The County of Santa Cruz
Integrated Community Health Center Commission

AGENDA

May 25th, 2016 @ 12:30 pm

Meeting Location:
  1080 Emeline Avenue, Small Auditorium (basement)
  Santa Cruz, CA 95060
By Phone:
  Rama Khalsa – Behavioral Health Concepts - 5901 Christie Ave, Ste 502 Emeryville, CA
  Samuel Gordon – Santa Clara Hall of Justice - 190 W Hedding St. San Jose, CA

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.
Welcome and Introductions

1. Welcome/Introductions

2. Oral Communications

3. Review and Accept March 9th, 2016 Meeting Minutes

4. Budget/Financial Update

5. Quality Management and Plan Approval

6. Extended Hours for Emeline Clinic - Approval

7. Commission Membership

Action Items from Previous Meetings:

Action Item	Person(s) Responsible	Date Completed	Comments

Next meeting: Wednesday, June 8th 12:30 pm-2:30 pm (small auditorium, 1080 Emeline, Santa Cruz, CA)

The County of Santa Cruz Integrated Community Health Center Commission

Minute Taker: Jessica McElveny

Minutes of the meeting held *March 9th, 2016*

1. Attendance	
Rahn Garcia	Co-Chair
Rama Khalsa	Chair
Pamela Hammond	Member
Raquel Ramirez-Ruiz	Member
Christina Berberich	Member
Dr. George Wolfe	Member
Kristen Meyer	Member
Amy Peeler	County of Santa Cruz, Health Services, CEO of Clinics
Michael Beaton	County of Santa Cruz, Health Services, Director of Administrative Services
Kristina Riera	County of Santa Cruz, Health Services, Analyst
Nikki Yates	County of Santa Cruz, Health Services, Accountant III
Joey Crottogini	County of Santa Cruz, Health Services, HPHP Health Center Manager
Jessica McElveny	County of Santa Cruz, Health Services, Administrative Aide

Meeting Commenced at 12:30 pm and concluded at 1:34 pm

2. Apologies/Absent

Apologies were noted from: Nicole Pfeil and Gustavo Mendoza
Absent: Sam Gordon and Fernando Alcantar

3. Oral Communications

4. Review of February 10th, 2016 minutes

Raquel Ramirez-Ruiz motioned for the acceptance of the minutes, the motion was seconded by Dr. George Wolfe. The rest of the members present were in favour.

5. HPHP Update

Joey Crottogini did a presentation on the water damage and status of construction at HPHP which included a confirmation that no mold was found.

6. Budget/Financial Update

Nikki Yates, provided a budget/financial update. Pam requested that quarterly a budget comparison is done.

7. State Payback

Michael Beaton, reported that the appeal regarding past MediCal payments with the State of California was completed and decided in the County's favour, no money will be returned to the State.

8. Quality Management

Amy Peeler, CEO provided a status update on the Quality Management.

9. CEO Update

Amy Peeler, CEO provided an update.

Action Item 1: Rama requested a summary of the UDS report	**Amy Peeler**

Next Meeting: *April 13th at 12:30 pm at 1080 Emeline Ave, Santa Cruz, CA*

Other Notes:

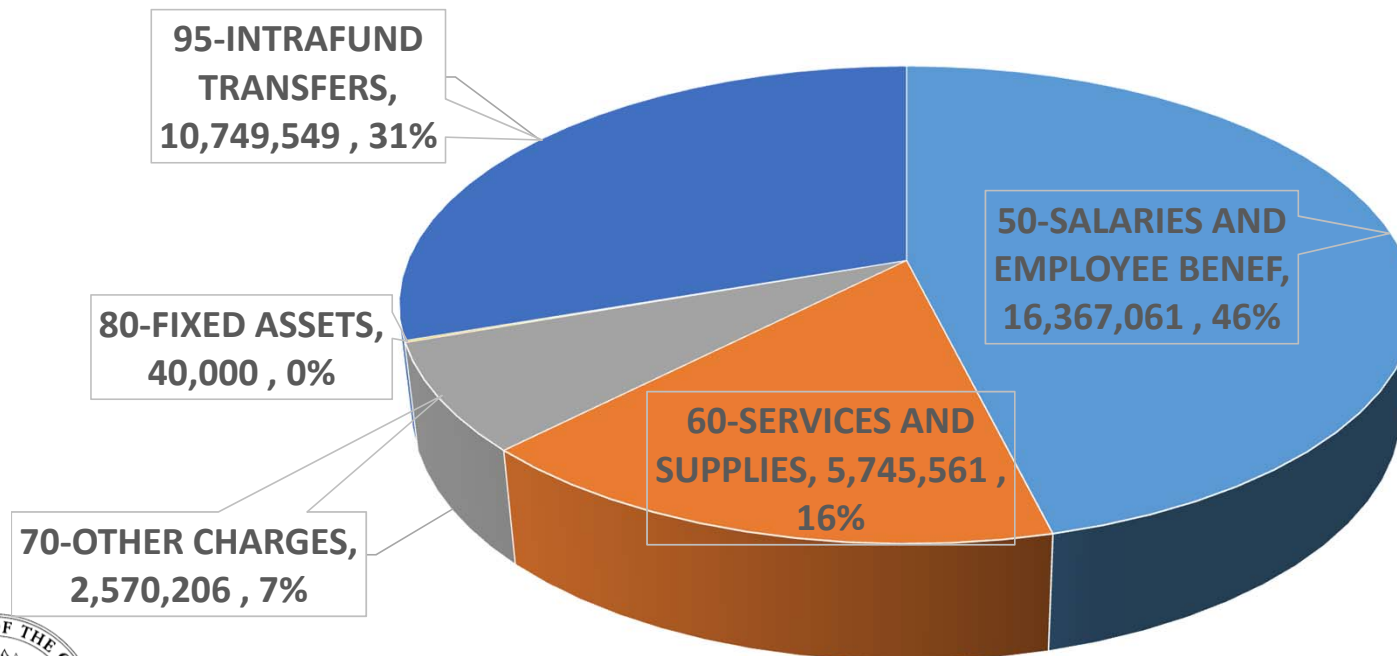# HEALTH SERVICES AGENCY-CLINIC SERVICES FY 2016-17 BUDGET

BUDGET PRESENTATION

COUNTY OF SANTA CRUZ
INTEGRATED COMMUNITY HEALTH CENTERS
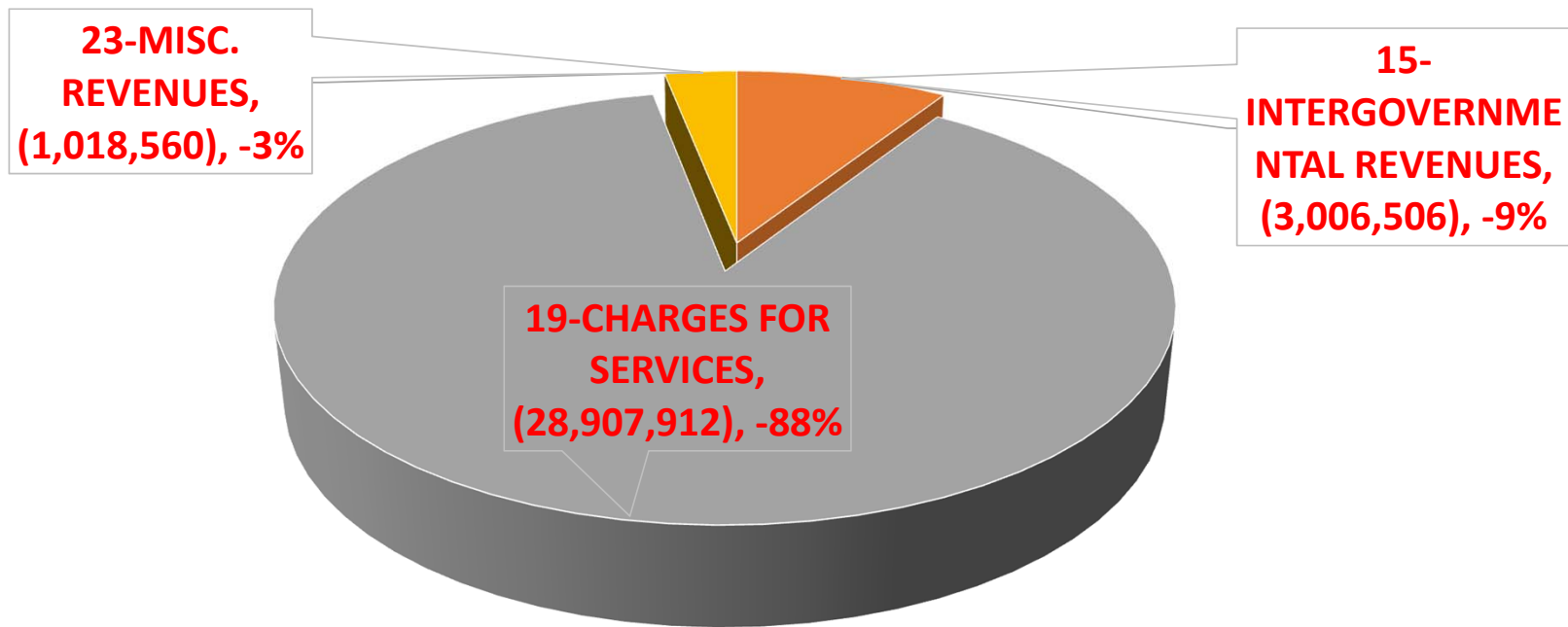**CO-APPLICANT COMMISSION**

Presented by: **AMY PEELER, CHIEF OF CLINIC SERVICES**

MICHAEL BEATON, DIRECTOR OF ADMINISTRATION

CLINICS FY 2016-17 RECOMMENDED BUDGET $35,472,377 APPROPRIATIONS

95-INTRAFUND TRANSFERS, 10,749,549 , 31%

80-FIXED ASSETS, 40,000 , 0%

70-OTHER CHARGES, 2,570,206 , 7%

60-SERVICES AND SUPPLIES, 5,745,561 , 16%

50-SALARIES AND EMPLOYEE BENEF, 16,367,061 , 46%

CLINICS FY 2016-17 RECOMMENDED BUDGET $32,932,978 REVENUES

23-MISC. REVENUES, (1,018,560), -3%

15-INTERGOVERNMENTAL REVENUES, (3,006,506), -9%

19-CHARGES FOR SERVICES, (28,907,912), -88%

CLINICS FY 2016-17 RECOMMENDED BUDGET
Three Year Budget Trend

	FY 14-15 Adopted (REV)	FY 15-16 BUD (REV)	FY 16-17 Proposed
EXPENDITURE	20,707,806	37,470,337	35,472,377
50-SALARIES AND EMPLOYEE BENEF	15,989,108	16,045,500	16,367,061
60-SERVICES AND SUPPLIES	3,334,764	5,631,384	5,745,561
70-OTHER CHARGES	1,495,988	1,713,921	2,570,206
80-FIXED ASSETS	100,000	100,000	40,000
95-INTRAFUND TRANSFERS	(212,054)	13,979,532	10,749,549
REVENUES	(17,876,915)	(34,680,938)	(32,932,978)
5-LICENSES, PERMITS AND FRANCHIS			
15-INTERGOVERNMENTAL REVENUES	(2,568,238)	(2,633,768)	(3,006,506)
19-CHARGES FOR SERVICES	(15,220,117)	(31,928,610)	(28,907,912)
23-MISC. REVENUES	(88,560)	(118,560)	(1,018,560)
29-OTHER GOVERNMENTAL UNIT			
NET COUNTY COST (GENERAL FUND)	2,830,891	2,789,399	2,539,399

4

CLINICS FY 2016-17 RECOMMENDED BUDGET
Salaries and Benefits

Row Labels	Sum of FY 14-15 Adopted (REV))	FY 15-16 BUD (REV	FY 16-17 Proposed
EXPENDITURE	**15,989,108**	**16,045,500**	**16,367,061**
50-SALARIES AND EMPLOYEE BENEF	**15,989,108**	**16,045,500**	**16,367,061**
51000-REGULAR PAY-PERMANENT	10,261,322	10,267,154	10,556,505
51005-OVERTIME PAY-PERMANENT	158,500	158,500	148,500
51010-REGULAR PAY-EXTRA HELP	366,000	466,000	361,000
51040-DIFFERENTIAL PAY	205,709	194,478	243,571
52010-OASDI-SOCIAL SECURITY	765,177	764,951	789,289
52015-PERS	1,987,409	1,797,595	1,928,342
53010-EMPLOYEE INSURANCE & BENEFITS	2,013,582	2,167,161	2,071,086
53015-UNEMPLOYMENT INSURANCE	24,409	9,264	11,605
54010-WORKERS COMPENSATION INSURANCE	207,000	220,397	257,163
55021-OTHER BENEFITS MISC			
Grand Total	**15,989,108**	**16,045,500**	**16,367,061**

CLINICS FY 2016-17 RECOMMENDED BUDGET
Clinic Staffing Changes Recommended YOY

Position	Salary Range	2015-16 Allow	Mid Year Change	2015-16 Total	2016-17 Request	2016-17 Recomm.	Recomm. Change	2016-17 Unfunded
Clinic Nurse II	WA	6.10		6.10	5.50	5.50	-0.60	*
Med Dir - HS Clinics	DV	2.75		2.75	2.00	2.00	-0.75	**
Medical Assistant	Y7	29.50		29.50	31.50	31.50	2.00	
Program Coordinator	BV	1.00		1.00	0.00	0.00	-1.00	*
Public Health Nurse II	VK	3.25		3.25	3.50	3.50	0.25	
Rad Technologist	AJ	0.50		0.50	0.60	0.60	0.10	
Sr Accounting Tech	JL	0.00		0.00	1.00	1.00	1.00	
Typist Clerk III	JF	1.00		1.00	0.50	0.50	-0.50	*
Totals		**123.00**	**0.00**	**123.00**	**123.50**	**123.50**	**0.50**	**0.00**

*Position reduction is that of a Vacant Position (being converted through budget process).

**Position reduction is that of a Current Un-Funded Position (being converted through budget process).

6

CLINICS FY 2016-17 RECOMMENDED BUDGET
Other Charges

	14-15 Adopted (REV)	FY 15-16 BUD (REV)	FY 16-17 Proposed
EXPENDITURE	**1,495,988**	**1,713,921**	**2,570,206**
70-OTHER CHARGES	**1,495,988**	**1,713,921**	**2,570,206**
75000-UNCOLLECTIBLE ACCOUNTS-EXPENSE			
75220-CITY OF WATSONVILLE			
75330-HSA COST ALLOCATION-ADMIN	839,351	1,043,823	1,855,422
75331-HSA COST ALLOCATION-COMBINED	516,637	530,098	574,784
75334-HSA COST ALLOC-PUBLIC HEALTH	140,000	140,000	140,000
Grand Total	**1,495,988**	**1,713,921**	**2,570,206***

*Includes the cost of Accounting Support, IT Support, Personnel Support, Strategic planning, General Administration, County A-87 Cost plan Allocations, Janitorial Services, and cost of Medical Director Oversight.
Allocations are determined based on a combination of FTE, Budget Size, Building Usage, Claims Processed, and Time Studies.

CLINICS FY 2016-17 RECOMMENDED BUDGET INTRA-FUND CHARGES

Row Labels	14-15 Adopted (REV)	FY 15-16 BUD (REV)	FY 16-17 Proposed
EXPENDITURE	**(212,054)**	**13,979,532**	**10,749,549**
95-INTRAFUND TRANSFERS	**(212,054)**	**13,979,532**	**10,749,549**
95211-INTRA-FUND TRF-JV HLL MED CARE	(212,054)	(212,054)	(212,054)
95225-INTRA-FUND TRF-OTHER		14,191,586	10,961,603
MENTAL HEALTH FQHC REVENUE		14,191,586	10,961,603
Grand Total	**(212,054)**	**13,979,532**	**10,749,549**

Decrease year over year is due to slow start up of the Integrated Behavioral Health program and staffing issues with Psychiatry and Clinical Staff. FY 2016-17 represents projected costs paid to Mental Health based on current projected staffing patterns.

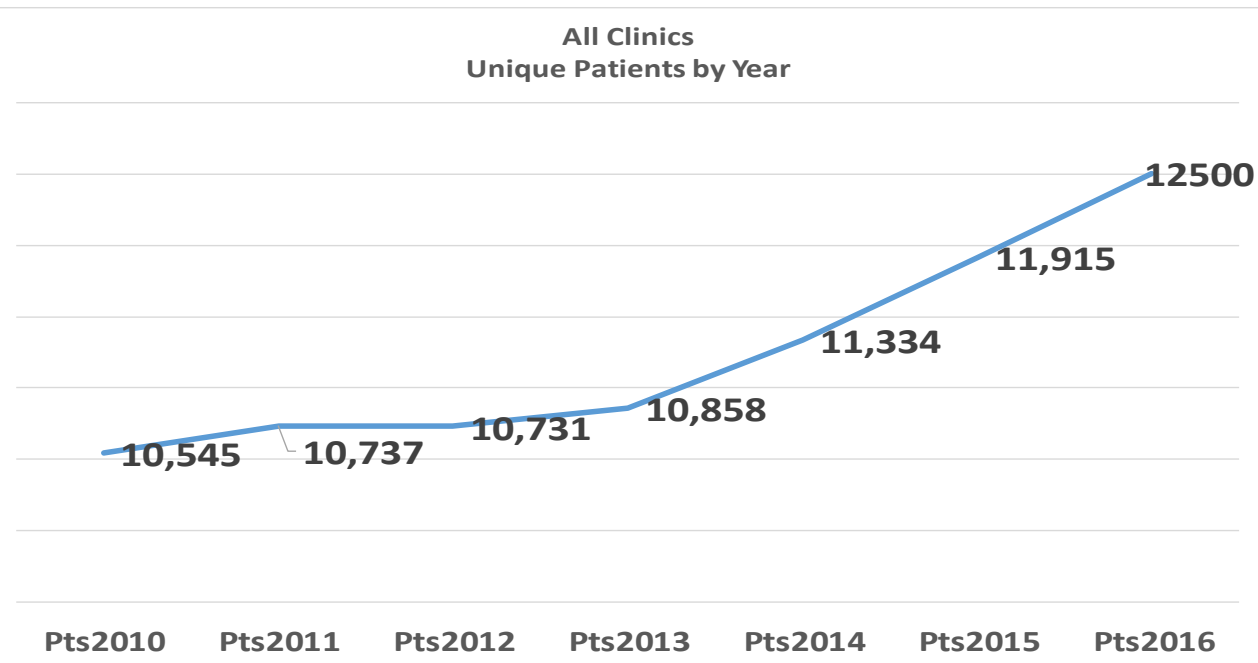# CLINICS FY 2016-17 RECOMMENDED BUDGET INTERGOVERNMENTAL REVENUE

Row Labels	14-15 Adopted (REV)	FY 15-16 BUD (REV)	FY 16-17 Proposed
REVENUES	**(2,568,238)**	**(2,633,768)**	**(3,006,506)**
15-INTERGOVERNMENTAL REVENUES	**(2,568,238)**	**(2,633,768)**	**(3,006,506)**
40935-FED-MAA/TCM MEDI-CAL ADMIN ACT	(265,000)	(265,000)	(265,000)
40954-FED-EMERGENCY SHELTER GRANT	(489,506)	(489,506)	(489,506)
40996-FED-HEALTH PROGRAMS	(1,421,637)	(1,631,088)	(2,252,000)
HRSA GRANT REVENUE	(1,421,637)	(1,631,088)	(2,252,000) ★
41095-FED-MISC GRANTS	(392,095)	(248,174)	0
PH HPHP PROJECT HOME BASE REVENUE	(350,000)	(248,174)	0
Sup-Project Home Base CIMH	(42,095)		

★ HRSA GRANT IS OUR FEDERAL AWARD TO SUPPORT THE UNINSURED AND UNDER INSURED POPULATION. BUDGET ALSO REFLECTS LOSS OF THE PROJECT HOME BASE GRANT.

CLINICS FY 2016-17 RECOMMENDED BUDGET CHARGES FOR SERVICES

Row Labels	14-15 Adopted (REV)	FY 15-16 BUD (REV)	FY 16-17 Proposed
19-CHARGES FOR SERVICES	(15,220,117)	(31,928,610)	(28,907,912)

**All Clinics
Unique Patients by Year**

12500

11,915

11,334

10,858

10,731

10,545   10,737

Pts2010   Pts2011   Pts2012   Pts2013   Pts2014   Pts2015   Pts2016

Decrease due to IBH slow start. Budget based on actual projected staffing

Client volume reflects strong demand for services

Clinic services is facing space capacity issues

10

CLINICS FY 2016-17 RECOMMENDED BUDGET CHARGES FOR SERVICES

Row Labels	15-16 Adopted	16-17 Recommended	Variance
EMELINE CLINIC	(6,252,168)	(6,074,453)	(177,715)
WATSONVILLE CLINIC	(7,112,966)	(7,224,071)	111,105
WATSONVILLE DENTAL	(2,150,000)	(2,656,785)	506,785
FQHC MENTAL HEALTH	(15,299,726)	(12,061,603)	(3,238,123)
CORAL STREET CLINIC (HPHP)	(1,113,750)	(891,000)	(222,750)
Grand Total	**(31,928,610)**	**(28,907,912)**	**(3,020,698)**

CLINICS FY 2016-17 RECOMMENDED BUDGET MISC REVENUE

Row Labels	14-15 Adopted (REV)	FY 15-16 BUD (REV)	FY 16-17 Proposed
23-MISC. REVENUES	**(88,560)**	**(118,560)**	**(1,018,560)**
42384-OTHER REVENUE	**(88,560)**	**(118,560)**	**(1,018,560)**
PH PROJECT CONNECT REVENUE	(88,560)	(88,560)	(88,560)
CENTRAL COAST ALLIANCE REVENUE CBI		(30,000)	(930,000)
Grand Total	**(88,560)**	**(118,560)**	**(1,018,560)**

Budget reflects an increase in funding from Care Based Incentive Revenue from the Central California Alliance for Health

CLINICS FY 2016-17
BUDGET UPDATES SINCE SUBMISSION

ITEMS SINCE RECOMMENDED BUDGET

- HRSA Grant Award $925K for Capital Expansion Emeline 14 Medical Treatment rooms and 6 therapy rooms.

- HRSA Grant Award $325K for treatment services for co-occurring disorder clients

Potential Grants on the Horizon

- Alliance Grant for Capital $2.5 Million to expand capacity

OUTPATIENT MEDICAL CLINICS (36/10/00)

Requirements	Actual 2014-15	Appropriated 2015-16	Estimated 2015-16	Requested 2016-17	Recommended 2016-17	Change From 2015-16
Salaries & Benefits	$11,414,131	$16,045,500	$14,569,227	$16,367,061	$16,367,061	$321,561
Services & Supplies	$2,247,382	$5,631,384	$4,637,159	$5,745,561	$5,745,561	$114,177
Other Charges	$1,375,498	$1,713,921	$1,713,921	$2,570,206	$2,570,206	$856,285
Fixed Assets	$123,874	$100,000	$126,676	$40,000	$40,000	($60,000)
Intra-Fund Charges	($262,589)	$13,979,532	$7,977,085	$10,749,549	$10,749,549	($3,229,983)
TOTAL EXPEND	**$14,898,296**	**$37,470,337**	**$29,024,068**	**$35,472,377**	**$35,472,377**	**($1,997,960)**
Less: Revenue	($12,110,941)	($34,680,938)	($26,234,663)	($32,932,978)	($32,932,978)	$1,747,960
NET COUNTY COST	**$2,787,355**	**$2,789,399**	**$2,789,405**	**$2,539,399**	**$2,539,399**	**($250,000)**
Positions		123.00	123.00	123.50	123.50	0.50
Positions Unfunded		2.75	2.75	0.00	0.00	-2.75

The County's Outpatient Medical Clinics protect the health of individuals and the community through a coordinated health care delivery network offering primary and specialty care, case management and ancillary support services such as pharmacy, laboratory, and imaging. HSA operates clinics in Santa Cruz and Watsonville that provide services to individuals and families who are among the poorest members of the community. Many of these individuals present highly complex medical issues as well as complex social issues due to mental disabilities, substance abuse addiction, and/or homelessness in addition to chronic conditions such as diabetes, HIV/AIDS, or hypertension. Often these patients cannot access mainstream medical care in the community.

2016-17 RECOMMENDED BUDGET

The recommended budget for Clinics provides for a decrease of $1,997,960 in expenditures offset by a decrease of $1,747,960 in revenues.

Expenditures

The recommended decrease of $1,997,960 in expenditures is primarily related to the following:
- Salaries and benefits reflect an increase of $321,561 primarily due to the increased cost of salaries and benefits to support the workforce and associated recommended staffing changes.
- Services and Supplies reflect an increase of $114,177 primarily due to increased data processing costs and medical supplies.
- Other charges reflect an increase of $856,285 in administrative allocation costs. Administrative allocations are done based on FTE and budget size. Over the past year the Clinic budget and FTE have substantially grown and the increased administrative costs reflected in this request is reflective of the growth.
- Intrafund transfers reflect a decrease of $3,229,983 related to an anticipated decrease in client volume due to the newly established Integrated Behavioral Health program.
- Fixed Assets are requested at $40,000 to finalize the replacement of the County's X-ray units. In the FY 2015-16 adopted budget your board authorized $85,000 for replacement of the clinics two X-ray units. An additional $40,000 in appropriations is being requested to finalize the purchase and installations.

Fixed Asset Detail

GL KEY	Quantity	New (N) Replace (R)	Description	Recommended Amount
361260	2	R	New X-Ray Table and Components	$ 40,000
Total	**2**	**R**		**$ 40,000**

Revenues

The overall recommended decrease of $1,747,960 is primarily due to the anticipated changes in client volume within the clinic setting related to the newly established Integrated Behavioral Health program.

Clinics Staffing

Position	Salary Range	2015-16 Allow	Mid Year Change	2015-16 Total	2016-17 Request	2016-17 Recomm.	Recomm. Change	2016-17 Unfunded
Accounting Technician	V2	3.00		3.00	3.00	3.00		0.00
Admin Aide	LO	3.00		3.00	3.00	3.00		0.00
Admin Svcs Mgr	B1	1.00		1.00	1.00	1.00		0.00
Admin Svcs Off I/ II	PR	1.00	(1.00)	0.00	0.00	0.00	(1.00)	0.00
Chief Clinic Services	9A	1.00		1.00	1.00	1.00		0.00
Chief Rad Technologist	BG	1.00		1.00	1.00	1.00		0.00
Clerical Supervisor I	VO	1.00		1.00	1.00	1.00		0.00
Clerk III	FB	6.00		6.00	6.00	6.00		0.00
Clinic Nurse II	WA	6.10		6.10	5.50	5.50	(0.60)	0.00
Clinic Nurse III	VK	5.00		5.00	5.00	5.00		0.00
Clinic Physician-HSA	G9	11.05		11.05	11.05	11.05		0.00
Clinical Lab Scientist	GH	1.00		1.00	1.00	1.00		0.00
Community Hlth Wkr II	K7	2.00		2.00	2.00	2.00		0.00
Deptl Info Systems Analyst	61	1.00		1.00	1.00	1.00		0.00
Deten Nurse Spec II/I	CO/CY	1.35		1.35	1.35	1.35		0.00
Dir Of Laboratory Svcs	AF	1.00		1.00	1.00	1.00		0.00
Health Center Mgr	VE	1.00	2.00	3.00	3.00	3.00	2.00	0.00
Health Service Mgr	VE	1.00	(1.00)	0.00	0.00	0.00	(1.00)	0.00
LabAsst/Phlebotomist	I2	3.60		3.60	3.60	3.60		0.00
Med Billing Tech/Sr Acct Clk	V2/I9	6.00		6.00	6.00	6.00		0.00
Med Care Service Worker	L6	2.00		2.00	2.00	2.00		0.00
Med Dir - HS Clinics	DV	2.75		2.75	2.00	2.00	(0.75)	0.00
Sr MH Client Specialist	GG	7.00		7.00	7.00	7.00		0.00
Medical Assistant	Y7	29.50		29.50	31.50	31.50	2.00	0.00
Mental Health Client Specialist	SG	1.00		1.00	1.00	1.00		0.00
MH Supvg Client Specialist	MT	0.80		0.80	0.80	0.80		0.00
Phys Asst/Nurse Pract	IA	9.10		9.10	9.10	9.10		0.00
Program Coordinator	BV	1.00		1.00	0.00	0.00	(1.00)	0.00
Public Health Nurse II	VK	3.25		3.25	3.50	3.50	0.25	0.00
Public Health Nurse III	YI	1.00		1.00	1.00	1.00		0.00
Rad Technologist	AJ	0.50		0.50	0.60	0.60	0.10	0.00
Sr Accounting Tech	JL	0.00		0.00	1.00	1.00	1.00	0.00
Sr Health Svcs Mgr	W2	2.00		2.00	2.00	2.00		0.00
Sr Hum Svcs Analyst	LL	1.00		1.00	1.00	1.00		0.00
Sr Pub Hlth Microbiolg	XP	3.00		3.00	3.00	3.00		0.00
Sr Receptionist	JF	1.00		1.00	1.00	1.00		0.00
Typist Clerk III	JF	1.00		1.00	0.50	0.50	(0.50)	0.00
Totals		123.00	0.00	123.00	123.50	123.50	0.50	0.00

EHC and WHC Survey Comments:

Winter 2015/2016

1 - May be some or a kids area for pediatrics

5 - Todo Bien: **Everything is good**

18 - En tener mas herremientas mescesarias en cada cuarto. En realizar estudios suficientes cuando una persona no se encuentre satisfecha nadamas con una explicacion y sin haber hecho un estudio a fondo a su problema planteado: **Have more of the necessary tools in each exam room. To have enough studies done on the person's problem if that person is not satisfied with just an explanation and no studies have been done.**

23 - Noting wrong so far, Everyone was great.

29 - Perhaps a greater understanding of my medical condition for the sake of continuing medical…….???

32 - Keep up the good work and keep providing good work environment to your staff

35 - When checking in, I'd rather be asked if my info has changed rather than reception beginning right away to recite my address and or phone #

40 – Solo debo agradecer a Dios y a ustedes la bendición en que me han atendidio. ¡Muchas Gracias! Que Dios los bendiga: **I just want to thank God and staff for the blessings on how I have been attended to. Thank you so much! May God bless you!**

45 – Algunas veces cuando marco directamente con la asistente de me doctor para pedir referencia para ver al especialista recomendado por mi doctor preguntan "Quién le dió este númeo" en lugar de decir muy bien voy a ver su expediente y le envoi la referencias necesario; en lugar de contester molesto. **Sometimes when I call my Doctor's assistant to ask for a reference from my Doctor to see a recommended specialist they ask me "Who gave you this number?" instead of saying, "Great I will look at your chart and I will send you the necessary references"; instead of answering as if they are annoyed.**

47 - See Survey for Many Comments on multiple questions

52 – Puntualidad: **Punctuality**

55 – My Dr. Santiano is one of the most helpful, understanding doctors I have had in a long time. He cares and wants the best for me. I trust him completely. The front desk ladys are always super sweet, and very helpful. They do all they can to get you the help you need. I am very happy with my care.

56 – Mees.on time several times mistakes have been made.

58 - I have been very happy with this clinic over the years

61 - At the Lab: Please use a non-stick bandage

62 – Quisas mejorar en el tiempo de espera despues de la hor de la cita: **Maybe better the wait time after the scheduled appointment.**

65 – I have and continue to be treated with the best care from the gals at checkin to my doctos I'm so grateful you are here for me and I sing your praises to the people in my world. Thank you

76 - I haven't been here since a year and I was told I can't get my RX of alprazolam (??)

82 - Maybe have a way to get some week appointments

88 - Very nice staff and Dr is excellent

89 - Time waiting excessive.

91 - I am very thankful to all the staff for their assistance and help.

92 - Son buenos Los Servicos : **Services are good.**

94 - I love my Dr. but she's so hard to get to see. I wish there were two of her. Overall everything from here is great.

99 - Sometimes the wait is a long time…. But that means the doctor is giving the patient the time needed so it a tradeoff I guess

101 - All of the front staff should be commended surviving the everyday assault of crazy situations that walk up to them every day.

102 – Well I'm old like 70. See if we can have more privileges of getting bus passes or have doctor help us get them so we can get to more doctors' appointments, so we can be on time,

104 - A+

110 – If I need medical care and do not have an appointment, it is almost impossible to get medical attention. Triage sucks it is inadequate and too limited in access Doctors on Duty and such "doc in the box" require a credit card. If I have medi/medi, and I come to Santa Cruz Health Center with a medical problem – of any sort I should be able to see a doctors or NP even is it is not my usual OCO. The nurse hotline is very helpful and good advice.

114 – Lo que puedo decir es que su trabajo le hacen como lo que son. Professional y el trabajo es excelente la clinica. Está limpio y mejorado mucho los felicito. **What I can say is that you do the work as it supposed to be. The clinic work is excellent and Professional. It is clean and has improve a lot. I congratulate you.**

115 - While the wait time for me ranges from 20- 40 minutes it has given me time to prepare for certain upcoming things like exam where I quiz myself using flash cards on my cell phone or even presentations.

123 - Nothing, I really appreciate all the help I have received here are the staff are helpful and keep everything in order.

124 - Let patient know if Dr is running late with appointments + approx time of delay before being seen - Notify patient when checking in + when put into exam room.

126 – Un buen servicio a nivel general: **Very good service on a general level.**

130 – Ninguna: **Not one**

135 – Lo único que hay veces que las lineas telefónicas están muy ocupadas y es imposible hacer citas. Tengo que marcar muchas veces al dia. Talvez pueden mejorar en ese aspecto**: The only thing is that sometimes the telephone lines is very busy and it is impossible to make appointments. I have to call many times per day. Maybe you can improve on this.**

140 – Para me el servicio es Bueno: To me the service is good.

159 - Less waiting time to get communicated with receptionist while on hold

164 – Me gusta venir esta clínica siempre si ayuda y me atíendan bién: **I like coming to this clinic. They always help me and they treat me well.**

165 – Tuve que hacerme dos veces un examen de sangre porque se pierden lost muestras, es algo que no tiene que suceder! El servicio es deficiente: **I have to have my blood examined two times because they lost the first samples. This is something that shouldn't happen. Service is deficient.**

171 – Para mi la clínica y el personal son muy amables y serviciales siempre que tengoi una cita. Gracias por ser haci y nunca cambien su manera de ser. Que Dios los bendiga siempre ha todo el personal: **For me, every time I have an appointment the clinic and its staff are very sweet and helpful. Thank you for being this way and never change. May God bless the staff always.**

173 - no where! This a real good clinic with excellent staff and all around great medical care, Merry Christmas

177 - Excellent Staff

186 – Todo me parece bien en todo el servicio que brinda el centro: **Everything is good to me and all the services the clinic provides.**

188 – Pues de mi parte todo está muy bien. Me gustan todos los servicios, gracias: **Everything is good to me. I like all the services provided. Thank you.**

193 - 5 Star Rating!!! "Outstanding Job Red Team!

199 - I would like to see Dr Brooks very 3wks instead 5-6 wk. I need more treatment she provides

201 – Se necesita mejorar en no hacer esperar tanto tiempo en las citas. Salimos 3 horas. Esto es mucho tiempo, y es muy deficil cuando las personas son ancianas: **Improvement is needed in having us wait so long in our appointments. It took us 3 hours to leave. This is way too long and it is difficult when you are elderly.**

204 – Thank you for the services I receive here. I am experiencing a lot of health changes and I appreciate having the ability to receive health care at all as I only have medical. What medical insurance is available to attach to medical to help improve my insurance.

205 – No tengo ningun comentario. Gracias: **I don't have any comment. Thank you.**

208 - This is my first time using a government health service. I am very thankful for all the services I have receive. I look forward to get a full time well paying job so I can pay back all the free services I have received. There is always room for improvement for perfection! Thank you!

215 - Need a reliable dentist. Dienties and western Dental are crooked. Dermatology im not confident with. Also

217 - On my last visit on 11/4/15, I had an appt for the Lab to draw blood and get my second HEP B shot, since my doctor rescheduled my appt, I came in around 9:00 am, and the first receptionist said she will work me in for the shot. But after I had my blood drawn, I went back to the reception desk and got a different receptionist. She was very short with me and said that I would have to come back in the afternoon, "we only do inoculations in the afternoon".

219 – Yo soy el que tengo que mejorar mi hora y venir cuando me llaman y me toca: **I am the one who needs to be better at coming in when I am called for an appointment.**

Santa Cruz County Health Services Agency
Clinic Services Division
Quality Management Plan
April 2016

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.
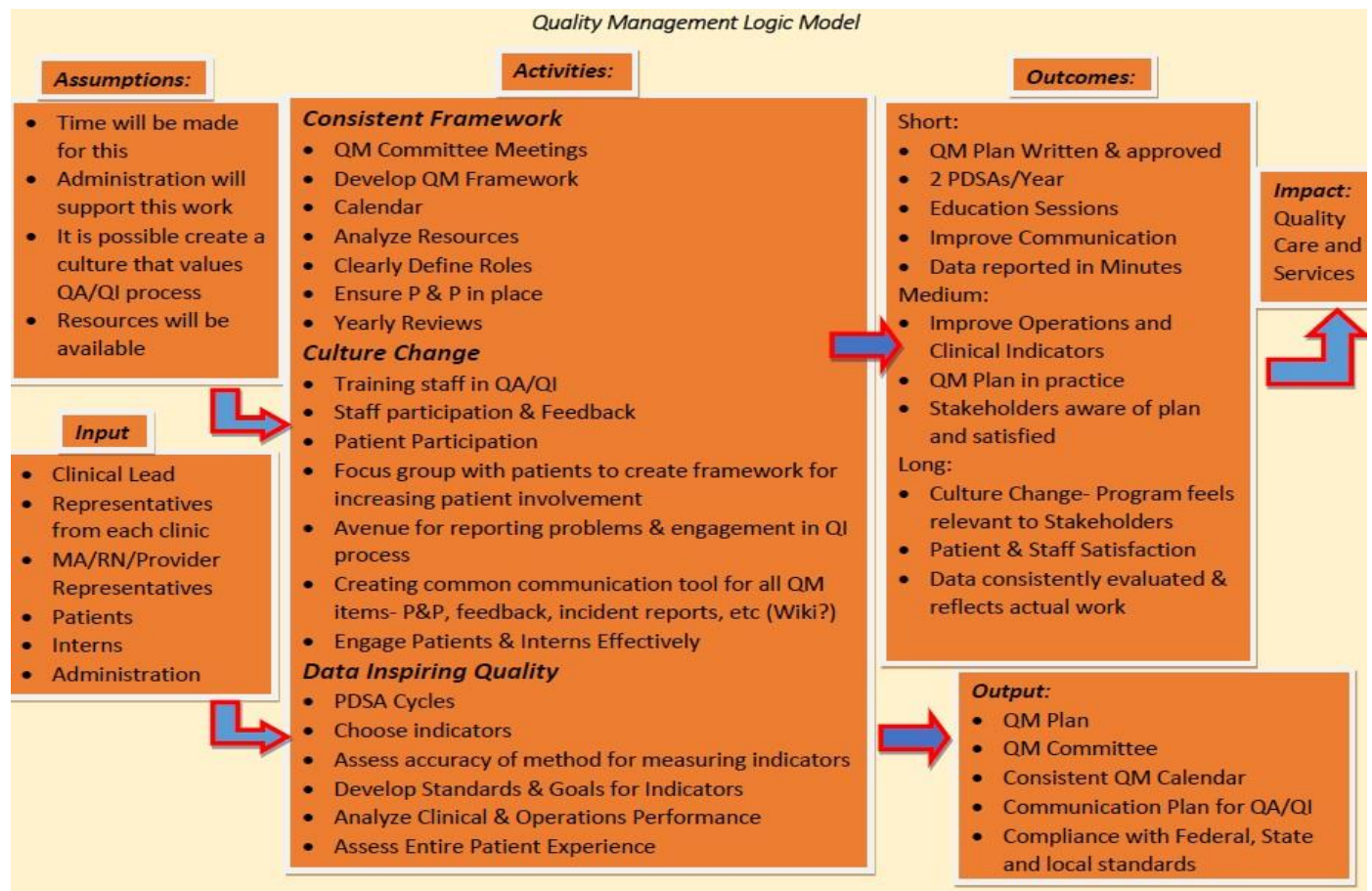
Our Theory of Change

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.

Quality Management Logic Model

Assumptions:
- Time will be made for this
- Administration will support this work
- It is possible create a culture that values QA/QI process
- Resources will be available

Input
- Clinical Lead
- Representatives from each clinic
- MA/RN/Provider Representatives
- Patients
- Interns
- Administration

Activities:

Consistent Framework
- QM Committee Meetings
- Develop QM Framework
- Calendar
- Analyze Resources
- Clearly Define Roles
- Ensure P & P in place
- Yearly Reviews

Culture Change
- Training staff in QA/QI
- Staff participation & Feedback
- Patient Participation
- Focus group with patients to create framework for increasing patient involvement
- Avenue for reporting problems & engagement in QI process
- Creating common communication tool for all QM items- P&P, feedback, incident reports, etc (Wiki?)
- Engage Patients & Interns Effectively

Data Inspiring Quality
- PDSA Cycles
- Choose indicators
- Assess accuracy of method for measuring indicators
- Develop Standards & Goals for Indicators
- Analyze Clinical & Operations Performance
- Assess Entire Patient Experience

Outcomes:

Short:
- QM Plan Written & approved
- 2 PDSAs/Year
- Education Sessions
- Improve Communication
- Data reported in Minutes

Medium:
- Improve Operations and Clinical Indicators
- QM Plan in practice
- Stakeholders aware of plan and satisfied

Long:
- Culture Change- Program feels relevant to Stakeholders
- Patient & Staff Satisfaction
- Data consistently evaluated & reflects actual work

Impact:
Quality Care and Services

Output:
- QM Plan
- QM Committee
- Consistent QM Calendar
- Communication Plan for QA/QI
- Compliance with Federal, State and local standards

Scope of Work

The scope of work within our Quality Management plan is comprehensive, and includes all stakeholders involved in the direct or indirect provision 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 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 Services Director. The Medical Services Director 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 Services Director
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/Clinics Physician 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. Representative At-Large (Intern, patient, registration staff, or community partner)
12. Representative from Integrated Behavioral Health team

The Senior Health Services Manager is currently 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 on a monthly basis. A Yearly Calendar has been created to ensure that the Quality Management Committee meets all of 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' provides 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 meet the second objective outlined in our Strategic Plan that focuses on strengthening 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 the purpose of this plan, CSD has chosen to adopt the World Health Organization (WHO)[1] 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.
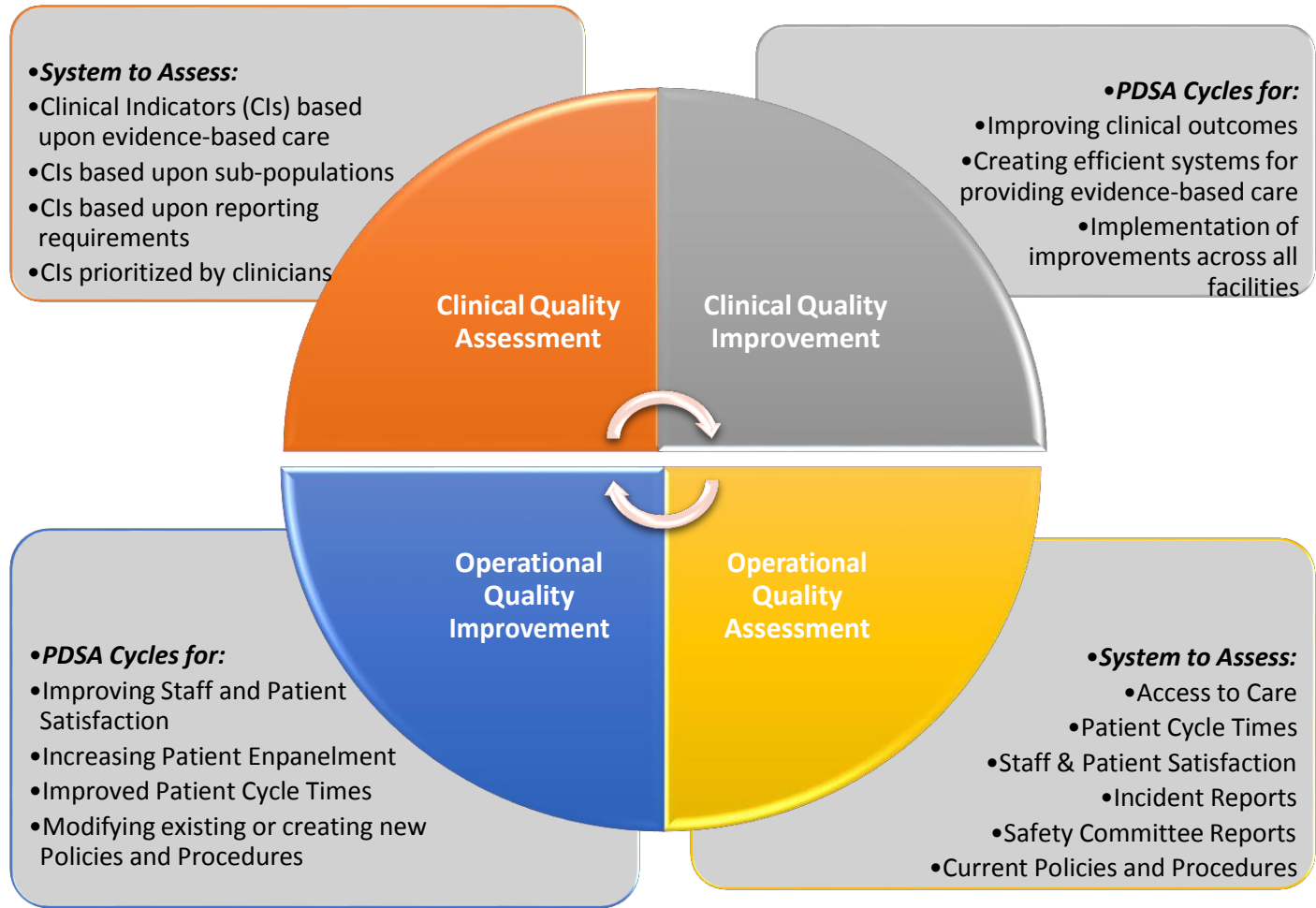
Our shared definition of Quality requires that health care be:

- **_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 takes into account 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 of 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.

- **System to Assess:**
- Clinical Indicators (CIs) based upon evidence-based care
- CIs based upon sub-populations
- CIs based upon reporting requirements
- CIs prioritized by clinicians

- **PDSA Cycles for:**
- Improving clinical outcomes
- Creating efficient systems for providing evidence-based care
- Implementation of improvements across all facilities

- **PDSA Cycles for:**
- Improving Staff and Patient Satisfaction
- Increasing Patient Enpanelment
- Improved Patient Cycle Times
- Modifying existing or creating new Policies and Procedures

- **System to Assess:**
- Access to Care
- Patient Cycle Times
- Staff & Patient Satisfaction
- Incident Reports
- Safety Committee Reports
- Current Policies and Procedures

Clinical Quality Assessment

Clinical Quality Improvement

Operational Quality Improvement

Operational Quality Assessment

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 of 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

- o Departmental Communication Systems
- Indicators reflecting Evidence-based Clinical Care
    - o Clinical Indicators identified by external sources such as the Uniform Data System (UDS) Clinical Outcomes and Quality Care measures and other Clinical Guidelines
    - o Clinical Indicators reflecting health of sub-populations served by CSD such as those living with HIV, homelessness, mental illness or substance abuse
    - o 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 of 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[2] 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.

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.

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[2] Adapted from Institute for Healthcare Improvement
http://www.ihi.org/resources/Pages/HowtoImprove/ScienceofImprovementFormingtheTeam.aspx

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 Work Flow for Issues Brought to the Committee:

1. Comes to 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
- Staff participation & Feedback
- Patient Participation
- 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 a Wiki 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.

Confidentiality

The activities of the Quality Management Program are legally protected under the California Health & Safety Code Section 1370. The law protects those who participate in quality of care or utilization review. It provides further that "neither the proceedings nor the records of such reviews shall be subject to discovery, nor shall any person in attendance at such reviews be required to testify as to what transpired threat."

All copies of minutes, reports, worksheets and other data are stored in a manner ensuring strict confidentiality. A written confidentiality policy detailing procedures for maintenance and release of data and other QI related information governs the release of such information. This policy specifies the use of record number or other identifiers in place of patient names, and code numbers in place of physician or other provider and staff names. This policy also provides methods for restricting all quality improvement documents solely to authorized individuals. In addition, all data will be treated as Medical Staff peer review information as defined in the California Statute and shall be considered protected information under the provisions of the California Evidence Code 1157.

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.

Attachment 1: Quality Management Work Plan Template- 2016 Update
County of Santa Cruz, Health Services Agency, Clinic Services Division

Our goal for 2016 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. These include Patient & Staff Satisfaction, Clinical Care, and Clinical Operations. 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 1 PDSA within each category per year. In addition, Quality Assurance activities will be conducted throughout the year.

	PATIENT & STAFF SATISFACTION	CLINICAL CARE	CLINICAL OPERATIONS
DEFINE/CLARIFY KEY INDICATORS			
IMPROVE DATA COLLECTION METHODS			
BUILD UPON PRIOR PROJECTS			
IMPROVE- PDSAs			

Attachment 2: Quality Management Committee Meeting Agenda and Minutes

QM Committee:	
Date/Time:	-------, 8:30 to 10:00 am
Meeting Location:	1080 Emeline, Room 230
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 230