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

August 2, 2022 @ 3:00 pm

MEETING LOCATION: Microsoft Teams Meeting or call in (audio only) +1 916-318-9542, 500021499# United States, Sacramento Phone Conference ID: **500 021 499#** / 1080 Emeline Ave., Bldg. D, Santa Cruz, CA 95060

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. July 5, 2022, Meeting Minutes – Action Required
4. Service Area Review-Action Required
5. Hours of Operation- Action Required
6. Continuity of Care/Hospital Admitting Policy- Action Required
7. Quality Management Plan Review-Action Required
8. Quality Management Update
9. Social Justice
10. Financial Update - Action Required
11. CEO/COVID-19 Update

Action Items from Previous Meetings:

Action Item	Person(s) Responsible	Date Completed	Comments
was asked by one of the commissioners if there was a form that acknowledge an employee's great service.	**Raquel**		

Next meeting: September 6, 2022, 3:00pm - 5:00pm

Meeting Location: Microsoft Teams Meeting Or call in (audio only) +1 916-318-9542, 500021499# United States, Sacramento Phone Conference ID: **500 021 499#** / 1080 Emeline Ave., Bldg. D, Santa Cruz, CA 95060

The County of Santa Cruz Integrated Community Health Center Commission

Minute Taker: Mary Olivares

Minutes of the meeting held August 2, 2022.

TELECOMMUNICATION MEETING: Microsoft Teams Meeting - or call-in number +1 916-318-9542 – PIN# 500021499#

Attendance	
Christina Berberich	Chair
Len Finocchio	Vice Chair
Rahn Garcia	Member
Dinah Phillips	Member
Marco Martinez-Galarce	Member
Kim "Coach" Campbell	Member
Michelle Morton	Member
Gidget Martinez	Member
Amy Peeler	County of Santa Cruz, Chief of Clinic Services
Raquel Ramirez Ruiz	County of Santa Cruz, Sr. Health Services Mgr.
Mary Olivares	County of Santa Cruz, Admin Aide
Meeting Commenced at 3:06 pm and concluded at 4:37 pm	

Excused/Absent:

Absent: Ardella Davies
Excused: Caitlin Brune

1. Welcome/Introductions

2. Oral Communications:

3. County of Santa Cruz Integrated Health Center Commission will meet via teleconference as authorized under AB 361 and Government Code section 54953(e)(3).

This item was added to the agenda as an emergency item and needs to be on every agenda. Rahn made a motion to add language regarding making a finding on the need to meet remotely due to the continuing nature of the coronavirus and the additional Monkeypox virus. The rest of the members present were all in favor.

4. July 5, 2022, Meeting Minutes - Action item

Review of July 5, 2022, Meeting Minutes – Recommended for Approval. Len moved to accept minutes as presented. Marco second, and the rest of the members present were all in favor.

5. Service Area Review-Action Required

Raquel presented the Service Area Review – Recommended for Approval. Raquel reviewed with the commission the defined services, medically underserved population areas, delivery of site, and hours of operation. Raquel gave this overview and stated we must prove to HRSA that 75% of our patients reside in the county and the zip codes that we say we are serving. She stated the purpose of this is to ensure we are meeting the priorities of the Federal Government in terms of the funding that we receive from HRSA.

Raquel also presented last year's list of hours of operation and stated today we are asking for approval to change some of the hours of operation, she reported the following. Corral Street Recuperated Center currently we have someone on site 20-35 hrs. a week. We are proposing to reduce that by 5 hours; Dientes - Beach Flats are going from a 30-hr. site to 37.7 hr. site; HPHP will reduce by 1-hour and 1430 Freedom Blvd. Buildings C and D are accounting for evening hours as well as open during lunch time. Raquel combined two action items.

6. Hours of Operation- Action Required

Rahn stated we are combining for approval items 5 and 6 on the agenda. Rahn made a motion to approve the Service Area Review with edits on form HRSA 5-B and further accept the recommendation to approve the continuation of continued current service delivery site and services and recommends approving the edits of hours of operations. Len second the approval and all the members present all in favor.

7. Continuity of Care/Hospital Admitting Policy- Action Required

Raquel stated this is a new policy that is needed for our HRSA regulations. She stated this is giving a general statement of how we want to track our emergency visits and how we track and what we do once our patients go to the emergency

room. Our goal is to call and reach out to those patients within 24-72 hours to get them into follow up care with their primary care physician. The question was asked from one of the commissioners on how we are going to know that this is being acted upon when someone is admitted? Raquel will check with staff member who is doing this to determine how they are tracking. Raquel will report back on how this is being monitored. Rahn motion to accept policy, Dinah second, and the rest of the members present all in favor.

8. Quality Management Plan Review-Action Required

Raquel stated that HRSA requires us to review our Quality Management Plan with our committee and bring to the commission for final review/approval. Raquel reviewed the track changes with commissioners and stated the only changes they are making is to include the Patient Family Advisory Panel that they are starting up at the different health centers. Kim "Coach" motioned to accept and approve, Dinah second, and the rest of the members present all in favor.

9. Quality Management Committee Update

Raquel reported that at the last Quality Management Committee meeting they reviewed the risk management plan, immunizations data, and the Quality Improvement template. She stated they have a template where they list all the Quality Improvement Projects and they were debating about using a different tool but landed back on the same tool because it works and functions for them. Raquel also reported at the Peer Review Committee meeting they had Privacy Officer, James Dyer report on HIPAA assessments and review and perhaps she will invite him to present at our next meeting. She also reported they had reviewed the chart audit form that they use on a quarterly basis and made some edits to the form.

10. Social Justice

This item tabled for next month's meeting.

11. Financial Update

Julian presented a high-level overview of the fiscal 2022/2023 budget year which was approved by the Board Of Supervisors on 6/28/22. The action he is requesting today is to ratify the recommend Clinical Services Division Budget for this coming year. Julian went over strengths, weakness, opportunities, and threats. Julian presented the 4-year budget trend he stated expenditures overall are up about 10.8%, and there was an 8% increase in revenues. Julian reported on some of the potential revenue and balances:

- Grants and Revenue: $3,969,109.66COVID 19 ARP balance: ($1,774,015.66)
- COVID 19 ARP Phase 4 balance ($0)
- HRSA ARP Infrastructure Grant ($680,136)
- "Proposed" Saturday Clinic Net Revenue ($355,808)
- Ryan White Part C funding ($409,150)
- SAHMSA Grant: $750,000 annually over 5 years (decision in September)
- Suite B Remodel will add 4 exam rooms when completed

Julian also reported on the positions supported in whole or in part by the federal section grant H8F grant and stated they were almost all filled. Len moved to ratify 2022/2023 budget. Kim "Coach" second rest of members present in favor.

12. CEO/COVID 19 update

Amy reported we will have a new patient member Tami Rose. She is scheduled to be nominated on August 9th and we are hoping to see her at September's meeting. Amy also reported that next week is National Health Center Week and one of the things we are doing is an open house at HPHP on Thursday August 11, from 9-11 am. Amy also stated she will be doing a presentation at the Health Improvement Partnership and we also have a board proclamation for National Health Center week.

There was discussion after the meeting regarding Integrated Health Center Commission will meet via teleconference as authorized under AB 361 and Government Code section 54953(e)(3). Rahn stated this needs to be added to every agenda and voted on. The AB 361 form needs to also needs to be attached. Mary to send through DocuSign to Christina for signature and fill in AYES: NOES: ABSENT: and ABSTAIN sections.

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

SUBJECT: Continuity of Care and Hospital Admitting	**POLICY NO.:** **300.31**	COUNTY OF SANTA CRUZ HEALTH SERVICES AGENCY
SERIES: 300 Patient Care and Treatment	**PAGE:** 1 **OF** 2 **EFFECTIVE DATE:** August 2022	**Clinics and Ancillary Services**
APPROVED BY: Amy Peeler, Chief of Clinic Services	**REVISED:**	

GENERAL STATEMENT:

This policy outlines the process of tracking hospital and emergency department (ED) visits for established primary care patients seen in the health center within the past 24 months. The Health Services Agency Clinic Services Division will provide Continuity of Care visits post Hospital and Emergency Room admissions. Hospital admissions visits are staffed by a hospitalist group through a written agreement.

POLICY STATEMENT:

Tracking hospital and emergency visits as close as possible to when they happen can enhance follow-up, prevent readmission, and improve monitoring, which may prevent the condition from worsening. To accomplish this effectively, there is two-way communication with the health centers and hospital systems via the Santa Cruz Health Information Exchange (HIE). The clinician is notified through the HIE of an admission or ED visit. Health center staff will utilize the Central California Alliance for Health reporting portal to reach out to patients within 24-72 hours after a hospital admission or ED visit and will continue to follow up until contact is made, patient is seen or at least three attempts are completed. The goal of outreach will be to offer an appointment with the patient's primary clinician for continuity of care and follow up of any outstanding medical issues.

Clinical staff should also ask patients at the beginning of appropriate visits whether they have had a hospital admission or ED visit since their last health center appointment.

REFERENCE:

Health Resources & Services Administration (HRSA) Health Center Program Compliance Manual Chapter 8: Continuity of Care and Hospital Admitting

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

July 2022

Introduction and Statement of Purpose

Santa Cruz County Health Services Agency's Clinic Services Division (CSD) 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 Clinics, ***is to provide high quality, comprehensive primary care services, outreach, and advocacy to community members who have traditionally been marginalized by socioeconomic, cultural, language or other barriers to health care.*** 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.

CSD 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, CSD 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.

Our Theory of Change

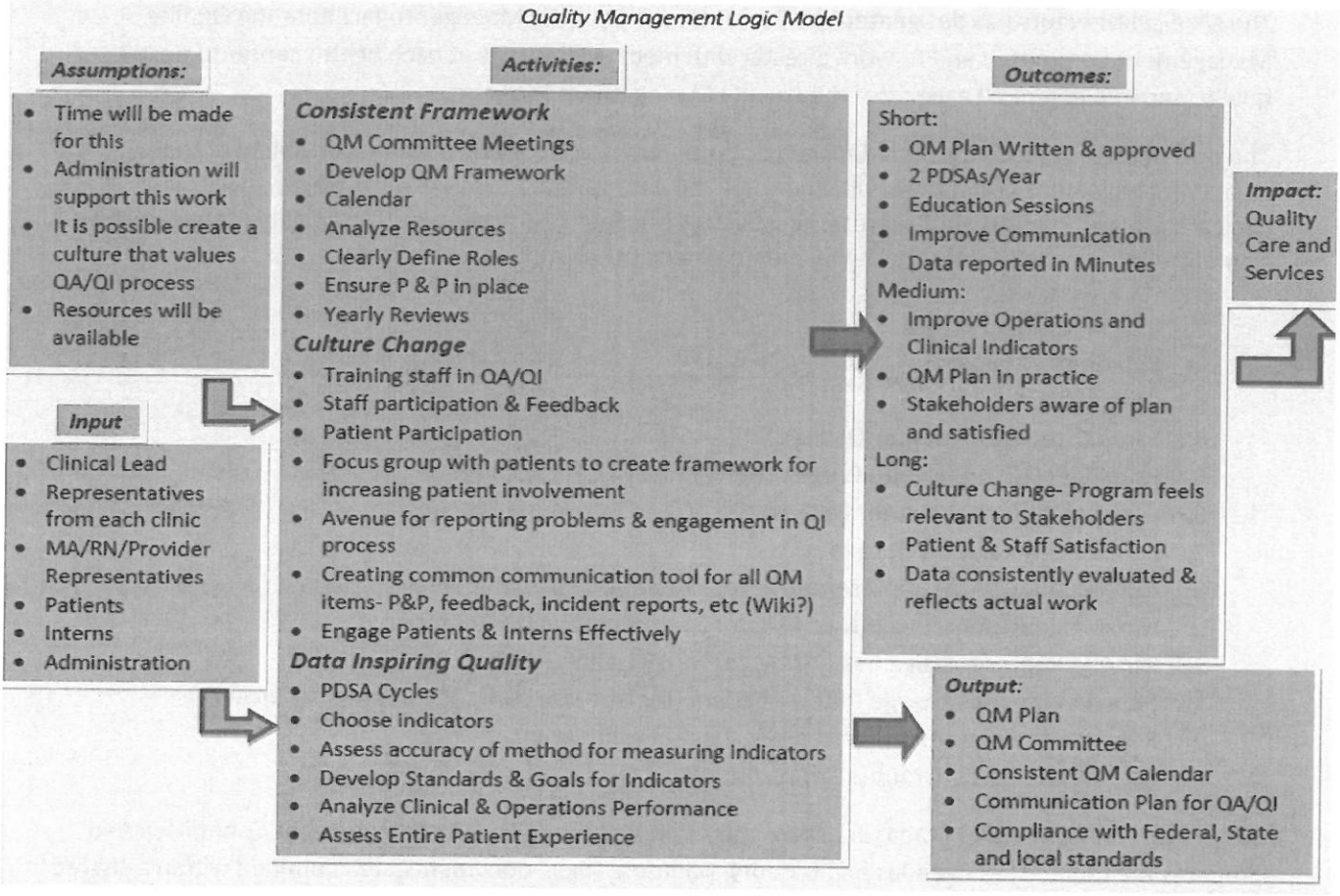
Our Quality Management team has defined a clear set of objectives that will allow us to overcome barriers and reach our goal of consistently high-quality patient care that is confirmed through objective measures.

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.



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, Immunizations, 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 Clinics Services Division. 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 CSD Quality Management program is the collaborative responsibility of the CSD 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. CSD Medical Directors
2. CSD Chief of Clinics
3. Data Analyst
4. Santa Cruz Health Center QI Lead
5. Homeless Persons Health Project (HPHP) Health Center QI Lead
6. Watsonville Health Center QI Lead
7. Public Health Liaison QI Lead
8. Nursing (RN or MA) Representative for Watsonville Health Center
9. Nursing Representative (RN or MA) for Santa Cruz Health Center
10. Nursing Representative (RN or MA) for HPHP Health Center
11. Representatives At-Large (Intern, patient, registration staff, or community partner)
12. Representative from Integrated Behavioral Health team
13. 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 CSD computer system. A quorum is defined as presence of 4 core members.

Representatives to the committee are re-assessed on an annual basis.

The Quality Management Committee is responsible for:

- Developing priorities and setting thresholds for Quality Indicators
- Ensuring that all sub-populations are represented in Quality indicators and activities
- Requesting further investigation of specific topics
- Analyzing data and audits
- Recommending membership on Quality Improvement Teams
- Participating in and assessing patient satisfaction surveys
- Reporting committee findings and recommendations to all stakeholders
- Facilitating an annual evaluation of the Quality Management Program.

Meeting Structure

Meetings are conducted on the same day and time monthly. A Yearly Calendar has been created to ensure that the Quality Management Committee meets all its objectives for the year. The template includes key operational and clinical indicators, reporting expectations, and quality improvement activities. As this is an iterative process, we utilize our experience in prior years to improve upon our processes for the following year.

A template for the meeting Agenda and Minutes can be found in Attachment 2. An annual 'open house' or presentation to provide all stakeholders with the opportunity to learn more about the committee, contribute additional ideas and consider membership. This provides the committee with an opportunity to further engage stakeholders and promotes the ability to strengthen the institutional value of quality assurance and quality improvement. To this end, the Quality Management Committee has identified the following key stakeholders:

- Patients
- Clinic Providers
- Nurses, Medical Assistants
- Front Office Staff
- Administrators
- Community Partners
- Co-Applicant Commission

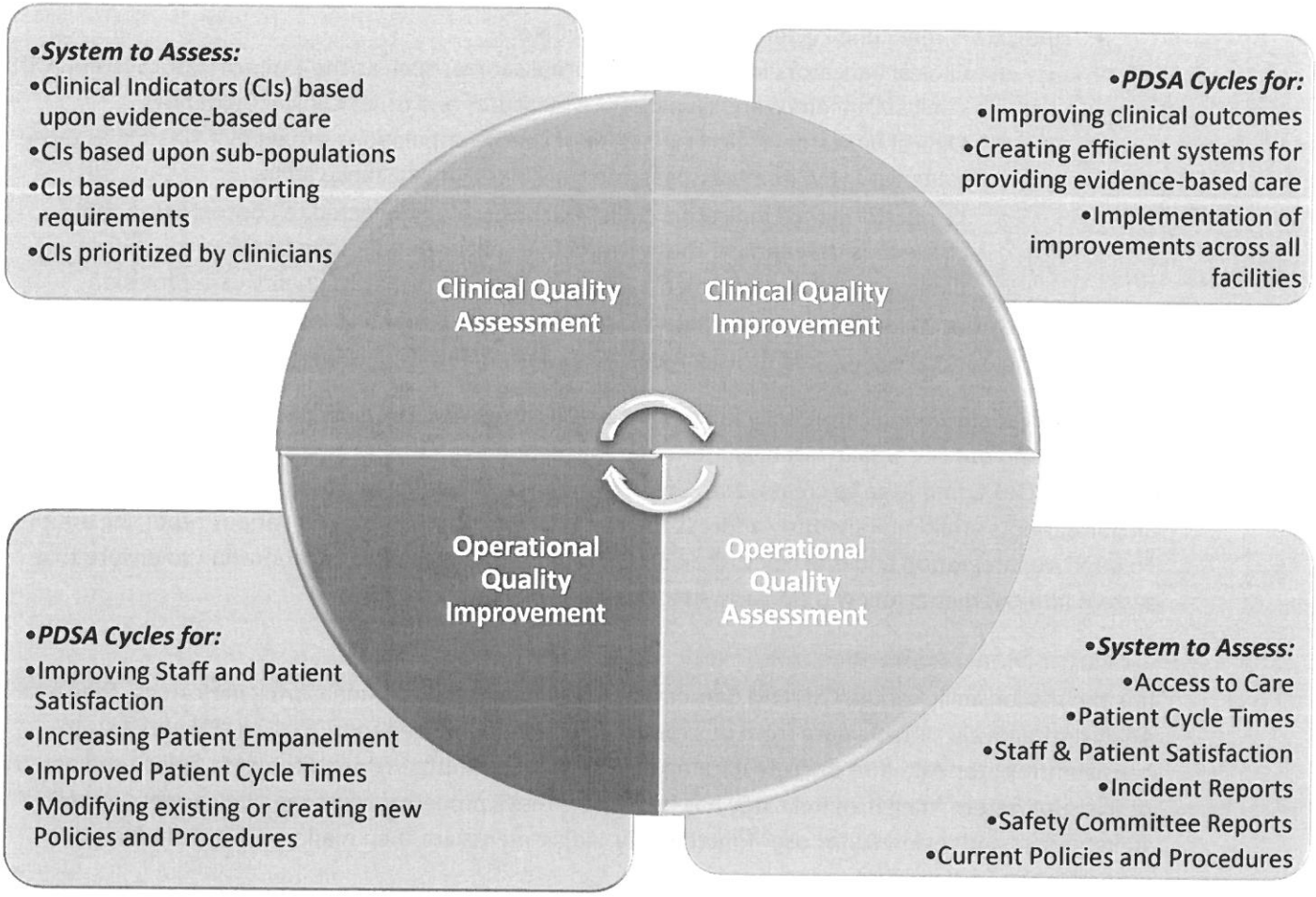
Defining Quality and Quality Management

Developing a comprehensive Quality Management Plan requires a commonly agreed upon definition of Quality. This is particularly important as we engage stakeholders in the integration of quality management into our institutional work. For this plan, CSD has chosen to adopt the World Health Organization (WHO) and Institute of Medicine (IOM) definition of quality as it pertains to health systems. The definition emphasizes a whole-system perspective that reflects a concern for the outcomes achieved for both individual service users and whole communities. This is particularly applicable given our dual role of providing individual clinical care and protecting public health. The WHO and IOM definition suggests that a health system should seek to make improvements in six areas of quality.

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.



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

    - 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 CSD 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 CSD 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 CSD 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 CSD QM Committee facilitates collaboration to ensure that system improvements follow a similarly streamlined approach.

Indicator Measurement

It is the responsibility of the CSD 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 CSD QM Committee is responsible for developing standards and goals for the indicators we have chosen to follow. Results will be compared to HSA Clinics' internal goals and to external benchmarking standards. Indicators are reviewed by the CSD 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 Clinics 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.

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 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 CSD 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

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 CSD 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

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 p~~P~~atient p~~P~~articipation via patient focus groups such as the Patient Family Advisory Panel (PFAP)
- ~~Focus group with patients to create framework for increasing patient involvement~~
- 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

Utilization Management

The CSD 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 CSD 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 CSD Quality Management Program.

Health Records

Santa Cruz Health Services Agency Clinics 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.

☐ Board approved _____ ___/___/___

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

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.

AR QI 1		Practice Name(s):	WHC
		Required Information:	**WHC**
Clinical Quality Measure 1	**A**	Category	
		Name (Measure Source)	
	B	Reason for selection	
		Numerator description	
		Denominator description	
	Baseline Performance Data		
	C	Numerator	
		Denominator	
		Percentage	-
		Reporting period	
	D	Goal for improvement	
	E	Action Initiation Date	
		Actions to improve	
	Evidence of Remeasurement (Optional)		
	F	Numerator	
		Denominator	
		Percentage	-
		Reporting period	
	G	Assessment of actions	

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

Clinic Services Division

Quality Management Report

August 2022

Quality Management Committee

- Quality Management Plan
- Immunization Data
- Quality Improvement Template Review

		Practice Name(s):
		Required Information
Measure 1	**A**	Category
		Name (Measure Source)
	B	Reason for selection
		Numerator description
		Denominator description
	Baseline Performance Data	
	C	Numerator
		Denominator
		Percentage
		Reporting period
	D	Goal for improvement
	E	Action Initiation Date
		Actions to improve
	Evidence of Remeasurement (Optional)	
	F	Numerator
		Denominator
		Percentage
		Reporting period
	G	Assessment of actions

Peer Review and Risk Management Committee

- Security Risk Assessment

Photo Example

- Chart Audit Form Revision
- Risk Management Trainings Needs

Questions?

Thank You

HEALTH SERVICES AGENCY
CLINIC SERVICES DIVISION
FY 2022-23 BOS APPROVED BUDGET

Budget Presentation
for
County of Santa Cruz
Community Health Center Commission

Aug 2, 2022

Presented by: Dr. Julian N. Wren, CFO of Clinic Services

REQUESTED ACTION

- Commission to Ratify the recommended Clinic Services Division Fiscal Year 22/23 budget.

SWOT

Strengths

* Necessary piece of safety-net
* Revenue generating with PPS rate
* Innovative health community
* Dedicated workforce
* Historically stable bipartisan supported federal funding
*Mobile Unit

Weaknesses

* Space
* Competing priorities
* Case Management
*Multiple construction projects are taking longer then expected.

Opportunities

* Strategic Planning
* Deeper collaboration with FQHCs and CBOs
* Opioid crisis funding
* Homeless funding
* CalAIM
* Additional clinic hours

Threats

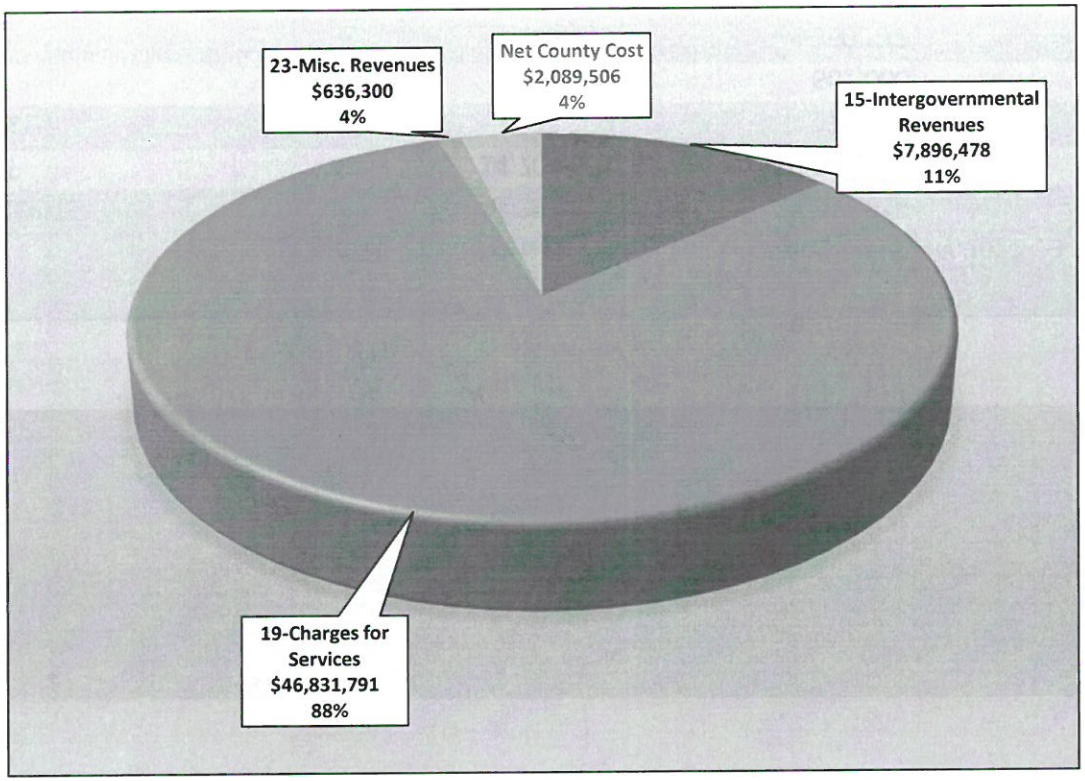
* Space Challenges
* PH Emergencies
*Competitive Job market for Clinicians
*Expensive housing market
*Additional Private insurances covering Medi-Cal patients may affect our base population

	FY 19-20 Budgeted	FY 20-21 Budgeted	FY 21-22 Recommended	FY 22-23 BOS Approved	Percent Change
EXPENDITURES	**44,759,585**	**42,041,525**	**48,073,648**	**53,275,063**	10.8%
50-SALARIES AND EMPLOYEE BENEF	25,985,173	24,291,511	27,397,016	31,736,711	15.8%
60-SERVICES AND SUPPLIES	6,566,010	6,262,919	7,668,703	6,991,981	-8.8%
70-OTHER CHARGES	2,741,421	2,552,213	3,367,280	4,256,325	26.4%
80-FIXED ASSETS	323,334	196,135	196,211	893,873	355.6%
95-INTRAFUND TRANSFERS	9,235,873	8,538,747	9,444,438	9,396,173	-0.5%
90-OTHER FINANCING USES	100,000	200,000	0	0	0.0%
REVENUES	**-44,827,400**	**-43,474,521**	**-49,316,833**	**-53,275,063**	8.0%
15-INTERGOVERNMENTAL REVENUES	-4,030,520	-5,144,475	-6,417,946	-6,991,981	8.9%
19-CHARGES FOR SERVICES	-39,307,722	-36,650,741	-42,087,878	-46,831,791	11.3%
23-MISC. REVENUES	-1,489,158	-1,679,305	-811,009	-636,300	-21.5%
NET COUNTY COST (GENERAL FUND)	**124,412**	**-1,432,996**	**-1,243,185**	**-2,089,506**	68.1%

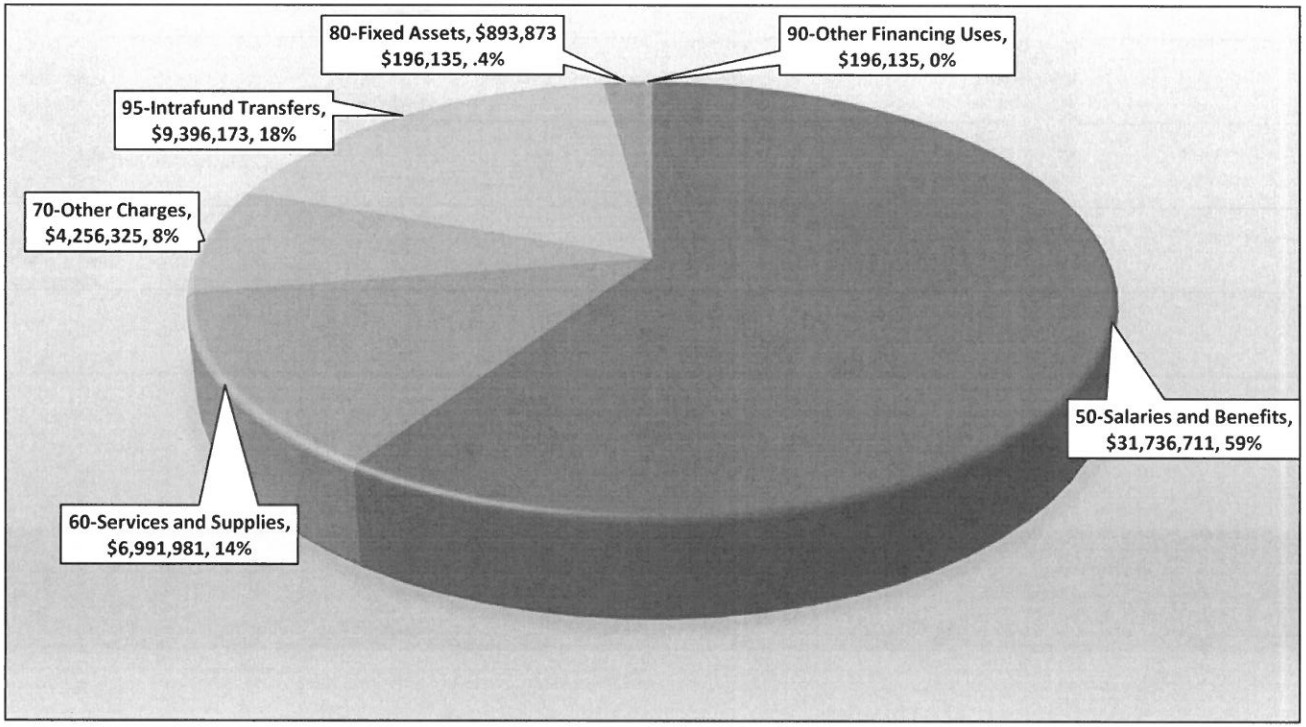
CLINIC SERVICES DIVISION
FY 2022-23 RECOMMENDED BUDGET
Salaries and Benefits Budget Trend

EXPENDITURE	FY 2020-21 Budgeted	FY 2021-22 Budgeted	FY 2022-23 Recommended	Percent Change
50-SALARIES AND EMPLOYEE BENEFITS	**24,291,511**	**27,397,016**	**31,736,711**	**15.8%**
51000-REGULAR PAY-PERMANENT	14,704,601	16,399,242	19,037,160	16.1%
51005-OVERTIME PAY-PERMANENT	274,500	274,500	274,500	0.0%
51010-REGULAR PAY-EXTRA HELP	661,000	661,000	661,000	0.0%
51040-DIFFERENTIAL PAY	269,743	356,577	332,119	-6.9%
52010-OASDI-SOCIAL SECURITY	1,111,319	1,258,209	1,452,269	15.4%
52015-PERS	3,549,407	4,221,157	5,296,855	25.5%
53010-EMPLOYEE INSURANCE & BENEFITS	3,294,324	3,857,303	4,260,398	10.5%
53015-UNEMPLOYMENT INSURANCE	24,341	17,974	20,206	12.4%
54010-WORKERS COMPENSATION INSURANCE	402,276	351,054	402,204	14.6%
55021-OTHER BENEFITS MISC	0	0	0	0%
SALARIES AND EMPLOYEE BENEFITS TOTAL	**24,291,511**	**27,397,016**	**31,736,711**	**15.8%**

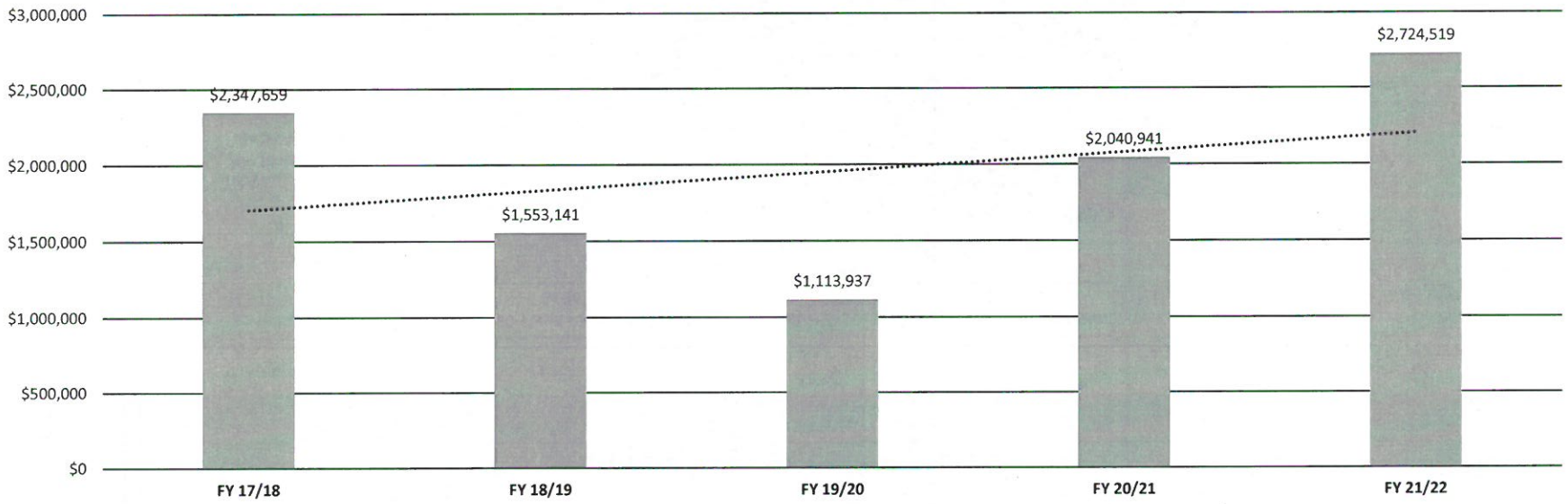
CLINIC SERVICES DIVISION
FY 2022-23 RECOMMENDED BUDGET
$55,364,569 FUNDING SOURCES



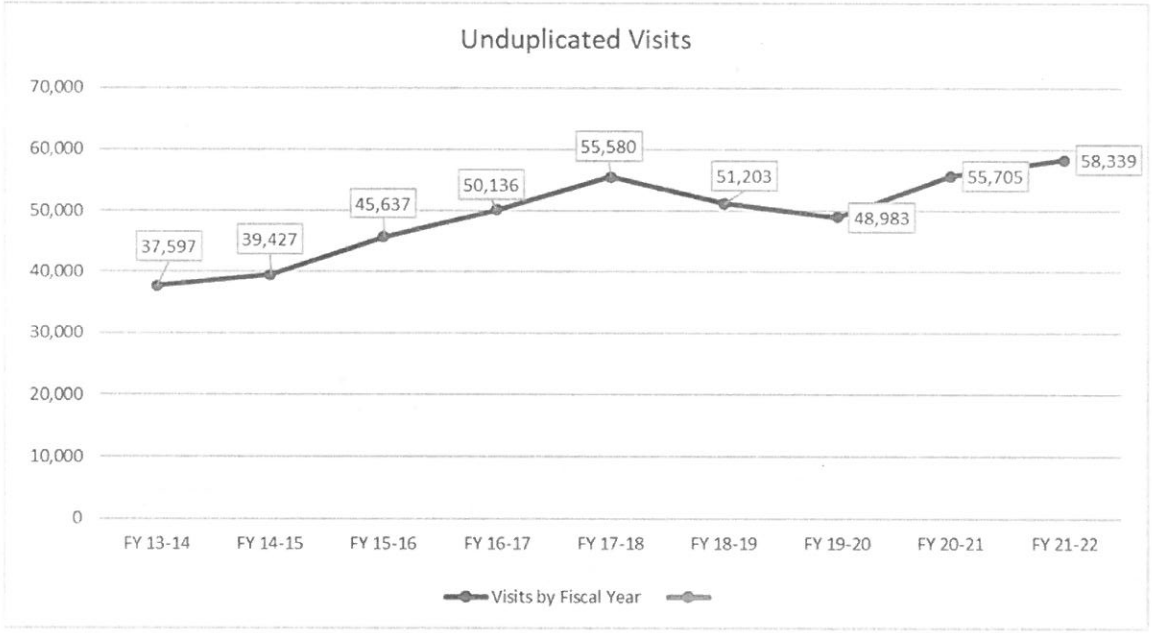
CLINIC SERVICES DIVISION
FY 2022-23 RECOMMENDED BUDGET
$53,471,198 EXPENDITURES



[redacted]


$3,000,000
$2,500,000
$2,000,000
$1,500,000
$1,000,000
$500,000
$0
$2,347,659
$1,553,141
$1,113,937
$2,040,941
$2,724,519
FY 17/18
FY 18/19
FY 19/20
FY 20/21
FY 21/22

CLINIC SERVICES DIVISION
FY 2022-23 RECOMMENDED BUDGET
Unduplicated Visits Trend



Potential revenue and balances

- Grants and Revenue: $3,969,109.66
  - COVID 19 ARP balance: ($1,774,015.66)
  - COVID 19 ARP Phase 4 balance ($0)
  - HRSA ARP Infrastructure Grant ($680,136)
  - "Proposed" Saturday Clinic Net Revenue ($355,808)
  - Ryan White Part C funding ($409,150)
  - SAHMSA Grant: $750,000 annually over 5 years (decision in September)
  - Suite B Remodel will add 4 exam rooms when completed

Additional Budget Narrative: Personnel Object Class Category Justification

Information required for staff positions supported in whole or in part by federal section H8F grant 3610

Filled Positions highlighted

GL KEY	Name	Position Title	Position Code
361115	TBD	MEDICAL CARE SERVICE WORKERS	SM7005AA
361115	TBD	MEDICAL CARE SERVICE WORKERS	SM7003AA
361115	TBD	MEDICAL CARE SERVICE WORKERS	SM7004AA
361115	TBD	MEDICAL CARE SERVICE WORKERS	SM7007AA
361115	TBD	CLERICAL SUPERVISOR II	
361112	TBD	MEDICAL BILLING TECH	CH4999AA
361233	TBD	SR MH CLIENT SPECIALIST	
361333	TBD	SR MH CLIENT SPECIALIST	SK5323AA
361933	TBD	SR MH CLIENT SPECIALIST	
361233	TBD	MH SUPVG CLIENT SPEC	SK8031AA
361331	TBD	CLINIC PHYSICIAN	PT3005AA
361951	TBD	CLINIC PHYSICIAN	PT3028AA
361341	TBD	CLINIC NURSE	PG5134AA
361100	TBD	MEDICAL CARE SERVICE WORKERS	
361100	TBD	MEDICAL CARE SERVICE WORKERS	
361951	TBD	MEDICAL ASSISTANT	NW7086AA
361233	TBD	MEDICAL ASSISTANT	NW7085AA
361341	TBD	MEDICAL ASSISTANT	NW7088AA
361341	TBD	MEDICAL ASSISTANT	NW7087AA
361341	TBD	MEDICAL ASSISTANT	NW7089AA
361241	TBD	MEDICAL ASSISTANT	NW7090AA
361241	TBD	MEDICAL ASSISTANT	SM7008AA
361250	TBD	LAB DIRECTOR	NE9999

Supplies & Fixed Assets

HPHP HVAC Unit Project.

Equipment for Triage Suite D at WHC.

Power Exam Tables.

Management Software for lab.

SUV for WHC.

SUV for MAT/HPHP.

Mobile Ultrasound

Questions?