

# The County of Santa Cruz

## Integrated Community Health Center Commission

### MEETING AGENDA

July 2, 2020 @ 11:00 am

**MEETING LOCATION:** ZOOM Meeting Dial - 1 669 900 9128: Meeting ID: 885 7832 3198  
 or Teleconference Call Information - 831-454-2222: Code: 850702  
 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. June 4, 2020 Meeting Minutes – Recommend for Approval
4. Quality Management Plan – Approval Required
5. Quality Management Committee Update
6. Financial Update
7. CEO/COVID-19 Update

**Action Items from Previous Meetings:**

| Action Item  | Person(s) Responsible | Date Completed | Comments |
|--|-----------------------|----------------|----------|
| Bring updated corrected UDS report.  | Raquel                |                |          |
| Keep Commission updated on novel coronavirus (COVID-19)  | Amy                   |                |          |
| Medication Management Therapy. Report back on this topic at the next meeting.  | Raquel                |                |          |
| Send Emergency Operations Plan (EOP) signature page to Christina for signature.  | Mary                  |                |          |
| Report back on maximum out of pocket limit set. Check with other county agencies   | Julian                |                |          |
| Invite Mimi or Dr Newel to our next meeting to give an update on COVID-19  | Amy                   |                |          |
| Bring to Quality Management Committee perhaps have a focus group or do a patient survey on diabetic supply access for our patients | Raquel                |                |          |
| Report how COVID-19 has affected our current budget.   | Julian                |                |          |

Next meeting: August 6, 2020 11:00 am- 1:00 pm

Meeting Location: ZOOM Meeting/Teleconference Call Information - 831-454-2222: Code: 850702  
 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 June 4, 2020

**TELECOMMUNICATION MEETING: ZOOM Meeting - or call in number 831-454-2222: Meeting Code: 850702.**

|   |  |
|---|--|
| <b>Attendance</b>   |  |
| Christina Berberich   | Chair  |
| Len Finocchio   | Vice Chair   |
| Caitlin Brune   | Member at Large                                      |
| Rahn Garcia   | Member   |
| Dinah Phillips  | Member   |
| Pamela Hammond  | Member   |
| Marco Martinez-Galarce  | Member   |
| Amy Peeler  | County of Santa Cruz, Chief of Clinic Services       |
| Raquel Ramirez Ruiz   | County of Santa Cruz, Senior Health Services Manager |
| Julian Wren   | Administrative Services Manager                      |
| Mary Olivares   | Admin Aide   |
| <b>Meeting Commenced at 11:07 am and Concluded at 12:14 pm</b>  |  |
| Excused/Absent:   |  |
| Absent: Gustavo Mendoza   |  |
| 1. Welcome/Introductions  |  |
|   |  |
| 2. Oral Communications:   |  |
| <p>Christina expressed her gratitude for the ability to log in with a web conferencing platform. Christina mentioned that if there was anything that the Commission can do to support the Clinics with COVID-19 to please let them know. She commended Amy for the wonderful work that Clinics is doing during this pandemic.</p> <p>Christina also stated that the Executive Committee is wrapping up Amy's evaluation. Christina asked for a close session Meeting through ZOOM to be scheduled next week to include Len, Caitlin, and herself to discuss Amy's evaluation. Mary to set up.</p>   |  |
| 3. May 7, 2020 Meeting Minutes - Action item  |  |
| Review of May 7, 2020 Meeting Minutes - Recommended for Approval. Rahn moved to review and accept minutes as submitted. Len second, and the rest of the members present were in favour.   |  |
| 4. Quality Management Committee Update  |  |
| <p>Raquel reported that the July she will bring the Quality Management Plan for 2020-21 for review and approval. Raquel reported on the current projects that Quality Management Committee is working on. Watsonville Clinic will begin a Medication Therapy Management Program in collaboration with the Alliance. The pilot program will run for six months. Two providers from the Watsonville Health Center will work with patients with an A1c value of nine or greater to help them get to a healthy range with medication therapy as well as medical nutrition therapy. The Alliance will generate a list from our electronic health record system to review which medications are prescribed and give the providers recommendations on those patients. A Commission member stated how hard it is for him to access some of the diabetic supplies and would it be practical for Clinics to carry these supplies. There was much discussion on this topic Raquel stated she will bring this item to the Quality Management Committee perhaps we can have a focus group or do a patient survey. Raquel also reported on the produce box distribution. We will be providing 300 families a produce box targeting patients with diabetes and obese children in collaboration with Esperanza Community Farms. Raquel also reported that Clinics is working on a recovery team to slowly integrate patients back into the clinics. Watsonville Clinic is starting with well child visits and well women exams. Emeline is receiving feedback from providers as to how they would like to schedule patients. Some possibilities are scheduling half tele-visits and half in person visits, still to be decided.</p> |  |
| 5. 20/21 Budget Financial Update – Action Required  |  |
| <p>Julian reported on the Clinic Services Division fiscal year 20/21 budget. He stated that the Health Services Agency will have their budget hearing on June 22, and 23. He stated as more information is gathered the budget will be modified. Health Services Agency will go to final board approval on August 18, 2020. He presented to the commission a summary of strengths, weaknesses, opportunities, and threats. Julian gave an overall budget summary and reported:</p> <ul style="list-style-type: none"> <li>➤ Decreased budgeted expenditures by adjusting services and supplies and ID of grants to cover normally</li> </ul>  |  |

- paid by clinic revenue.
- Decrease in budgeted fixed assets purchases reflects one-time expenditures in FY 19/20.
- Increased budgeted revenue by filling vacancies using incentives, expanding services (acupuncture), incentive payments, grant funding, and HPHP Mobile Health Unit.
- Health Benefits Rep to increase Medi-Cal and Medi-Care enrolment will increase net collection revenue.
- The COVID-19 pandemic is and will continue to have significant effect on all areas of the budget that were unforeseen.

Julian stated he is planning to do a deep dive to see how COVID-19 has affected our budget. In July, he will have more specifics on how the budget looks for this upcoming fiscal year.

Rahn moved to approve recommend fiscal budget 20/21, Dinah second, and the rest of the members present were in favour.

6 CEO/COVID-19 Update

Amy reported we have started back up with strategic planning and at next month's Commission Meeting she will be able to report our final mission statement. Amy also stated we have two strong candidates for Medical Director and that we used a recruitment firm that works specifically with FQHC. Clinics has agreed to test our staff for COVID-19 on a monthly basis. We have had one of our employees test positive and this was discovered through our testing.

Action items:

Next Meeting: July 2, 2020 11:00 am - 1:00 pm  
 ZOOM Meeting: 1080 Emeline, Santa Cruz, CA

Minutes approved \_\_\_\_\_  
 (Signature of Board Chair or Co-Chair)

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
 (Date)

Santa Cruz County Health Services Agency  
Clinic Services Division  
Quality Management Plan  
July 2020~~19~~

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## 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 (HHP), 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

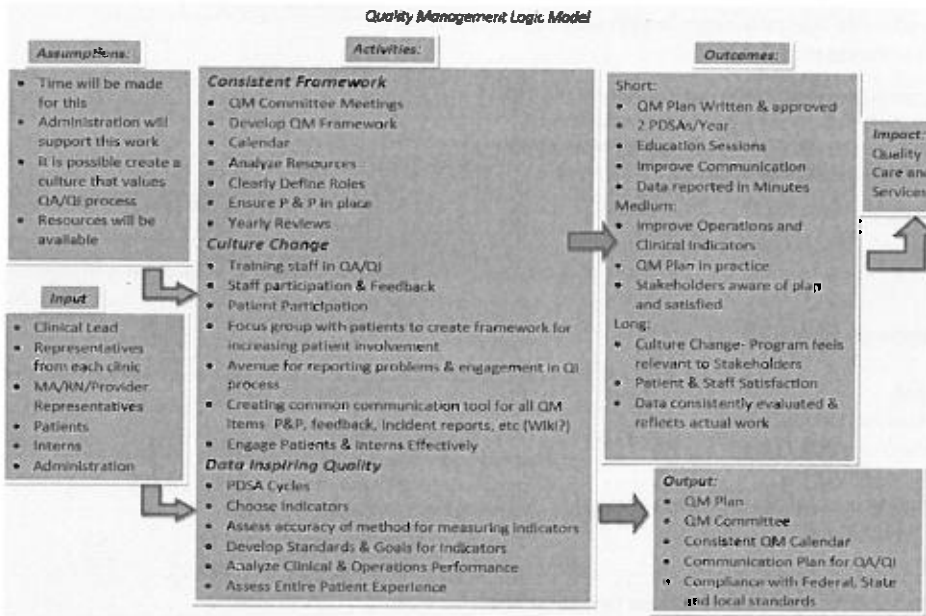
Our Quality Management team has defined a clear set of objectives that will allow us to overcome barriers and reach our goal of consistently high-quality patient care that is confirmed through objective measures.

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 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 Directors. 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.

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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 Directors
2. CSD Chief of Clinics
3. Data Analyst
4. Santa Cruz Health Center QI Lead
5. Homeless Persons Health Project (HHP) Health Center QI Lead
6. Watsonville Health Center QI Lead
7. Public Health/Clinic 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. Representatives At-Large (Intern, patient, registration staff, or community partner)
12. Representative from Integrated Behavioral Health team
13. Ryan White Part C Grantee Representative

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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' presentation is provided 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.

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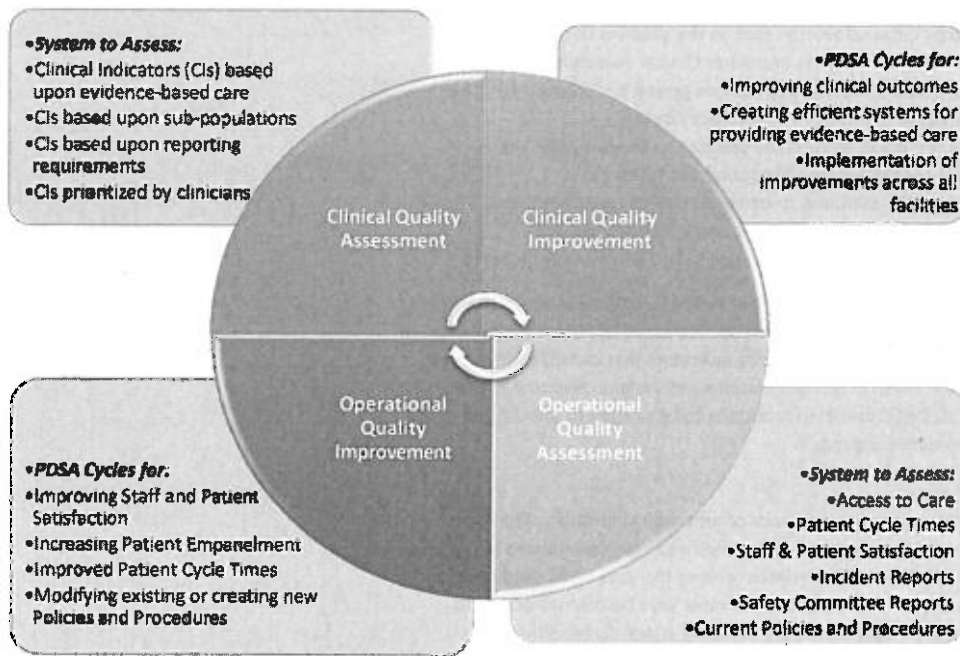
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Our shared definition of Quality requires that health care be:

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

|                      | Expected Activities | Time Frame and Expected Key Outcomes (Clarify Key Indicators) | DATA COLLECTION METHODS | IMPROVE- PDSAs | Actual Outcome Results (to be filled out after PDSA) |
|----------------------|---------------------|---|-------------------------|----------------|--|
| PATIENT SATISFACTION |                     |   |                         |                |  |
| STAFF SATISFACTION   |                     |   |                         |                |  |
| CLINICAL CARE        |                     |   |                         |                |  |
| CLINICAL OPERATIONS  |                     |   |                         |                |  |



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    |
| <b>Calendar Activities for Month</b> |            |                      |                 |           |          |
|                                      |            |                      |                 |           |          |
|                                      |            |                      |                 |           |          |
|                                      |            |                      |                 |           |          |
| <b>Other Action Items Due</b>        |            |                      |                 |           |          |
|                                      |            |                      |                 |           |          |

Minutes approved \_\_\_\_\_  
 / / (Signature of committee facilitator) (Date)

**Next Meeting**

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

# Santa Cruz County Health Services Agency Clinics

Fiscal Presentation

Data through

Through 5/31/20

| Row Labels                     | Forecasted as of 5/31/20 | Actual       | Difference   | % of Forecasted | Notes  |
|--------------------------------|--------------------------|--------------|--------------|-----------------|--|
| REVENUE                        | (41,650,033)             | (27,398,962) | (14,251,071) | 66%             | Revenue Down 34% than Forecasted as of 5-31-20 |
| 15-INTERGOVERNMENTAL REVENUES  | (5,701,912)              | (3,879,226)  | (1,822,687)  | 68%             |  |
| 19-CHARGES FOR SERVICES        | (33,390,463)             | (22,712,498) | (10,677,965) | 68%             |  |
| 23-MISC. REVENUES              | (2,557,658)              | (807,238)    | (1,750,419)  | 32%             |  |
| EXPENDITURE                    | 41,764,078               | 31,846,212   | 9,917,865    | 76%             |  |
| 50-SALARIES AND EMPLOYEE BENEF | 24,085,714               | 19,969,522   | 4,116,192    | 83%             |  |
| 60-SERVICES AND SUPPLIES       | 6,311,121                | 4,652,497    | 1,658,624    | 74%             |  |
| 70-OTHER CHARGES               | 2,512,970                | 2,403,449    | 109,521      | 96%             |  |
| 80-FIXED ASSETS                | 296,390                  | 135,304      | 161,085      | 46%             |  |
| 90-OTHER FINANCING USES        | 91,667                   | 0            | 91,667       | 0%              |  |
| 95-INTRAFUND TRANSFERS         | 8,466,217                | 4,685,440    | 3,780,777    | 55%             |  |
| Grand Total                    | 114,044                  | 4,447,258    |              |                 |  |

\*Forecasted Budget estimated Net County Cost.

Actual Net County Cost as of end of May.

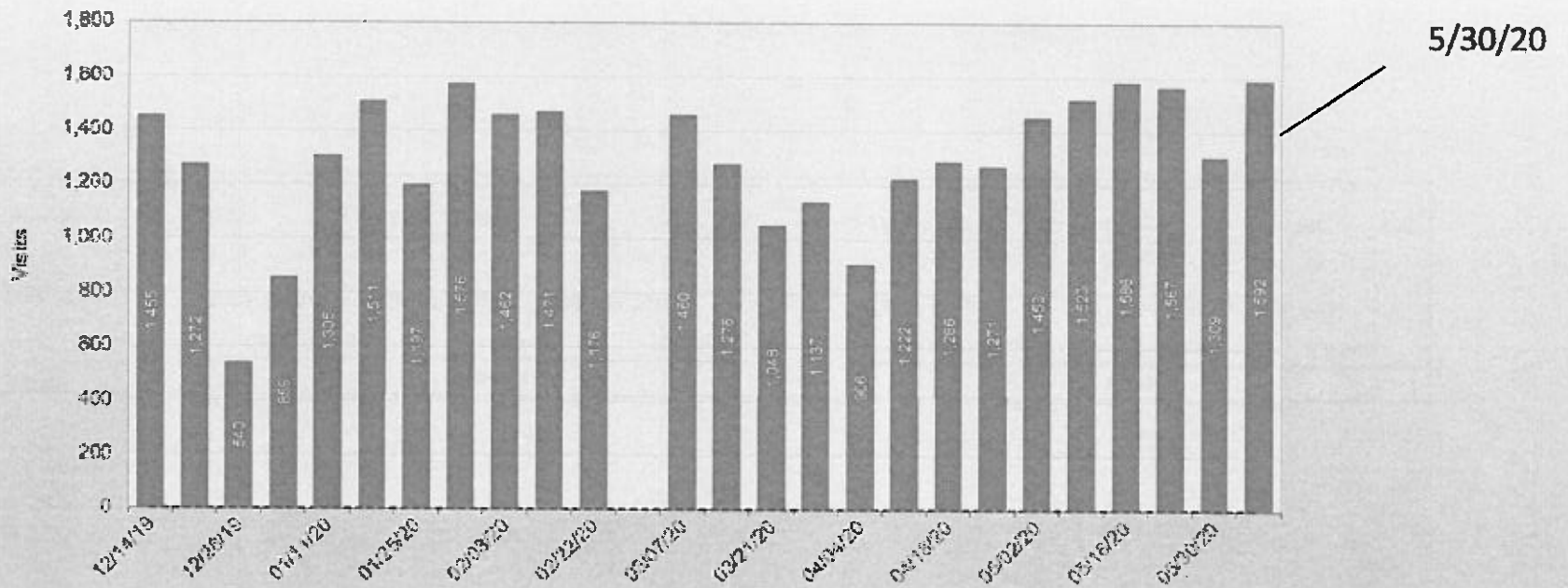
Clinic Services Estimated Actual Net Cost (6/12/20).

\$300,000

\*Our revenues are down YTD however, our expenditures are also underbudget.

\*Many of the visits we have been doing are Virtual Vists, where reimbursement is less than PPS Rate.

### Visit Metrics



Visit Volume: Weekly total of all arrived or completed appointments.

# Visits and Patients from 5/1/19 to 5/31/20

| <u>Revenue Group</u>                      | Patients       |         |           |           |         |         |        | Visits         |         |     |           |         |         |        |
|---|----------------|---------|-----------|-----------|---------|---------|--------|----------------|---------|-----|-----------|---------|---------|--------|
|   | Current Period |         |           | Last Year |         |         | Change | Current Period |         |     | Last Year |         |         | Change |
|   | Total          | Virtual | % Virtual | Total     | Virtual | % Total | %      | Total          | Virtual | %   | Total     | Virtual | % Total | %      |
| Totals for all<br>(Unduplicated Patients) | 10,559         | 3952    | 37%       | 11,380    | 0       | -7%     | 0%     | 44,471         | 8,025   | 18% | 47,327    | 0       | -6%     | 0%     |

# Data References

- Epic Revenue Management Report
- FQHC Defined Visits Report
- Clinic Services Division Financials