to individuals and families with annual incomes at or below 100% of the Federal Poverty Guidelines. The Business Office Manager and Health Center Managers are authorized to waive patient fees due to expressed financial hardship or disputes. An example of a financial hardship is, but is not limited to, (temporary earnings reduction, loss of employment, natural disaster like flood or fire, or experiencing homelessness).

   A) The Business Office staff, or the registration desk staff will request the waiver from the Health Center Manager or the Business Office Manager prior to waiving of any fees either through email, in person, or by telephone. Patients who are covered by a third-party Insurance with "out of pocket" costs (i.e. co-insurance, co-pays, share of cost) may apply for the ATP program, if it is not prohibited by the third-party insurance.

   B) Staff will screen patient for eligibility for the ATP program by asking the patient to complete the application and provide proof of income.

   C) Once the sliding fee level for the patient is assessed, the patient may pay the lesser of the charge discounted to the patient's sliding fee level OR the patient's out of pocket costs.

10. No discounts are provided to individuals and families with annual incomes above 200% of the current FPL. Sliding Fee Discount Scale Program (ATP) levels are described in Attachment 1 for Clinic, Integrated Behavioral Health, and Acupuncture services. Ability to Pay scale levels are described in Attachment 2 for Dental Services.

11. Patients interested in applying for this program are required to complete an application and provide proof of household income. Registration staff collects preliminary income and family size documentation for each applicant then enters the information into the appropriate EPIC module for payment range determination in accordance with FPL. Self-declaration of income and household information will be accepted.

12. For full program qualification, patients must provide income verification documents to support their application, such as:

a. Most recent Federal tax return

b. IRS form W-2 or 1099

c. Two (2) most recent consecutive paystubs

d. Social Security, disability or pension benefit statements

e. Documentation of other governmental assistance

f. Verification of Student status and FAFSA form

g. Unemployment Benefits / Worker's Compensation

h. Self-declaration form may be accepted if formal documentation is not available.

13. The ATP shall apply to all required and additional health services within the HRSA-Approved scope of project for which there are distinct fees.

14. All documentation received from the patient related to the ATP application are filed and kept on site until the HSA Fiscal retention date has expired.

15. HSA will annually assess the ATP activity and present findings to the Integrated Community Health Center Commission that ensure the ATP does not create a barrier for patient access to care. HSA will:

    a. Collect utilization data that allows it to assess the rate at which patients within each of discount pay classes, as well as those at or below 100% of the FPG, are accessing health center services:

    b. Utilize this and, if applicable, other data (for example, results of patient satisfaction surveys or focus groups, surveys patients at various income levels to evaluate the effectiveness of its sliding fee scale discount program in reducing financial barriers to care; and

    c. Identify and implement changes as needed.

C. Sliding Fee Discount Program (SFDP) Evaluation

Authority

This policy adheres to Section 330(k)(3)(G) of the Public Health Service (PHS) Act and the following regulations: 42 CFR 51c.303(f), 42 CFR 51c.303(g), 42 CFR 51c.303(u), 42 CFR 56.303(f), 42 CFR 56.303(g), and 42 CFR 56.303(u).

Purpose

This section outlines the procedures for evaluating HSA Health Center Division's Sliding Fee Discount Program (SFDP) to ensure compliance with Section 330 of the PHS Act. The evaluation will be conducted at least once every three years.

Evaluation Process

The evaluation will involve a multi-faceted analysis aimed at assessing the effectiveness of the SFDP in reducing financial barriers to care.

1) On a quarterly basis, the Health Centers will conduct a patient experience survey and analyze the results to identify any financial barriers and areas for improvement.
2) Health Centers will also gather financial data to calculate the base fee for each tier in the SFDP scale.

Below is the equation that represents the calculation used to ascertain the new fee for each sliding fee scale tier:

New Tier Fee = (AT / TV) * Tier Collections (2 FY) / 2 + Base Tier Fee

where:

- **New Tier Fee** = The new fee amount for a specific sliding fee tier.
- **AT** = Total number of E&M visits across all tiers (2 FY).
- **TV** = Total amount collected from all other payments (excluding E&M) across all tiers (2 FY).
- **Tier Collections (2 FY)** = Sum of collections from E&M payments for the specific tier over a two-year fiscal period.
- **Base Tier Fee** = Existing fee amount for the specific sliding fee tier (before adjustment).

Explanation:

1. **(AT / TV):** This term calculates the average amount collected per E&M visit by dividing the total number of E&M visits (AT) by the total amount collected from all other payments (TV). This represents the additional flat fee needed to cover the average cost per visit.

2. **Tier Collections (2 FY) / 2:** This term calculates the average E&M revenue collected from a specific tier over a year. We sum the E&M collections for the tier over two fiscal years (2 FY) and then divide by 2 to get the yearly average.
3. **(AT / TV) * Tier Collections (2 FY) / 2:** This multiplies the average collected per visit by the average E&M revenue from the specific tier, essentially calculating the additional flat fee required for that tier.
4. **+ Base Tier Fee:** Finally, we add this additional flat fee to the existing base fee for the specific tier to arrive at the new sliding fee amount.

This equation considers both the overall cost per visit and the existing revenue collected from each tier to determine the adjusted fee schedule.

Outcomes and Action

Following the evaluation, a comprehensive report will be generated summarizing the findings and recommendations for improvement. Based on the results, HSA Health Center Division will identify and implement necessary changes to optimize the effectiveness of the SFDP in promoting access to affordable healthcare services.

Health Centers Division

Grant Application Approval

July 2024

HRSA Behavioral Health Service Expansion

- Application Due Date: 6/21/2024
- Term: 9/1/2024-8/31/2026
- Award Amount: $600K year 1; $500K year 2
- Funding:
  - Increase access to behavioral health services through expanding Mental Health Services and Substance Use Disorder services
  - Adding a Behavioral Health Manager to focus on Quality Improvement and a Nurse Practitioner/Physician Assistant

Central California Alliance for Health

- Application Due Date: 7/16/2024
- Term: 9/13/2024
- Award Amount: $250,000
- Funding:
  - To recruit and hire new health care professionals who will serve the Medi-Cal population in the Alliance service areas.
    - First year Salary, relocation expenses, liability insurance, recruitment agency, sign on bonus

HRSA Expanded Hours

- Application Due Date: 7/23/2024
- Term: 12/1/2024-11/30/2026
- Award Amount: $500K per year
- Funding:
- Will expand access to health center services at HPHP by increasing health center operating hours to meet identified patient and community needs.
- NP/PA PHNIII

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Santa Cruz County Health Services Agency
Health Centers Division
Quality Management Plan

June 2024~~3~~

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Introduction and Statement of Purpose

Santa Cruz County Health Services Agency's Health Centers Division (HCD) is committed to ensuring access to high quality patient-centered health care for all members of our community. Our Mission, embodied in the work of all staff who support patient care at HSA HCD, ***is to promote and protect the health and wellbeing of our community by providing access to quality, comprehensive and affordable primary and integrated behavioral health care services.*** Our collaborative approach fosters teamwork between clinicians, support staff, patients and outside community resources. As part of this commitment, our organization embarked upon a vigorous review of our existing Quality Management system. This has been a collaborative effort that includes administrators, clinicians, and support staff from Homeless Persons Health Project (HPHP), Watsonville Health Center and Santa Cruz Health Center.

HCD has clearly defined our division-wide goal for Quality Management, identified current barriers to reaching this goal, and developed a comprehensive approach to overcoming these barriers and providing consistent, high quality health care to all who are served at each of Santa Cruz County Health Service Agency's primary care health facilities. Throughout our planning process, HCD has included activities to ensure maintenance of the quality standards for primary health care that have been established by the Health Resources and Services Administration's Bureau of Primary Health Care. Specifically, our Quality Management Plan will provide leadership and guidance in support of the division's mission and for ensuring that the health centers are operating in accordance with applicable Federal, State, and local laws and regulations. This Quality Management document reflects the outcomes of our extensive planning work and provides a framework for continual reassessment of our Quality Management program over time.

Purpose:

The Purpose of our Quality Management Plan is to ensure high quality care and services for our patients that is reflected in a holistic set of indicators that are objectively measured and trusted and driven by stakeholder engagement and institutional value of providing high quality care.

Background:

Our Clinic Services Division established a Steering Committee in 2012 to improve communication between health centers and across the wide variety of Quality Improvement (QI) activities being conducted within the Health Services Agency. Despite improved communication, our organization continued to lack a systematic means of determining the quality of care our patients receive or a consistent approach to enacting change. Although QI projects were being successfully performed, there was no framework for expanding the new process at an institutional level. In addition, our organization was reporting on clinical indicators to various upstream stakeholders without clearly defined and agreed upon processes to regularly review clinical measures, design improvements or track changes over time. Because of the disconnect between health care providers and data reporting, the Steering Committee found that the accuracy of data generated from the Electronic Health Record (EHR) was inconsistent due to variability in data entry and access to discrete fields for data extraction. This had contributed to the devaluing of the Quality Management process amongst health care providers because the data did not consistently reflect the work being performed. Furthermore, we found that there has not been a clear process in place for reporting problems that arise from a staff or patient perspective.

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Our Theory of Change

Our Quality Management team has defined a clear set of objectives that will allow us to overcome barriers and reach our goal of consistently high-quality patient care that is confirmed through objective measures.

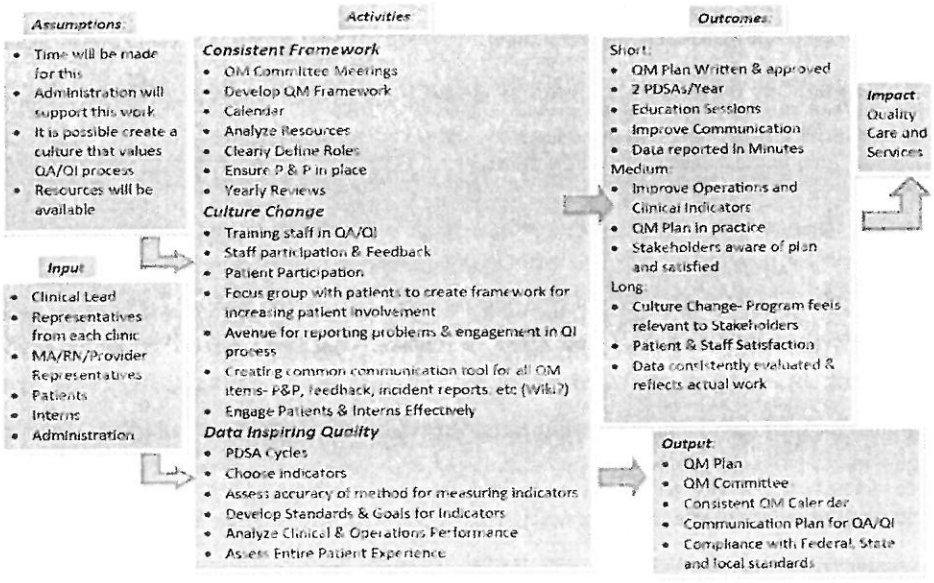
We will reach our goal by focusing on the following three Objectives:

1. ***Develop and Maintain a Cohesive and Comprehensive Framework that includes a plan for engagement of and communication to all stakeholders, as well as a playbook for change that provides a structured process for implementing improvements.***
2. ***Create an institutional consensus around shared definitions of Quality Assurance and Quality Improvement that provides the foundation for improving the perceived value of this process by all stakeholders.***
3. ***Utilize trustworthy data from our robust EHR to drive improvements in quality and efficiency of care and services to our patients.***

Our Logical Framework:

The Quality Management team has developed a logic model that will serve as a framework for continual reassessment of our Quality Management plan. The model is considered a fluid process that is open for stakeholder feedback and will be reevaluated yearly to ensure we are meeting our goals.

Quality Management Logic Model



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Scope of Work

The scope of work within our Quality Management plan is comprehensive, and includes all stakeholders, including but not limited to patients, involved in the direct or indirect experience of clinical care to patients seen at our four health facilities. Our goal is to provide a quality experience for all patients, including sub-populations such as those experiencing homelessness or living with HIV, throughout the entire process of accessing, receiving and continuing care. To this end, the scope includes all persons receiving care, administrative and clinical departments who participate in providing primary care, in-house specialty services such as HIV, Orthopedics, Tuberculosis, Behavioral Health, Dental, Acupuncture Immunizations, street medicine, health care for people experiencing homelessness, Medication Assisted Treatment and any support services. To ensure quality care is provided to HSA patients who are seen by outside service providers, we will undergo a due diligence process when signing contracts and perform intermittent quality reviews that include patient satisfaction surveys.

Program Structure and Accountability

Organizational Structure and Accountability

The Co-Applicant Board is ultimately accountable for the quality of care and services provided to the patients cared for at the health centers overseen by the HCD-. The Co-Applicant Board has delegated oversight responsibility for the effectiveness and efficiency of care and services to the Chief of Clinic Services, who has assigned responsibility for implementation of policies to the Medical Directors. The Medical Directors has designated the Senior Health Services Manager to facilitate the Quality Management Committee and to work directly with medical directors at each health center to ensure quality and implement all aspects of the Quality Management Program.

The operation of the HCD Quality Management program is the collaborative responsibility of ~~the HCD~~the HCD Quality Management Committee, which involves all appropriate personnel including management, clinical staff, and support staff representing each of our four health centers. The Quality Management Committee may consist of the following members and other staff as necessary:

1. -HCD Clinical Director of Quality
2. Medical Directors
3. -HCD Chief of Clinics
4. Data Analyst and Epic Site Specialist
5. Health Center Managers

~~6. Santa Cruz Health Center QI Lead (Nursing Supervisor)~~
~~7. Homeless Persons Health Project (HPHP) Health Center QI Lead (Nursing Supervisor)~~
~~8. Watsonville Health Center QI Lead (Nursing Supervisor)~~
~~9. Public Health Liaison QI Lead (Nursing Supervisor)~~

~~10.~~6. Nursing (RN ~~or MA~~) Representative for Watsonville Health Center
~~11.~~7. Nursing Representative (RN ~~or MA~~) for Santa Cruz Health Center
8. Nursing Representative (RN ~~or MA~~) for HPHP Health Center
9. Medical Assistant from Watsonville Health Center
10. Medical Assistant from Emeline Health Center
~~12.~~11. Medical Assistant from Homeless Persons Health Project
~~13.~~12. Representatives At-Large ~~(~~Intern, patient, registration supervisor or designee ~~staff~~, or community partner)
~~14.~~13. Representative from Integrated Behavioral Health team

Commented [RR1]: Check Compliance Manual for facility rep ...
Check with IBH

~~15.~~14. ___Ryan White Part C Grantee Representative

The Senior Health Services Manager acts as the facilitator of the Quality Management Committee and prepares the Committee Agendas and Meeting Minutes. These documents are contained within a shared drive on the HCD computer system. A quorum is defined as the presence of 4 core members.

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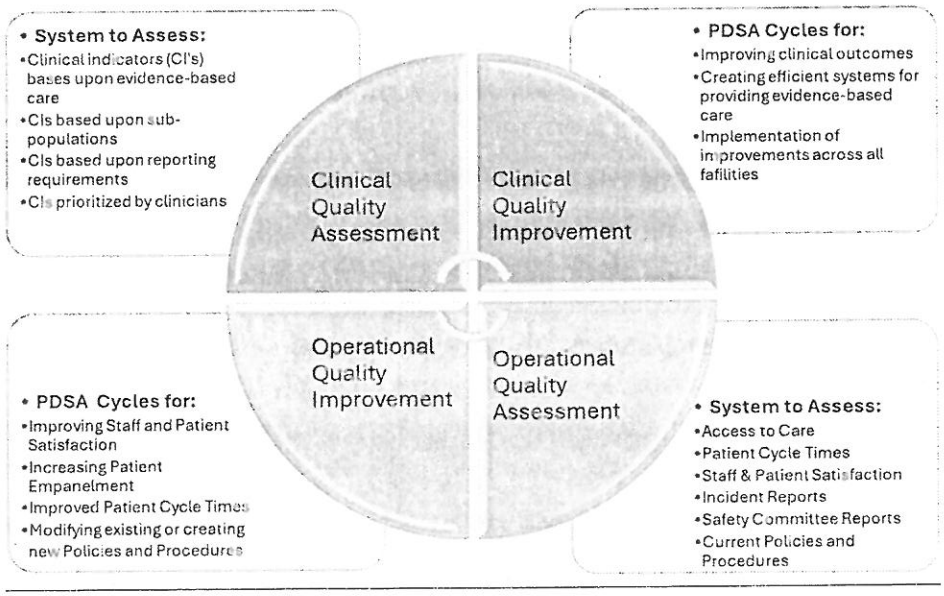
Our shared definition of Quality requires that health care be:

- ***Effective***- delivering health care that is adherent to an evidence base and results in improved health outcomes for individuals and communities, based on need.
- ***Efficient***- delivering health care in a manner which maximizes resource use and avoids waste.
- ***Accessible***- delivering health care that is timely, geographically reasonable, and provided in a setting where skills and resources are appropriate to medical need.
- ***Acceptable/Patient-Centered***- delivering health care which considers the preferences and aspirations of individual service users and the cultures of their communities.
- ***Equitable***- delivering health care which does not vary in quality because of personal characteristics such as gender, race, ethnicity, geographical location, or socioeconomic status.
- ***Safe***- delivering health care which minimizes risks and harm to service users.

Santa Cruz Health Services identifies three major components to Quality Management that includes Quality Assessment, Quality Improvement and Quality Assurance. By addressing these three separate and essential components to Quality Management, the Quality Management Committee strives to meet all these dimensions of quality health care. Because the committee recognizes that the entire health system from both an Operational and Clinical perspective must work collaboratively to achieve our goals, we consider quality indicators across all departments. The diagram below provides a simple illustration of the intersection of Quality Assessment and Quality Improvement across both Operations and Clinical Care.



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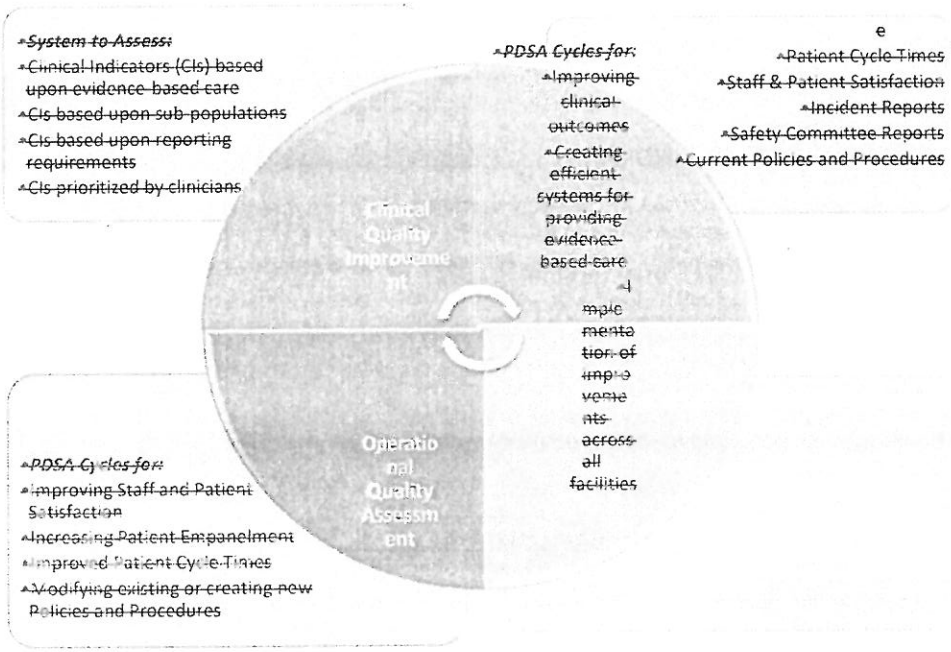

System to Assess:

Access

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Quality Assessment

Quality Assessment involves the identification of indicators that best reflect quality clinical and operational performance and review of these indicators to ensure that all our health facilities are meeting Standards and Goals that we have set for ourselves. Quality Assessment includes a thorough review of the process by which to measure these indicators to ensure accuracy.

Indicator Selection

Indicators are identified through a variety of internal and external processes that reflect a patient's ability to efficiently access high quality health care. For this reason, indicators often reflect both operational and clinical service provision. The following categories, along with specific examples, are major drivers in indicator selection:

- Indicators reflecting timely Access to Care
  - Time to next appointment
  - Timely phone responses
- Indicators reflecting efficient Provision of Care
  - Patient Cycle times
  - Use of My Chart EHR functionality

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  - Departmental Communication Systems
- Indicators reflecting Evidence-based Clinical Care
  - Clinical Indicators identified by external sources such as the Uniform Data System (UDS) Clinical Outcomes and Quality Care measures and other Clinical Guidelines
  - Clinical Indicators reflecting health of special populations served by HCD such as those living with HIV, homelessness, mental illness, or substance abuse
  - Key performance indicators (KPIs) will be carefully selected to contextualize the challenges that each of these respective special populations faces.
  - Clinical Indicators identified by HCD clinicians to be key to quality care provision
- Indicators driven by Patient and Staff Satisfaction via surveys and informal feedback
- Indicators reflecting Safe provision of care as identified through Safety and Incident Reports

In many cases, similar indicators may fall under several categories. For example, UDS measures Pap smear utilization and our HIV Quality Management Committee follows a similar indicator. It is the responsibility of the HCD QM Committee to create a streamlined means of selecting indicators that can efficiently serve all our patients and simultaneously address the needs of sub-populations and various reporting entities. To improve integration and efficiency, the HCD QM Committee facilitates collaboration to ensure that system improvements follow a similarly streamlined approach.

Indicator Measurement

It is the responsibility of the HCD QM Committee to review methods of measuring indicators. The Data Analyst effectively extracts data from our robust EHR system and depends upon all stakeholders to consistently enter data into discrete data fields. The QM Committee reviews the data fields used and the process for determining if an indicator has been met. These processes must then be communicated to stakeholders and reviewed for user functionality. Adjustments are then made, and stakeholders are trained in the final process.

Indicator Analysis

The HCD QM Committee is responsible for developing standards and goals for the indicators we have chosen to follow. Results will be compared to HSA HCD' internal goals and to external benchmarking standards. Indicators are reviewed by the HCD QM Committee at intervals determined by our yearly calendar and as indicated by stakeholder request. Results are available to all stakeholders upon request.

Indicator Reporting

Indicators are reported at QM Committee meetings based upon our set yearly calendar. All data reports reviewed at each meeting are included in the Meeting Minutes, and these Minutes are distributed to all HSA HCD staff members. Meeting Minutes are also made available upon request to patients and community partners.

Indicator Tracking

Indicators that have not met our internal goals or external benchmarking standards are identified and quality improvement activities are developed. It is the responsibility of the QM Committee to facilitate quality improvement teams, track progress, and determine successful outcomes.

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Quality Improvement

Once gaps in quality care have been identified through the process of Quality Assessment, the QM Committee chooses priority indicators to focus improvement efforts. A Process Improvement Team is appointed by the committee and tasked with first addressing the following three questions:

1. What are we trying to accomplish? (Setting our AIM)
2. How will we know that a change has led to improvement? (Establishing Measures)
3. What changes can we make that will result in improvement? (Selecting Change)

Once these questions are addressed, a pilot 'change' project is designed and implemented by the Process Improvement Team through a Plan, Do, Study, Act (PDSA) cycle. Baseline measures should be established prior to the PDSA cycle, and appropriate comparison measures should be obtained to assess ~~for~~the success of the intervention. The Process Improvement Team presents their findings to the QM Committee, and successful interventions are implemented throughout all health facilities. The QM Committee is responsible for ensuring consistent implementation, which includes communication to and training of appropriate staff members. This may also include the establishment or revision of Policies and Procedures. In this case, the QM Committee is responsible for appointing appropriate personnel to develop and implement the policy or procedure in a systematic way.

Clinic Level Quality Improvement

Although most system improvements will be expanded throughout all HCD health facilities, each health facility has unique sub-populations and system challenges. In these cases, the QM Committee representative from each health facility is responsible for choosing Process Improvement Teams for their sites and then reporting results to the QM Committee. When appropriate, system improvements may be replicated across all sites.

Provider Level

Since our EMR system allows health care providers to run reports on their individual patient panels, some providers have conducted their own internal improvement activities in collaboration with their team members (medical assistant and RN). Providers are encouraged to present their experiences to the QM Committee via their health center QI representative so that all providers can learn from their experience.

Effective Teams: Roles and Responsibilities

Effective teams include members representing three different kinds of expertise within the Clinic Services Division: system leadership, technical expertise, and day-to-day leadership. There may be one or more individuals on the team with each kind of expertise, or one individual may have expertise in more than one area, but all three areas should be represented to drive improvement successfully.

Clinical Leader (Medical Director, Health Center Manager, Clinic Nurse III, IBH Director or designee)
Teams need someone with enough authority in the organization to test and implement a change that has been suggested and to deal with issues that arise. The team's clinical leader understands both the clinical implications of proposed changes and the consequences such a change might trigger in other parts of the system.

Technical Expertise (IT Data Analyst or Epic Site Specialist)
A technical expert is someone who knows the subject intimately and who understands the processes of care. An expert on improvement methods can provide additional technical support by helping the team determine what to measure, assisting in design of simple, effective measurement tools, and providing

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guidance on collection, interpretation, and display of data.

Day-to-Day Leadership (Clinician, Clinic Nurse, Medical Assistant, Health Center Manager, and Reception Staff)
A day-to-day leader is the driver of the project, assuring that tests are implemented and overseeing data collection. It is important that this person understands not only the details of the system, but also the various effects of making change(s) in the system. This person also needs to be able to work effectively with the physician champion(s).

Project Sponsor (Senior Health Services Manager, Medical Director, or Health Center Manager)
In addition to the working members listed above, a successful improvement team needs a sponsor, someone with executive authority who can provide liaison with other areas of the organization, serve as a link to senior management and the strategic aims of the organization, provide resources and overcome barriers on behalf of the team, and provide accountability for the team members. The Sponsor is not a day-to-day participant in team meetings and testing but should review the team's progress on a regular basis.

Quality Assurance Activities

For the purposes of HCD Quality Management, Quality Assurance is considered a process of ensuring basic standard practices within the health system from both an operational and clinical standpoint. In addition to indicators that are chosen by the QM Committee, routine audits will be conducted. Audits may also be triggered by challenges brought to the committee through a variety of channels. When areas of deficit are noted, we follow the workflows described below, and determine the most appropriate action. In some cases, a new Policy or Procedure may be developed. In other cases, the QM Committee may consider quality improvement activities that will improve the system of care.

SOURCES OF AUDIT TOPICS

Audit and data collection may be directed at problem areas identified by:

1. Needs assessment data
2. Clinical Guidelines Audits
3. Licensing and funding standards
4. Data reports from internal and external sources
5. Peer Review
6. Prescribing patterns
7. Billing data
8. Scheduling and staffing plans
9. Incident/occurrence reports, and
10. Patient satisfaction surveys/grievance forms

Quality Assurance activities may also be triggered by:

1. Patient Complaint
2. Staff Complaint
3. Community Complaint
4. Provider variability in terms of meeting clinical indicators or utilization of services
5. Malpractice Data

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Quality Assurance Workflow for Issues Brought to the Committee:

1. Comes to the attention of the committee
2. Committee will:
   a. Determine who will investigate (internal or external auditor)
   b. Gather data (either committee members or investigator)
   c. Formulate plan of action
   d. Designated investigator reports back to committee with results and recommendations

Quarterly Audit Activities will be conducted, and may include 1-2 of these topics:

1. Registration
2. Clinical Care
3. Epic Documentation
4. Prescriptions
5. Referrals

Resource Assessment

Although quality care should not be driven by financial incentives alone, financial resources are essential to providing quality care and promoting health center program sustainability. The Quality Management Committee is tasked with ensuring that the quality of care we provide is reflected in the data that is presented to reporting and funding entities. When funding opportunities are missed, this must be reviewed to assess for avoidable causes and addressed by the QM Committee. In addition, the Quality Management Committee is tasked with advocating the need for the Health Services Agency to commit resources towards Quality Management for the promotion of consistency in the quality of care we provide across all health facilities and patient populations.

Strengthening Institutional Consensus

To maintain a successful Quality Management Program, it is essential that all stakeholders trust in the process we have created. The QM Committee is committed to building and maintaining an institutional consensus around Quality Improvement that promotes a shared definition of quality and unified approach to reaching our goals. To this end, we are developing a plan that will foster and maintain a culture shift within our organization that inspires stakeholder value in Quality Assessment and Improvement. This plan includes the following processes:

- Training staff in Quality Assessment, Quality Improvement, and Quality Assurance
- Develop training as determined by staff satisfaction survey
- Staff participation & Feedback
- Direct patient participation via patient focus groups such as the Patient Family Advisory Panel (PFAP)
- Avenue for reporting problems and involvement in QI process
- Create common communication tool such as an Intranet page for all QM items
- Engage Patients, Interns and Community Partners Effectively
- Data Quality- ensuring accuracy and communicating measurement process

Additional Components of Quality Management

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Utilization Management

The HCD Utilization Management program provides a comprehensive process through which review of services is performed in accordance with both quality clinical practices and the guidelines and standards of local, state, and federal regulatory entities. The Utilization Management program is designed to monitor, evaluate, and manage the quality and timeliness of health care services delivered to all health center patients. The program provides fair and consistent evaluation of the medical necessity and appropriateness of care through use of nationally recognized standards of practice and internally developed clinical practice guidelines. This work is integrated into the QM Committee's ongoing assessment of Operational Indicators.

Credentialing, Recredentialing, and Privileges

Our credentialing and privileging processes accomplish initial credentialing, required recredentialing, and specific privileging for all contracted, voluntary, and employed providers. This ensures appropriate qualifications to provide care and services and verifies the absence of any State and Centers for Medicare and Medicaid Services (CMS)-imposed sanctions. Specific quality indicators addressing the credentialing and privileging processes are part of HCD QM Program.

Risk Management and Patient Safety

The Clinic Services Division Risk Management program monitors the presence and effectiveness of patient risk minimization activity, including incident reports, sentinel events, infection control, lab quality control and patient safety. These risk minimization activities will be proactive whenever possible. Improvements to related processes and policies will also result from QM activities based upon triggers listed in the Quality Assurance section. The Santa Cruz County Health Services Agency's Safety Committee is ultimately responsible for monitoring the breadth of patient and staff safety within our Agency. The Safety Committee reports their findings to the Quality Management Committee, and the QM Committee will respond when appropriate and when the issue is within our Scope of Work. The total Risk Management program is closely integrated with the HCD Quality Management Program.

Health Records

Santa Cruz Health Services Agency HCD will achieve continued excellence with respect to its health records. These records will be maintained in a manner that is current, detailed, secure, and enabling of effective, confidential patient care and quality review. Health records will reflect all aspects of care and will be complete, accurate, systematically organized, legible, authenticated, and readily available to all appropriate health care practitioners and other necessary parties, in strict accordance with the Health Information Portability and Accountability Act (HIPAA) guidelines.

Process for Revision of Quality Management Plan

Each year, the Quality Management Committee will facilitate the review and update of our Quality Management Plan and logical framework. We will invite all stakeholders identified previously in this document to participate in this review. This annual review will be scheduled into our Yearly Calendar to ensure its prioritization.

Commented [RM2]: great one. No changes

Board approved _____ _____

(Signature of Board Chair or Co-Chair) (Date)

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Attachment 1: Quality Management Work Plan Template

County of Santa Cruz, Health Services Agency, Clinic Services Division

Our goal is to refine and further standardize our process for evaluating current practice and improving upon the quality of our services. The Quality Management Committee has identified three key categories to focus on outlined in the Clinic Services Division Operational Plan 2021-2023. These categories include Organizational Culture, Operational Excellence and Community Collaboration. Throughout the year, we will focus on clarifying key indicators within each of these categories and on improving the quality of the data we record, collect, and analyze. We will strive to build upon prior work and conduct PDSAs within each category per year as documented in the Patient Centered Medical Home (PCMH) Quality Improvement Worksheet which is submitted to the National Committee for Quality Assurance (NCQA) on an annual basis. In addition, Quality Assurance activities will be conducted throughout the year.

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Attachment 2: Quality Management Committee Meeting Agenda and Minutes

QM Committee:	
Date/Time:	-------, 8:30 to 9:30 am
Meeting Location:	
Leader:	
Facilitator/Transcriber:	
Attending:	
Guest(s):	

Persistent Focus on Excellence in Patient Care in a Compassionate Environment

Agenda Items	Discussion	Data/Trends Reviewed	Action/Decision	Who	Date Due
Agenda review and announcements				Committee	n/a
Approve minutes				Committee	Today
Review incident reports				Committee	Today
Calendar Activities for Month					
Other Action Items Due					

☐ Minutes approved _____
__/__/____
(Signature of committee facilitator) (Date)

Next Meeting

Date/Time:	
Meeting Location:	1080 Emeline, Room 200

Health Centers Division

Quality Management Report

July 2024

Quality Management Committee

- Quarterly Quality Improvement Presentation- HPHP: Double Booking (next slide)
- Finalized the Quality Management Plan (agenda item)
- CCAH Quarter 1- Care Based Incentive Data (Slide 4)

Improvement Project Title: Double Booking Establish Care visits to replace no-shows with Office Visits & Walk-ins

OUTCOME MEASURE:
Increased accessibility for walk-in patients and triage nurse to provider appts when converting OVL no-shows to walk-ins.

PROCESS MEASURE:
Health Center Manager will collect # double booked appts, result appts made, show rate, replacement rate, impact on wait times, feedback from providers and support staff.

BALANCING MEASURE:
Possible that double booking results in both appts showing up, which may impact clinic workflow and result in longer patient wait times.

Long-Term Sustainability Plan:
Schedulers, template builders, MAs will all implement with their providers.

Care-Based Incentive (CBI) Program
Practice Profile

Quality of Care Measures	Your Practice	Plan Benchmark	Plan Goal	Improvement Rate (%)	Percentile Group	Eligible for Measure	Possible Points	Practice Points
Breast Cancer Screening	Your Practice							
Members eligible	788							
Members screened	445							
Rate (%)	56.47%	52.6%	62.67%	0.83%	Between 50th and 74th	Yes	4.22	2.96
Cervical Cancer Screening	Your Practice							
Members eligible	2,595							
Members screened	1,526							
Rate (%)	58.81%	57.11%	66.48%	0.45%	Between 50th and 74th	Yes	4.22	2.96
Child and Adolescent Well-Care Visits	Your Practice							
Members eligible	2,499							
Members with a visit	1,507							
Rate (%)	60.30%	48.07%	61.15%	6.11%	Between 75th and 89th	Yes	4.22	4.22
Depression Screening for Adolescents and Adults	Your Practice							
Members eligible	6,927							
Members screened	0							
Rate (%)	0.00%	7%	17%	MNS	≤24th percentile	Yes	4.22	0.00
Diabetic HbA1c Poor Control >9.0% ↓	Your Practice							
Members eligible	1,048							
Members in poor control	299							
Rate (%)	28.53%	37.96%	29.44%	0.66%	≥90th percentile	Yes	4.22	4.22
Immunizations: Adolescents	Your Practice							
Members eligible	164							
Members immunized	95							
Rate (%)	57.93%	34.31%	48.8%	-2.74%	≥90th percentile	Yes	4.22	4.22
Immunizations: Children (Combo 10)	Your Practice							
Members eligible	64							
Members immunized	35							
Rate (%)	54.69%	30.9%	45.26%	-4.24%	≥90th percentile	Yes	4.22	4.22
Lead Screening in Children	Your Practice							
Members eligible	65							
Members screened	47							
Rate (%)	72.31%	62.79%	79.26%	MNS	Between 75th and 89th	Yes	4.22	4.22
Well-Child Visits in the First 15 Months	Your Practice							
Members eligible	46							
Members with visits	29							
Rate (%)	63.04%	58.38%	68.09%	-7.17%	Between 50th and 74th	Yes	4.22	2.96

Peer Review and Risk Management Committee

- Mortality Data: 8 reviewed; 2 had a Substance Use Disorders

Health Centers Division

Integrated Health Care Commission Monthly Budget

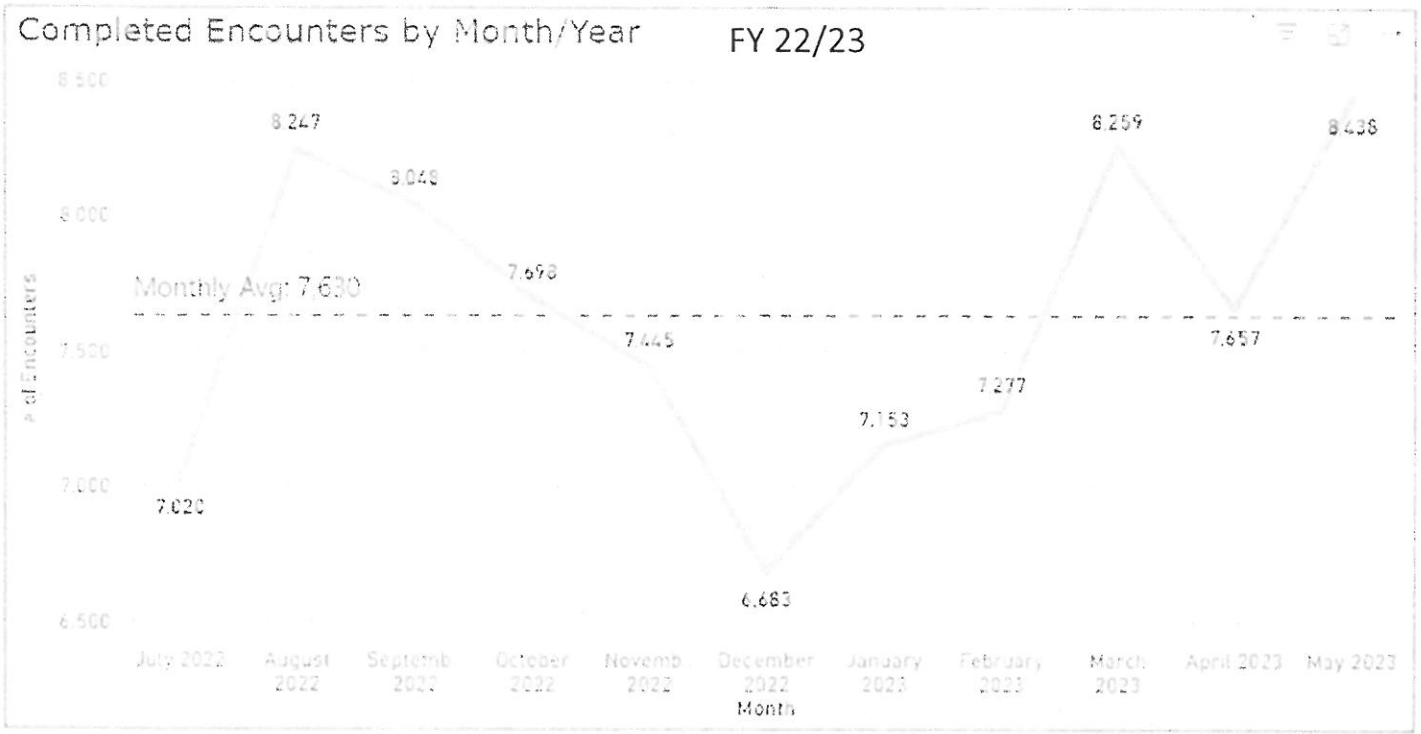
7/3/24

Division	HEALTH CENTERS
GLKey	(All)
JL Key & Title	(All)
FiscalMonth	(All)
Object	(All)

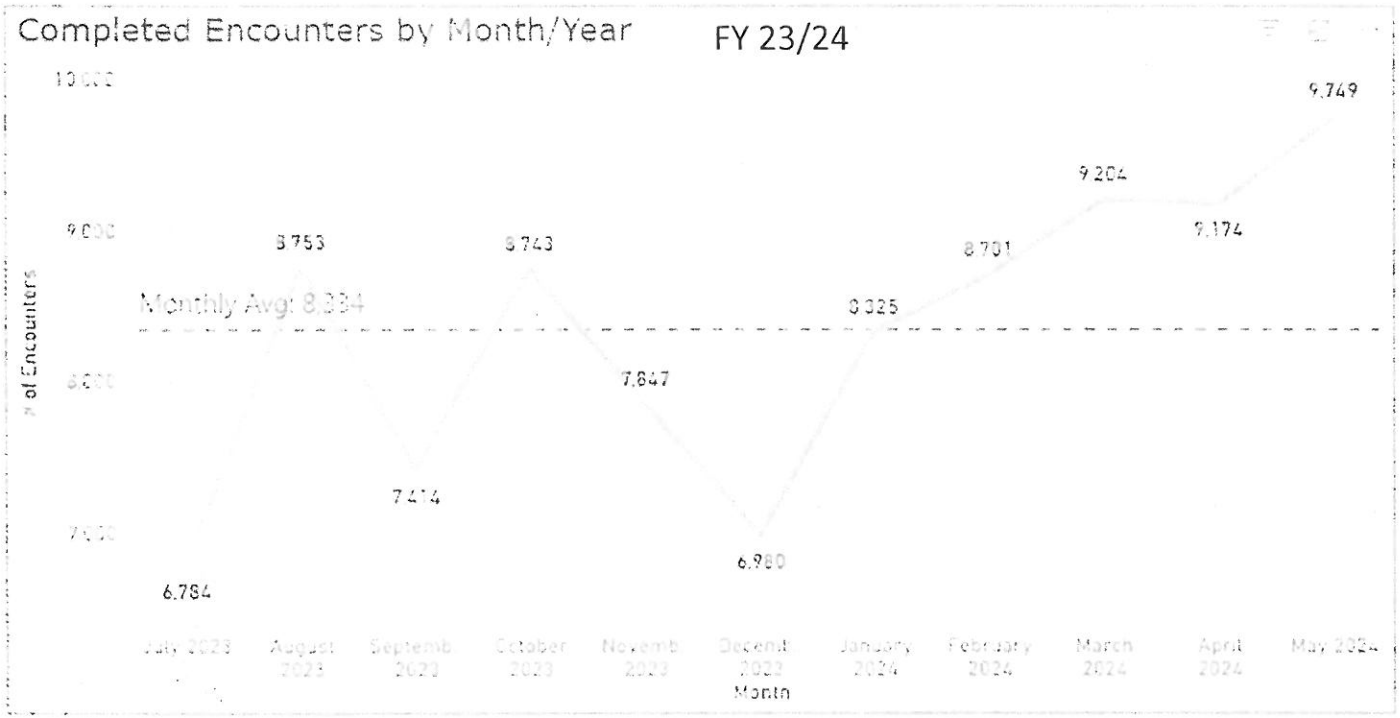
Row Labels	Adopted Budget	Adjusted Budget	Actual	Divison EA's 5.15.24
- REVENUE	(58,801,253)	(59,379,262)	(34,350,229)	(48,803,085)
+ 05-LICENSES, PERMITS AND FRANCHIS	0	0	0	0
+ 15-INTERGOVERNMENTAL REVENUES	(7,638,506)	(7,253,515)	(3,458,456)	(6,141,971)
+ 19-CHARGES FOR SERVICES	(50,905,161)	(51,418,875)	(28,144,473)	(39,676,278)
+ 23-MISC. REVENUES	(257,586)	(706,872)	(2,747,300)	(2,984,836)
- EXPENDITURE	56,833,410	57,411,419	46,858,993	52,152,071
+ 50-SALARIES AND EMPLOYEE BENEF	35,325,814	34,579,386	30,117,187	31,209,114
+ 60-SERVICES AND SUPPLIES	7,409,191	9,387,364	8,029,091	9,372,816
+ 70-OTHER CHARGES	4,508,292	48,404	48,402	48,404
+ 80-FIXED ASSETS	734,388	1,191,752	63,228	630,393
+ 90-OTHER FINANCING USES	97,875	97,875	0	0
+ 95-INTRAFUND TRANSFERS	8,757,850	12,106,638	8,601,086	10,891,344
Grand Total	(1,967,843)	(1,967,843)	12,508,764	3,348,986

Between $ 5,316,829.00
and $9,122,787.00

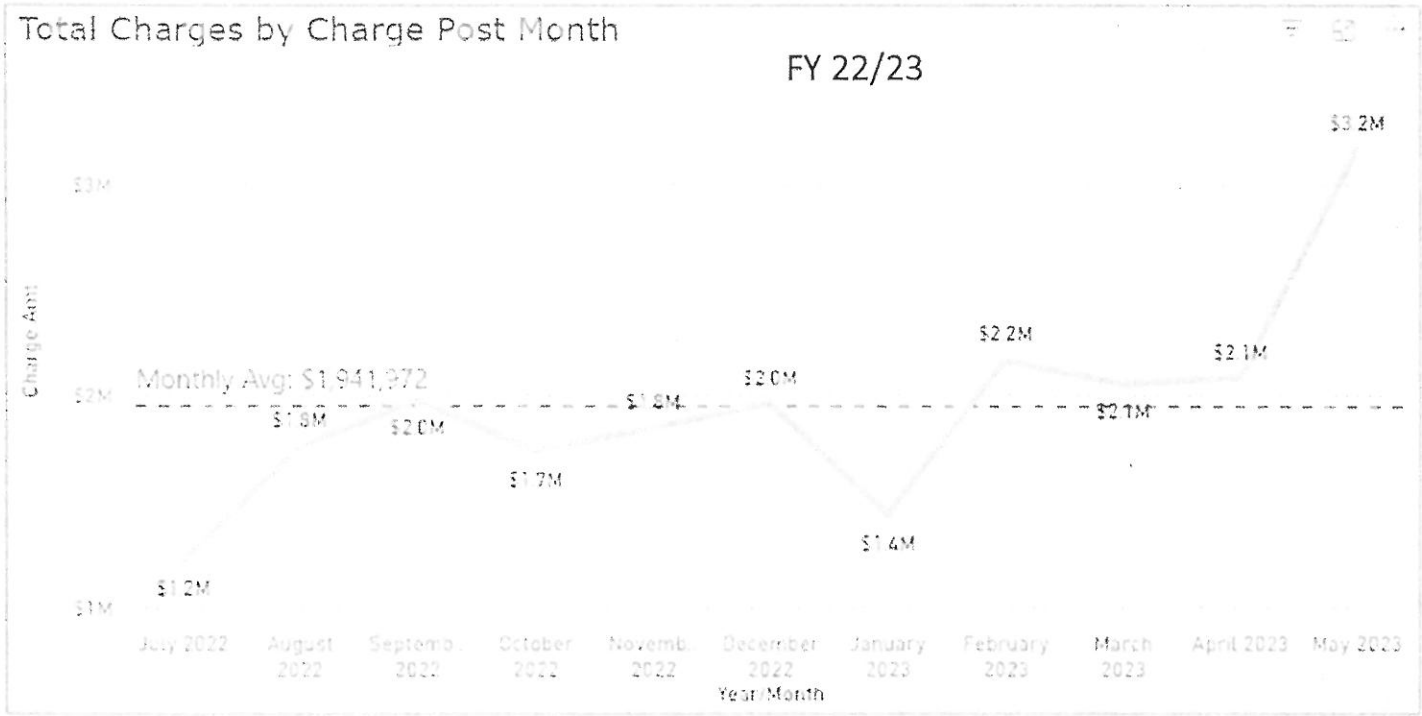
FY 22/23 averaged 7,630 completed encounters per month



In FY 23/24 averaged 704 more completed encounters than previous FY



FY 22/23 Averaged $1,941,972 in Monthly Charges



FY 23/24 Averaged $340,423 more charges per month than previous FY