

The County of Santa Cruz

Integrated Community Health Center Commission

AGENDA

July 12, 2018 @ 12:30 pm

Meeting Location: 1080 Emeline Avenue, DOC Conference Room (Second Floor), Santa Cruz, CA 95060
5901 Christie Ave., Suite 502, Emeryville, CA 94608, 1430 Freedom Blvd., Suite A,
Watsonville, CA 95076

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. May 10th, 2018 Meeting Minutes – Recommend for Approval
4. Meeting time and attendance
5. HRSA Operation Site Visit discussion
6. Policy Discussion – Recommend for Approval

	Policy #	Policy Name
1	640.01	Health Resources and Services Administration Legislative Mandates Limiting the Use of Funds on HRSA Grants
2	640.02	Salary Limitation
3	640.03	Gun Control
4	640.04	Anti-Lobbying and Legislative Advocacy Policy
5	640.05	Acknowledgement of Federal Funding and Branding Policy
6	640.06	Restriction on Abortions and Women's Reproductive Health Services
7	640.07	Exceptions to Restriction on Abortions
8	640.08	Ban on Funding of Human Embryo Research
9	640.09	Limitation on Use of Funds for Promotion of Legalization of Controlled Substances
10	640.10	Restriction on Distribution of Sterile Needles
11	640.11	Restriction of Pornography on Computer Networks
12	640.12	Restriction of Funding ACORN
13	640.13	Confidentiality Agreements
14	640.14	Definition – Health Care industry

7. Quality Management Committee Update – Recommended for Approval
8. Financial Update
9. CEO Update

Action Items from Previous Meetings:

Action Item	Person(s) Responsible	Date Completed	Comments
#1 Len Finocchio requested follow-up from Dr. Leff regarding the process of identifying Physicians in question of charging fee for service from Medi-Cal patients.			
#2 Len Finocchio requested additional time with Jenn Phan regarding her presentation of Service Area Review data.			
#3 Brown Act information to be sent out with next months agenda.			
#4 Current Patient Satisfaction Survey questions to be provided to members with next months agenda. The questions will be discussed for possible editing prior to distribution next January. Members would like to know where the survey questions originated.	Raquel		

Next meeting: August 9, 2018 12:30 pm-2:30 pm

1080 Emeline Ave, Building D, DOC Conference Room, Second Floor, Santa Cruz, CA

The County of Santa Cruz Integrated Community Health Center Commission

Minute Taker: Linda Manley

Minutes of the meeting held June 14, 2018

NO MEETING WAS HELD AS THERE WAS NOT A QUORUM

Next Meeting: Thursday July 12th, 2018 at 12:30 pm at 1080 Emeline Ave, Santa Cruz, Ca.

Item
5

**COMMISSION REPORT ON OPERATIONAL SITE VISIT FINDINGS
JULY 12, 2018**

1. SLIDING FEE DISCOUNT PROGRAM:

Sliding Fee for Column III Services: Within 90 days, provide documentation that the health center ensures its in scope service(s) provided to health center patients through formal referral arrangements (Form 5A: Column III) are EITHER discounted as follows: 1) A full discount or only a nominal charge is provided for individuals and families with annual incomes at or below 100 percent of the current Federal Poverty Guidelines (FPG); and partial discounts are provided for individuals and families with incomes above 100 percent of the current FPG and at or below 200 percent of the current FPG, adjusted based on gradations in income levels with at least three discount pay classes OR 2) Discounted in a manner such that individuals and families with incomes above 100 percent of the current FPG and at or below 200 percent of the FPG receive an equal or greater discount for these services than if the health center's SFDS were applied to the referral provider's fee schedule; and individuals and families at or below 100 percent of the FPG receive a full discount or are assessed only a nominal charge for these services.

TO DO: Update Sliding Fee Policy to include 340b

Sliding Fee Discount Program Policies: Within 90 days, provide updated policy(ies) for the health center's Sliding Fee Discount Program (SFDP) that apply to all patients and that address the following areas: 1) Definitions of income and family; 2) Assessment of all patients for sliding fee discount eligibility based only on income and family size; 3) Structure of the health center's sliding fee discount schedule(s); and if applicable, 4) Setting of a flat nominal charge(s) at a level that is nominal from the perspective of the patient and does not reflect the actual cost of the service being provided.

TO DO: Create definitions of household and income in Sliding Fee Policy

Sliding Fee for Column II Services: Within 90 days, provide documentation that the health center ensures its in scope service(s) provided to health center patients through contracts/agreements (Form 5A: Column II) are discounted as follows: 1) A full discount or only a nominal charge is provided for individuals and families with annual incomes at or below 100 percent of the current Federal Poverty Guidelines (FPG); 2) Partial discounts are provided for individuals and families with incomes above 100 percent of the current FPG and at or below 200 percent of the current FPG, adjusted based on gradations in income levels with at least three discount pay classes; and 3) No discounts are provided to individuals and families with annual incomes above 200 percent of the current FPG.

TO DO: Update form 5a on HRSA Electronic Handbook

Evaluation of the Sliding Fee Discount Program: Within 90 days, provide a completed evaluation of the health center's sliding fee discount program (SFDP) used to assess its effectiveness in reducing financial barriers to care for patients at or below 200% of the Federal Poverty Guidelines. In addition, provide examples of identified areas where changes to the SFDP were needed, if applicable, along with documentation of implementation of those changes. If the health center has identified the need for changes to its SFDP but documentation of the implementation of such changes is not yet available, provide an action plan detailing the steps the health center will take to implement such changes. Acceptance of this plan by HRSA will result in a condition, which provides 120 days for the health center to submit documentation that it has implemented changes to its SFDP, as identified in its evaluation.

TO DO: Update and provide Sliding Fee Scale Policy

2. BOARD COMPOSITION

Current Board Composition: Within 90 days, provide updated documentation that the health center governing board is composed of: 1) At least 9 and no more than 25 members; 2) A patient majority (at least 51 percent); 3) Patient board members, who as a group, represent the individuals who are served by the health center in terms of demographic factors, such as race, ethnicity, and gender, consistent with the demographics reported in the health center's Uniform Data System (UDS) report; 4) *For those health centers that receive any award/designation under one or more of the special populations subparts*, Representative(s) from or for each of the special population(s); and 5) Nonpatient board members representative of the community in which the health center is located, with relevant skills and expertise; and no more than 50 percent of such members earn more than 10 percent of their annual income from the health care industry.

TO DO: Provide minutes with discussion about quorum

3. Board Authority

Exercising Required Authorities and Responsibilities: Within 90 days, provide board minutes and any other relevant documentation that confirms the health center's governing board is exercising, without restriction, the following authorities and functions: 1) Holding monthly meetings where a quorum is present to ensure the board has the ability to exercise its required authorities and functions; 2) Approving the selection, evaluation and, if necessary, the dismissal or termination of the Project Director/CEO from the Health Center Program project; 3) Approving applications related to the Health Center Program project, including approving the annual budget, which outlines the proposed uses of both Health Center Program award and nonfederal resources and revenue; 4) Approving the Health Center Program project's sites, hours of operation and services, including decisions to subaward or contract for a substantial portion of the health center's services; 5) Monitoring the financial status of the health center, including reviewing the results of the annual audit, and ensuring appropriate follow-up actions are taken; 6) Conducting long range/strategic planning at least once every three years, which at a minimum addresses financial management and capital expenditure needs; and 7) Evaluating the performance of the health center based on quality assurance/quality improvement assessments and other information received from health center management, and ensuring appropriate follow-up actions are taken.

TO DO: Create and provide policy defining health industry

4. REQUIRED AND ADDITIONAL HEALTH SERVICES

Providing and Documenting Services within Scope of Project: Within 90 days, provide documentation that the health center is providing access to all required health services and that required and any additional service(s) are accurately recorded on Form 5A: Services Provided. If the health center is not

currently providing access to the service(s) OR the change(s) in scope required to correct Form 5A is not yet approved and verified, provide an action plan detailing the steps the health center will take to implement the provision of all required services and/or correct Form 5A. Acceptance of this plan by HRSA will result in a condition, which provides 120 days for the health center to submit documentation that it is providing access to the required service(s) and/or has corrected its Form 5A.

TO DO: Update form 5a on HRSA Electronic Handbook

5. QUALITY IMPROVEMENT/ASSURANCE

QI/QA Procedures or Processes: Within 90 days, provide documentation that the health center is addressing all of the following areas through operating procedures or processes/systems: 1) Adhering to current evidence-based clinical guidelines, standards of care, and standards of practice in the provision of health center services, as applicable; 2) Identifying, analyzing, and addressing patient safety and adverse events and implementing follow-up actions, as necessary; 3) Assessing patient satisfaction; 4) Hearing and resolving patient grievances; 5) Completing periodic quality improvement/quality assurance (QI/QA) assessments on at least a quarterly basis to inform the modification of the provision of health center services, as appropriate; and 6) Producing and sharing reports on QI/QA to support decision making and oversight by key management staff and by the governing board regarding the provision of health center services.

TO DO: Revise and provide updated QM policy

6. CLINICAL STAFFING

Procedures for Review of Privileges: Within 90 days, provide the health center's updated operating procedures for the initial granting and renewal of privileges for clinical staff members (licensed independent practitioners (LIPs), other licensed or certified practitioners (OLCPs), and other clinical staff providing services on behalf of the health center) who are health center employees, individual contractors, or volunteers. Specifically document that these privileging procedures address the following: 1) Verification of fitness for duty, immunization, and communicable disease status; 2) For initial privileging, verification of current clinical competence via training, education, and, as available, reference reviews; 3) For renewal of privileges, verification of current clinical competence via peer review or other comparable methods; and 4) Process for denying, modifying or removing privileges based on assessments of clinical competence and/or fitness for duty.

TO DO: Revise and provide updated credentialing procedure

Procedures for Review of Credentials: Within 90 days, provide the health center's updated operating procedures for the initial and recurring review of credentials for all clinical staff members (licensed independent practitioners (LIPs), other licensed or certified practitioners (OLCPs), and other clinical staff providing services on behalf of the health center) who are health center employees, individual contractors, or volunteers. Specifically document that these credentialing procedures contain provisions for verification of the following, as applicable: 1) Current licensure, registration, or certification using a primary source; 2) Education and training for initial credentialing; 3) Completion of a query through the National Practitioner Databank (NPDB); 4) Identity (for initial credentialing only); 5) Drug Enforcement Administration (DEA) registration; and 6) Current documentation of basic life support training.

TO DO: Revise and provide updated credentialing procedure

Credentialing and Privileging Records: Within 90 days, provide documentation of corrective actions taken to ensure up to date and complete credentialing and privileging of clinical staff (employees, individual contractors, and volunteers), including the maintenance of related files or records, consistent with operating procedures.

TO DO: Revise and provide updated credentialing procedure

Credentialing and Privileging of Contracted or Referral Providers: Within 90 days, provide documentation of actions taken by the health center to ensure that providers, who work for other organizations and provide services within the health center's scope of project (via contracts or formal written referral

arrangement), are licensed, certified or registered, as verified through a credentialing process in accordance with applicable Federal, state and local laws; and competent and fit to perform the specific health center service(s), as assessed through a privileging process.

TO DO: Provide Diente's credentialing procedure

7. COVERAGE FOR MEDICAL EMERGENCIES DURING AND AFTER HOURS

Procedures or Arrangements for After Hours Coverage: Within 90 days, provide the health center's updated procedure and/or formal arrangements for afterhours coverage that document all the following: 1) Coverage by an individual with the qualification and training necessary to exercise professional judgment in assessing a health center patient's need for emergency medical care; 2) The ability to refer patients either to a licensed independent practitioner for further consultation or to locations such as emergency rooms or urgent care facilities for further assessment or immediate care as needed; and 3) Patients, including those with limited English proficiency, are informed of and are able to access afterhours coverage.

TO DO: Provide after-hours policy and assurance the after hours line is correctly working

8. CONTRACTS AND SUBAWARDS


Subrecipient Monitoring: Within 90 days, provide documentation that the health center has a process and schedule for monitoring its subrecipient(s) that includes 1) Reviewing financial and performance reports to ensure performance goals are met, UDS data are submitted, and funds used for authorized purposes; 2) Ensuring that corrective action is taken by the subrecipient in response to audits, onsite reviews and other means; and 3) Issuing management decisions for audit findings pertaining to the subaward.

TO DO: Include auditor's office final report once finished in response.

Retention of Subaward Agreements and Records: Within 90 days, provide documentation of corrective action taken to ensure that the health center maintains final subrecipient agreements and related records, consistent with the Federal document maintenance requirements.

TO DO: Provide updated contract with Dientes

Anticipated completion date: August 30, 2019

<p>SUBJECT: Health Resources and Services Administration Legislative Mandates Limiting the Use of Funds on HRSA Grants</p> <p>SERIES: 600 Medical/Legal</p> <p>APPROVED BY: Amy Peeler, Chief of Clinic Services</p>	<p>POLICY NO.:</p> <p>640.01</p> <p>PAGE: 1 OF 1</p> <p>EFFECTIVE DATE: 5/1/2018</p> <p>REVISED:</p>	 <p>COUNTY OF SANTA CRUZ HEALTH SERVICES AGENCY</p> <hr/> <p>Clinics and Ancillary Services</p>
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GENERAL STATEMENT:

Health Services Agency will incorporate Legislative Mandates that limit the use of funds on Health Resources and Services Administration grants and cooperative agreements [Public Law 115-31] into policies and procedures. These policies are the following Legislative Mandates:

POLICY STATEMENT:


1. Salary Limitation (PL 115-31, Section 202)
2. Gun Control (PL 115-31, Section 210)
3. Anti-Lobbying (PL 115-31, Section 503)
4. Acknowledgment of Federal Funding (PL 115-31, Section 505)
5. Restriction on Abortions (PL 115-31, Section 506)
6. Exceptions to Restriction on Abortions (PL 115-31, Section 507)
7. Ban on Funding Human Embryo Research (PL 115-31, Section 508)
8. Limit on Use of Funds for Promotion of Legalization of Controlled Substances (PL 115-31, Section 509)
9. Dissemination of False or Misleading Information (PL 115-31, Section (515(b))
10. Restriction on Distribution of Sterile Needles (PL 115-31, Section 520)
11. Restriction of Pornography on Computer Networks (PL 115-31, Section 521)
12. Restriction on Funding ACORN (PL 115-31, Section 522)

REFERENCE:

Public Law 115-31; Title II [Department of Health & Human Services];

PROCEDURE:

The Compliance Officer in coordination with the Chief Executive Officer will conduct an annual review of policies related to HRSA's Legislative Mandates to incorporate any updates to the policies and procedures and submit these policies to the Commission for approval.

<p>SUBJECT: Salary Limitation</p> <p>SERIES: 600 Medical/Legal</p> <p>APPROVED BY: Amy Peeler, Chief of Clinic Services</p>	<p>POLICY NO.:</p> <p style="text-align: center;">640.02</p> <p>PAGE: 1 OF 1</p> <p>EFFECTIVE DATE: 5/1/2018</p> <p>REVISED:</p>	<div style="text-align: center;">  <p>COUNTY OF SANTA CRUZ</p> <hr/> <p>HEALTH SERVICES AGENCY</p> <p>Clinics and Ancillary Services</p> </div>
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GENERAL STATEMENT:

To guide the administration of the Health Center Program to ensure salary and fringe do not exceed allowable cap.

POLICY STATEMENT:

Health and Human Services funds may not be used to pay the salary of an individual at a rate in excess of Executive Level II. The Executive Level II salary of the Federal Executive Pay scale is \$187,000 effective January 2017. This amount reflects an individual's base salary exclusive of fringe and any income that an individual may be permitted to earn outside of the duties to the applicant organization. This salary limitation also applies to sub-awards/subcontracts under a Health Resources and Services Administration grant or cooperative agreement.

If an individual is under the salary cap limitation, fringe is applied as usual. If an individual is over the salary cap limitation, fringe is calculated on the adjusted base salary.

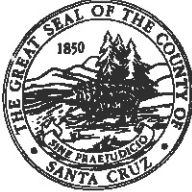
REFERENCE:

Public Law 115-31; Title II [Department of Health & Human Services]; § 202

PROCEDURE:

The Finance/Payroll Department will observe the following procedures:

- The HRSA budget is appropriately developed to ensure that no salary percentage allocation exceeds the limit of the Executive Level II salary cap described above.
- Review of individual employee salary.
- Review of individual employee fringe benefit allocation.
- Monitor prorated salaries to ensure that the salary when calculated at 100% does not exceed the HRSA Salary Limit.
- Monitor staff salaries to determine that the salary limit is not exceeded when the aggregate salary funding from other HHS and HRSA sources including Bureau of Primary Health Care and Ryan White funding (A and C) do not exceed the limitation.
- Review payroll reports, payroll allocation journals and employee contracts.
- Interview employees if payroll or income documentation is not available from the contractor or subcontractor provider.

<p>SUBJECT: Gun Control</p> <p>SERIES: 600 Medical/Legal</p> <p>APPROVED BY: Amy Peeler, Chief of Clinic Services</p>	<p>POLICY NO.:</p> <p>640.03</p> <p>PAGE: 1 OF 1</p> <p>EFFECTIVE DATE: 5/1/2018</p> <p>REVISED:</p>	 <p>COUNTY OF SANTA CRUZ HEALTH SERVICES AGENCY</p> <hr/> <p>Clinics and Ancillary Services</p>
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POLICY STATEMENT:

To guide the administration of the Health Center Program to ensure that Health Services Agency complies with Public Laws 115-31, Title II, § 210 [Gun Control].


This Policy establishes that Health and Human Services funds may not be used, in whole or in part, to advocate or promote gun control. This limitation also applies to subawards/subcontracts under a Health Resources and Services Administration grant or cooperative agreement.

REFERENCE:

Public Law 115-31; Title II [Department of Health & Human Services]; § 210

PROCEDURE:

HSA's Compliance Officer will ensure that the health center and/or sub-awardees/subcontractors comply with this policy: that HHS funds may not be used, in whole or in part, to advocate or promote gun control.

<p>SUBJECT: Anti-Lobbying and Legislative Advocacy Policy</p> <p>SERIES: 600 Medical/Legal</p> <p>APPROVED BY: Amy Peeler, Chief of Clinic Services</p>	<p>POLICY NO.:</p> <p style="text-align: center;">640.04</p> <p>PAGE: 1 OF 2</p> <p>EFFECTIVE DATE: 5/1/2018</p> <p>REVISED:</p>	<div style="text-align: center;">  <p>COUNTY OF SANTA CRUZ</p> <hr/> <p>HEALTH SERVICES AGENCY</p> <p>Clinics and Ancillary Services</p> </div>
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GENERAL STATEMENT:

This Policy guides the administration of the Health Center Program to ensure that Health Services Agency complies with Public Laws 115-31, Title V, § 503 [Anti-Lobbying].

POLICY STATEMENT:

This Policy also: (1) defines lobbying, legislative advocacy and its differences with political activity; (2) identifies the individuals within HSA staff covered by this policy; and, (3) specifies procedures to be followed in conducting lobbying-legislative advocacy.

Health and Human Services funds may not be used, in whole or in part, for publicity or propaganda purposes, for the preparation, distribution, or use of any kit, pamphlet, booklet, publication, electronic communication, radio, television, or video presentation designed to support or defeat the enactment of legislation before the Congress or any State or local legislature or legislative body, except in presentation to the Congress or any State or local legislature itself, or designed to support or defeat any proposed or pending regulation, administrative action, or order issued by the executive branch of any State or local government, except in presentation to the executive branch of any State or local government itself.

HHS funds may not be used, in whole or in part, to pay for salary or expenses of any grant or contract recipient, or agent acting for such recipient, related to any activity designed to influence the enactment of legislation, appropriations, regulation, administrative action, or Executive order proposed or pending before the Congress or any State government, State legislature or local legislature or legislative body, other than for normal and recognized executive-legislative relationships or participation by an agency or officer of a State or local government in policymaking and administrative processes within the executive branch of that government.

HHS funds may not be used, in whole or in part, to advocate or promote any proposed, pending or future Federal, State or local tax increase, or any pending or future requirement or restriction on any legal consumer product, including its sale or marketing.

These limitations also apply to subawards/subcontracts under a Health Resources and Services Administration grant or cooperative agreement.

DEFINITIONS:

Political Activity- Defined as participating or intervening in any political campaign on behalf of, or in opposition to, any candidate for public office. Federal regulations do not allow HSA to participate or intervene in any political campaign. Nevertheless, this restriction does not apply to an individual Commission member, staff member or a volunteer acting on his/her own behalf. Individuals must be

constantly aware to clearly make a distinction between their personal conduct from conduct that they carry out on behalf of HSA.


Legislative Advocacy- Also known as "Lobbying," is defined as carrying on propaganda, or otherwise attempting to influence legislation. Lobbying includes both Direct Lobbying and Grassroots Lobbying:

- 1) Direct Lobbying: Directly contacting members or employees of a legislative body, whether federal, state, or local, for the purpose of proposing, supporting, or opposing legislation or advocating the adoption or rejection of legislation.
- 2) Grassroots Lobbying: Communicating with members of the general public, or any segment of the public (e.g. health center patients) to contact members or employees of a local, state or federal legislative body urging them to support or oppose legislation

Legislation- Any action by Congress, a state or local legislative body (e.g. Board of Supervisors) or by the public in a referendum, initiative, constitutional amendment or similar procedure. This includes the discussion and approval of state and local government budgets and legislative proposals such as ballot and bond measures.

REFERENCE:

Internal Revenue Code (IRC) § 501 (c) (3) [List of Exempt Organizations], IRC § 501(h) [Expenditures by public charities to influence legislation] and Office of Management and Budget (OMB) Circular A-22 (Cost Principles for Non-Profit Organizations, paragraph 25 parts a-d (Lobbying); Public Law 115-31; Title V [General Provision]; § 503

<p>SUBJECT: Acknowledgement of Federal Funding and Branding Policy</p> <p>SERIES: 600 Medical/Legal</p> <p>APPROVED BY: Amy Peeler, Chief of Clinic Services</p>	<p>POLICY NO.: 640.05</p> <p>PAGE: 1 OF 1</p> <p>EFFECTIVE DATE: 5/1/2018</p> <p>REVISED:</p>	<div style="text-align: center;">  <p>COUNTY OF SANTA CRUZ HEALTH SERVICES AGENCY</p> <hr/> <p>Clinics and Ancillary Services</p> </div>
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POLICY STATEMENT:

This Policy is established to guide the administration of the Health Center Program to ensure that Health Services Agency complies with Public Laws 115-31, Title V, § 505 [Acknowledgement of Federal Funding]. As required by Health and Human Services appropriations acts, all HHS recipients, including Health Resources and Services Administration Bureau of Primary Health Care and Ryan White (Part A and C) grantees must acknowledge Federal funding when issuing statements, press releases, request for proposals, bid invitations, and other documents describing projects or programs funded in whole or in part with Federal funds. Recipients are required to state (1) the percentage and dollar amounts of the total program or project or project costs financed with Federal funds and (2) the percentage and dollar amount of the total costs financed by nongovernmental sources. These requirements also apply to subawards/subcontracts under a HRSA grant or cooperative agreement.


REFERENCE:

Public Law 115-31; Title V [General Provision]; § 505

PROCEDURE:

1) Acknowledgement of Federal Funding:

HSA's Compliance Officer and Chief Financial Officer will ensure that the health center and/or sub-awardees/subcontractors comply with this policy; that acknowledgement of Federal funding are cited as described in this policy.

<p>SUBJECT: Restriction on Abortions and Women's Reproductive Health Services</p> <p>SERIES: 600 Medical/Legal</p> <p>APPROVED BY: Amy Peeler, Chief of Clinic Services</p>	<p>POLICY NO.:</p> <p>640.06</p> <p>PAGE: 1 OF 3</p> <p>EFFECTIVE DATE: 5/1/2018</p> <p>REVISED:</p>	 <p>COUNTY OF SANTA CRUZ</p> <hr/> <p>HEALTH SERVICES AGENCY</p> <p>Clinics and Ancillary Services</p>
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GENERAL STATEMENT:

Health Services Agency (HSA) is committed to high standards and compliance with all applicable laws and regulations.

To guide the administration of the Health Center Program to ensure that HSA complies with Public Laws 115-31, Title V, § 506 [Restriction on Abortions] and 42 C.F.R. §§ 50.301, et seq. [Abortions and Related Medical Services in Federally Assisted Programs of the Public Health Service].

The purpose of this Policy is to provide safeguards that ensure HSA's compliance with laws and regulations relating to the provision of women's reproductive health services affecting health centers that receive federal grant funds under Section 330 of the Public Health Service Act ("Section 330") through the U.S. Department of Health and Human Services ("HHS").

HHS funds may not be used, in whole or in part, for any abortion. HHS funds may not be used, in whole or in part, for health benefits coverage that include coverage for abortion. The term "health benefits coverage" means the package of services covered by a managed care provider or organization pursuant to a contract or other arrangement.

These requirements also apply to subawards/subcontracts under a Health Resources and Services Administration grant or cooperative agreement.

POLICY STATEMENT:

Compliance with Federal Regulations:

- **Section 330 of the Public Health Act:** Under Section 330, Health Center is required to provide, either directly or through contracts or formal written referral arrangements, voluntary family planning services. HRSA defines voluntary family services in the Service Descriptor Guide as the following:

"Voluntary family planning services are appropriate counseling on available reproductive options consistent with Federal, state, local laws and regulations. These services may include management/treatment and procedures for a patient's chosen method (e.g., vasectomy, subdermal contraceptive placement, IUD placement, tubal ligation)."

As neither "appropriate counseling" nor "available reproductive options" are defined in Section 330, the implementing regulations, or HHS Health Resources and Services Administration ("HRSA") guidance, Health Center will use the criteria established under the Family Planning Program regulations authorized under Title X of the Public Health Service Act for guidance on how best to provide appropriate family planning options counseling to Health Center's patients.

- ***The Hyde Amendment:*** In providing women’s reproductive health services as a component of its Section 330-supported health center program, HSA will assure compliance with the Hyde Amendment. The Hyde Amendment is a statutory provision included as part of the annual HHS Appropriations legislation, which prohibits health centers from using federal funds to provide abortions (except in cases of rape or incest, or where a woman suffers from a physical disorder, physical injury, or physical illness, including a life endangering physical condition caused by or arising from the pregnancy itself, that would, as certified by a physician, place the woman in danger of death unless an abortion is performed). The Hyde Amendment prohibits the performance of abortion procedures, as well as the administration of drugs and devices that are used for “medication” abortions that terminate an early pregnancy (up to 70 days from the date of the woman’s last menstrual cycle) rather than prevent implantation, including, but are not limited to, administration of the combination of RU-486 (Mifepristone or Mifeprex) and Misoprostol, unless the abortion procedure or medication abortion fits within one of those explicit Hyde Amendment exceptions.
- ***Prohibition on Coercion:*** In providing women’s reproductive health services as a component of its Section 330-supported health center program, HSA will assure compliance with statutory requirements, as set forth in 42 U.S.C. §300a-8, which prohibits all HSA employed and contracted staff from coercing or endeavoring to coerce any person to undergo an abortion by threatening such person with the loss of, or disqualification for the receipt of, any benefit or other health center services. HSA will also assure that Health Center employed and contracted staff do not coerce or endeavor to coerce any person not to undergo an abortion by threatening such person with the loss of, or disqualification for the receipt of, any benefit or other health center services, consistent with guidelines to provide only neutral, factual information and nondirective options counseling.
- ***Providing Access to FDA-Approved Contraceptive Methods:*** HSA will ensure that its patients have access to the full range of Food and Drug Administration (“FDA”)-approved contraceptive methods designed to prevent a pregnancy.

REFERENCE:

Section 330 and Title X of the Public Health Service Act; 65 Fed. Reg. 41270, 41274 (July 3, 2000); 65 Fed. Reg. 41281 (July 3, 2000). Public Law 115-31; Title V [General Provision]; § 506 and 42 C.F.R. §§ 50.301, et seq. [Abortions and Related Medical Services in Federally Assisted Programs of the Public Health Service]; FY2016 Labor-HHS-Education Appropriations Legislation: Pub. Law 114-113, Division H, Title V, §§ 506-507; Medicaid Regulations 42 C.F.R. §§441.200-441.208. Corporation for National and Community Service: 45 C.F.R. §§2520.65(a)(10) and 2520.65(b).

PROCEDURE:

1. Complying with the Hyde Amendment

All Health Center employed and contractors who provide clinical services and non-clinical support staff agree that HSA shall not provide abortion services, either directly or by contract, within Health Center’s Section 330-supported health center program, unless the abortion fits within a Hyde Amendment exception, as described in Section II(3). These same HSA staff agree that this prohibition includes the administration of “medication” abortions that terminate an early pregnancy (up to 70 days from the date of the woman’s last menstrual cycle) rather than prevent implantation. Medication abortions include, but are not limited to, administering the combination of RU-486 (Mifepristone or Mifeprex) and Misoprostol which results in the termination of a pregnancy.

2. Options Counseling

HSA staff providing options counseling shall offer pregnant women the opportunity to be provided information and counseling regarding each of the following options:

- a. prenatal care and delivery;
- b. infant care, foster care, or adoption; and
- c. pregnancy termination.

If requested to provide such information and counseling, HSA staff will provide neutral, factual information and nondirective counseling on each of the options, and referral upon request (subject to Section 7 below), except with respect to any option(s) about which the pregnant woman indicates that she does not wish to receive such information and counseling.

3. Prohibition on Coercion.

HSA staff are strictly prohibited from coercing or endeavoring to coerce any person to undergo or not to undergo an abortion by threatening such person with the loss of, or disqualification for the receipt of, any benefit or other health center services.

4. Contraceptive Methods.


Health Center staff, upon request, will provide patients with information regarding the management/treatment, as appropriate, for a patient's chosen family planning method. Such management/treatment information may address vasectomy, tubal ligation, and placement of long-acting reversible contraception (e.g., IUDs and implants). In addition, Health Center Staff will ensure that its patients have access to the full range of FDA-approved contraceptive methods designed to prevent a pregnancy.

5. Referrals for Abortion Services.

- a. If a patient requests an abortion either for a pregnancy resulting from rape or incest or because the patient suffers from a physical disorder, physical injury, or physical illness, including a life endangering physical condition caused by or arising from the pregnancy itself, that would, as certified by a physician, place the patient in danger of death unless an abortion is performed, in accordance with the Hyde Amendment exceptions, and the health center does not furnish abortions in such limited circumstances, HSA staff will provide the patient with a referral to another medical facility.
- b. In the event that a patient's pregnancy is not the result of rape or incest, or the pregnancy does not endanger the life of the woman (as defined in Section II (7)(a) above), and accordingly does not meet a Hyde Amendment exception, and the pregnant woman requests a referral to an abortion provider, HSA staff offering referral assistance may provide the name, address, telephone number, and other relevant information (such as whether the provider accepts Medicaid, charges, etc.) about an abortion provider. Such HSA staff will not take further affirmative action (such as negotiating a fee reduction, making an appointment, providing transportation) to secure abortion services for the requesting patient. Staff may provide language translation assistance for the making of an appointment if the patient is also on the phone with the abortion provider.

6. Restriction on Abortions

HSA's Chief Medical Officer will ensure that the health center and/or sub-awardees/subcontractors comply with this policy: that HHS funds may not be used, in whole or in part, for any abortion. The Policy "Exceptions to Restriction on Abortions" establishes exemptions to the Policy "Restriction on Abortions."

<p>SUBJECT: Exceptions to Restriction on Abortions</p> <p>SERIES: 600 Medical/Legal</p> <p>APPROVED BY: Amy Peeler, Chief of Clinic Services</p>	<p>POLICY NO.: 640.07</p> <p>PAGE: 1 OF 1</p> <p>EFFECTIVE DATE: 5/1/2018</p> <p>REVISED:</p>	 <p>COUNTY OF SANTA CRUZ HEALTH SERVICES AGENCY</p> <hr/> <p>Clinics and Ancillary Services</p>
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POLICY STATEMENT:

To guide the administration of the Health Center Program to ensure that Health Services Agency (HSA) complies with Public Laws 115-31, Title V, § 507 [Exceptions to Restriction on Abortions] and 42 C.F.R. §§ 50.301, et seq. [Abortions and Related Medical Services in Federally Assisted Programs of the Public Health Service].

This Policy establishes the following exemptions to the prohibition that Health and Human Services funds may not be used, in whole or in part, for any abortion:

- 1) In cases where the pregnancy is the result of an act of rape or incest; or,
- 2) Where the life of the woman would be endangered, as certified by a physician, unless an abortion is performed.

Nothing in the Policy “Restrictions on Abortions” shall be construed as prohibiting the expenditure by the State, locality, entity or private person of State, local or private funds (other than a State’s or locality’s contribution of Medicaid matching funds).

Nothing in the Policy “Restrictions on Abortions” shall be construed as restricting the ability of any managed care provider from offering abortion coverage or the ability of a State or locality to contract separately with such a provider for such coverage with State funds (other than a State’s or locality’s contribution of Medicaid matching funds).


These exemptions also apply to subawards/subcontracts under a Health Resources and Services Administration grant or cooperative agreement.

REFERENCE:

Public Law 115-31; Title V [General Provision]; § 507 and 42 C.F.R. §§ 50.301, et seq. [Abortions and Related Medical Services in Federally Assisted Programs of the Public Health Service]

PROCEDURE:

HSA’s Chief Medical Officer will ensure that the health center and/or sub-awardees/subcontractors comply with this policy.

<p>SUBJECT: Ban on Funding of Human Embryo Research</p> <p>SERIES: 600 Medical/Legal</p> <p>APPROVED BY: Amy Peeler, Chief of Clinic Services</p>	<p>POLICY NO.: 640.08</p> <p>PAGE: 1 OF 1</p> <p>EFFECTIVE DATE: 5/1/2018</p> <p>REVISED:</p>	 <p>COUNTY OF SANTA CRUZ HEALTH SERVICES AGENCY</p> <hr/> <p>Clinics and Ancillary Services</p>
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POLICY STATEMENT:

To guide the administration of the Health Center Program to ensure that Health Services Agency complies with Public Laws 115-31, Title V, § 508 [Ban on Funding of Human Embryo Research], 45 C.F.R. § 46.204(b) [Research involving Pregnant Women or Fetuses], and § 498(b) of the Public Health Service Act [Research on Transplantation of Fetal Tissue].

This Policy establishes that Health and Human Services funds may not be used for:

- 1) The creation of a human embryo or embryos for research purposes; or,
- 2) Research in which a human embryo or embryos are destroyed, discarded, or knowingly subjected to risk of injury or death greater than that allowed for research on fetuses in utero under 45 C.F.R. § 46.204(b) [Research involving Pregnant Women or Fetuses], and § 498(b) of the Public Health Service Act [Research on Transplantation of Fetal Tissue].

For the purposes of this Policy the term “human embryo or embryos” includes any organism, not protected as a human subject under 45 C.F.R. § 46 as of the date of enactment of this Act, that is derived by fertilization, parthenogenesis, cloning, or any other means from one or more human gametes or human diploid cells.

HSA does not conduct research involving pregnant women or fetuses.


These limitations also apply to subawards/subcontracts under a Health Resources and Services Administration grant or cooperative agreement.

REFERENCE:

Public Law 115-31; Title V [General Provision]; § 508 and 45 C.F.R. § 46.204(b) [Research involving Pregnant Women or Fetuses], § 498(b) of the Public Health Service Act [Research on Transplantation of Fetal Tissue]

PROCEDURE:

HSA’s Chief Medical Officer will ensure that the health center and/or sub-awardees/subcontractors comply with this policy.

<p>SUBJECT: Limitation on Use of Funds for Promotion of Legalization of Controlled Substances</p> <p>SERIES: 600 Medical/Legal</p> <p>APPROVED BY: Amy Peeler, Chief of Clinic Services</p>	<p>POLICY NO.: 640.09</p> <p>PAGE: 1 OF 1</p> <p>EFFECTIVE DATE: 5/1/2018</p> <p>REVISED:</p>	<div style="text-align: center;">  <p>COUNTY OF SANTA CRUZ HEALTH SERVICES AGENCY</p> <hr/> <p>Clinics and Ancillary Services</p> </div>
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POLICY STATEMENT:

To guide the administration of the Health Center Program to ensure that Health Services Agency complies with Public Laws 115-31, Title V, § 509 [Limitation on Use of Funds for Promotion of Legalization of Controlled Substances], and § 202 of the Controlled Substances Act.

This Policy establishes that Health and Human Services funds may not be used for:

- 1) Any activity that promotes the legalization of any drug or other substance included in Schedule I of the Schedules of Controlled Substances established under § 202 of the Controlled Substances Act except for normal and recognized executive-congressional communications;
- 2) The limitation in Section 1 of this Policy shall not apply when there is a significant medical evidence of a therapeutic advantage to the use of such drug or other substance or that federally sponsored clinical trials are being conducted to determine therapeutic advantage.


These limitations also apply to subawards/subcontracts under a Health Resources and Services Administration grant or cooperative agreement.

REFERENCE:

Public Law 115-31; Title V [General Provision]; § 509 [Limitation on Use of Funds for Promotion of Legalization of Controlled Substances] and § 202 of the Controlled Substances Act

PROCEDURE:

HSA's Chief Medical Officer will ensure that the health center and/or sub-awardees/subcontractors comply with this policy.

<p>SUBJECT: Restriction on Distribution of Sterile Needles</p> <p>SERIES: 600 Medical/Legal</p> <p>APPROVED BY: Amy Peeler, Chief of Clinic Services</p>	<p>POLICY NO.: 640.10</p> <p>PAGE: 1 OF 1</p> <p>EFFECTIVE DATE: 5/1/2018</p> <p>REVISED:</p>	<div style="text-align: center;">  <p>COUNTY OF SANTA CRUZ HEALTH SERVICES AGENCY</p> <hr/> <p>Clinics and Ancillary Services</p> </div>
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POLICY STATEMENT:

To guide the administration of the Health Center Program to ensure that Health Services Agency complies with Public Laws 115-31, Title V, § 520 [Restriction on Distribution of Sterile Needles].

This Policy establishes that Health and Human Services funds may not be used to purchase sterile needles or syringes for the hypodermic injection of any illegal drug, provided that such limitation does not apply to the use of funds for elements of a program other than making such purchases if the relevant State or local health department, in consultation with the Center for Disease Control and Prevention, determines that the State or local jurisdiction, as applicable, is experiencing, or is at risk for, a significant increase in hepatitis infections or HIV outbreaks due to injection drug use, and such program is operating in accordance with State and local law.


This limitation and exemption also applies to subawards/subcontracts under a Health Resources and Services Administration grant or cooperative agreement.

REFERENCE:

Public Law 115-31; Title V [General Provision]; § 520 [Restriction on Distribution of Sterile Needles]

PROCEDURE:

HSA's Chief Medical Officer will ensure that the health center and/or sub-awardees/subcontractors comply with this policy.

<p>SUBJECT: Restriction of Pornography on Computer Networks</p> <p>SERIES: 600 Medical/Legal</p> <p>APPROVED BY: Amy Peeler, Chief of Clinic Services</p>	<p>POLICY NO.:</p> <p style="text-align: center;">640.11</p> <p>PAGE: 1 OF 1</p> <p>EFFECTIVE DATE: 5/1/2018</p> <p>REVISED:</p>	<div style="text-align: center;">  </div> <hr/> <p style="text-align: center;">COUNTY OF SANTA CRUZ HEALTH SERVICES AGENCY</p> <p style="text-align: center;">Clinics and Ancillary Services</p>
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POLICY STATEMENT:

To guide the administration of the Health Center Program to ensure that Health Services Agency complies with Public Laws 115-31, Title V, § 521 [Restriction of Pornography on Computer Networks].

This Policy establishes that HHS funds may not be used to maintain or establish a computer network unless such network blocks the viewing, downloading, and exchanging of pornography.

Nothing in this Policy shall limit the use of funds necessary for any Federal, State, or local law enforcement agency or any other entity carrying out criminal investigations, prosecution, or adjudication activities.

These limitations also apply to subawards/subcontracts under a Health Resources and Services Administration grant or cooperative agreement.

REFERENCE:

Public Law 115-31; Title V [General Provision]; § 521 [Restriction of Pornography on Computer Networks]

PROCEDURE:

HSA's Chief Compliance Officer will ensure that the health center and/or sub-awardees/subcontractors comply with this policy.

<p>SUBJECT: Restrictions on Funding ACORN</p> <p>SERIES: 600 Medical/Legal</p> <p>APPROVED BY: Amy Peeler, Chief of Clinic Services</p>	<p>POLICY NO.: 640.12</p> <p>PAGE: 1 OF 1</p> <p>EFFECTIVE DATE: 5/1/2018</p> <p>REVISED:</p>	<div data-bbox="1068 121 1263 310" style="text-align: center;"> </div> <hr/> <p style="text-align: center;">COUNTY OF SANTA CRUZ HEALTH SERVICES AGENCY</p> <p style="text-align: center;">Clinics and Ancillary Services</p>
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POLICY STATEMENT:

To guide the administration of the Health Center Program to ensure that Health Services Agency complies with Public Laws 115-31, Title V, § 522 [Restriction on Funding ACORN].

This Policy establishes that Health and Human Services funds may not be provided to the Association of Community Organizations for Reform Now [ACORN], or any of its affiliates, subsidiaries, allied organizations, or successors.

This limitation also applies to subawards/subcontracts under a Health Resources and Services Administration grant or cooperative agreement.

REFERENCE:

Public Law 115-31; Title V [General Provision]; § 522 [Restriction on Funding ACORN]

PROCEDURE:

HSA's Chief Compliance Officer will ensure that the health center and/or sub-awardees/subcontractors comply with this policy.

<p>SUBJECT: Confidentiality Agreements</p> <p>SERIES: 600 Medical/Legal</p> <p>APPROVED BY: Amy Peeler, Chief of Clinic Services</p>	<p>POLICY NO.:</p> <p>640.13</p> <p>PAGE: 1 OF 1</p> <p>EFFECTIVE DATE: 5/01/2018</p> <p>REVISED:</p>	<div data-bbox="1071 115 1274 325" style="text-align: center;"> </div> <hr/> <p style="text-align: center;">COUNTY OF SANTA CRUZ HEALTH SERVICES AGENCY</p> <p style="text-align: center;">Clinics and Ancillary Services</p>
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POLICY STATEMENT:


None of the funds appropriated or otherwise made available by the Health Resources and Services Administration (HRSA) may be available for a contract, grant, or cooperative agreement with an entity that requires employees or contractors of such entity seeking to report fraud, waste, or abuse to sign internal confidentiality agreements or statements prohibiting or otherwise restricting such employees or contractors from lawfully reporting such waste, fraud, or abuse to a designated investigative or law enforcement representative of a Federal department or agency authorized to receive such information.

Any limitation shall not contravene requirements applicable to Standard Form 312, Form 4414, or any other form issued by a Federal department or agency governing the nondisclosure of classified information.

This limitation also applies to subawards/subcontracts under a HRSA grant or cooperative agreement.

REFERENCE:

Public Law 115-31; Title V [General Provision]; § 743 (b) [Confidentiality Agreements]

<p>SUBJECT: Commission Composition</p> <p>SERIES: 600 Medical/Legal</p> <p>APPROVED BY: Amy Peeler, Chief of Clinic Services</p>	<p>POLICY NO.:</p> <p style="text-align: center;">640.14</p> <p>PAGE: 1 OF 1</p> <p>EFFECTIVE DATE: 6/01/2018</p> <p>REVISED:</p>	<div style="text-align: center;">  <p>1850 SANTA CRUZ</p> </div> <hr/> <p style="text-align: center;">COUNTY OF SANTA CRUZ HEALTH SERVICES AGENCY</p> <p style="text-align: center;">Clinics and Ancillary Services</p>
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POLICY STATEMENT:

The Health Services Agency's (HSA) Integrated Community Health Center Commission (ICHCC) must consist of at least nine and no more than 25 members. The majority [at least 51 percent] of the health center commission members must be patients served by the health center. These health center patient commission members must, as a group, represent the individuals who are served by the health center in terms of demographic factors, such as race, ethnicity, and gender. Non-patient health center commission members must be representative of the community served by the health center and must be selected for their expertise in relevant subject areas, such as community affairs, local government, finance and banking, legal affairs, trade unions, and other commercial and industrial concerns, or social service agencies within the community. A health center commission member may not be an employee of the HSA, or spouse or child, parent, brother or sister by blood or marriage of such an employee. The project director (Chief Executive Officer (CEO) may be a non-voting, ex-officio member of the commission.

Of the non-patient health center commission members, no more than one-half may derive more than 10 percent of their annual income from the health care industry.

DEFINITION:

For the purposes of the ICHCC, health care industry is defined as providing direct medical services to patients (e.g. physician, nurse) and/or working on local, state, or federal policies that directly apply to Federally Qualified Health Centers.

REFERENCE:

Section 330(k)(3)(H) of the PHS Act; and 42 CFR 51c.304 and 42 CFR 56.304

Santa Cruz County Health Services Agency
Clinic Services Division
Quality Management Plan
May ~~2017~~2018

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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 (HPPH), 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

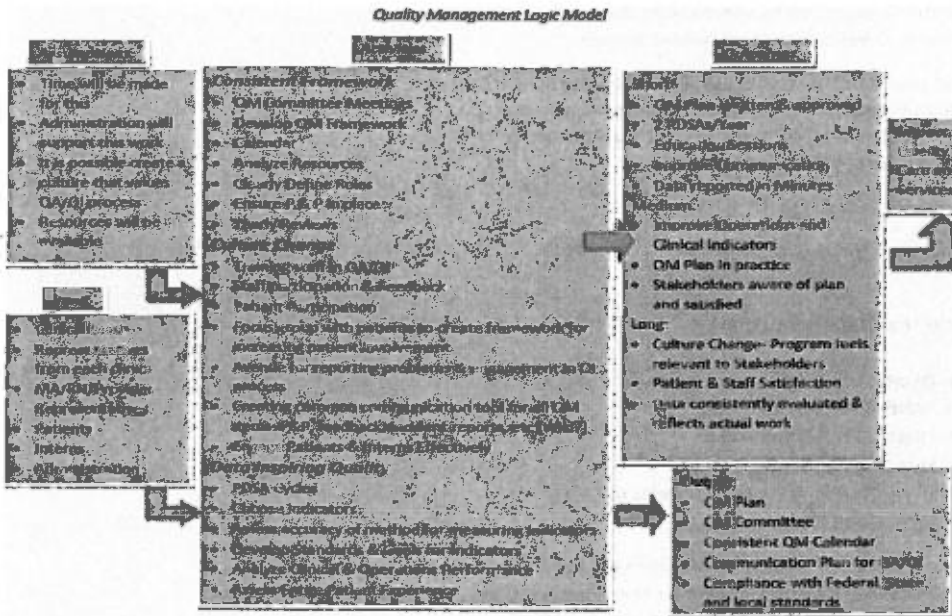
Our Quality Management team has defined a clear set of objectives that will allow us to overcome barriers and reach our goal of consistently high quality patient care that is confirmed through objective measures.

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 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 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 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.

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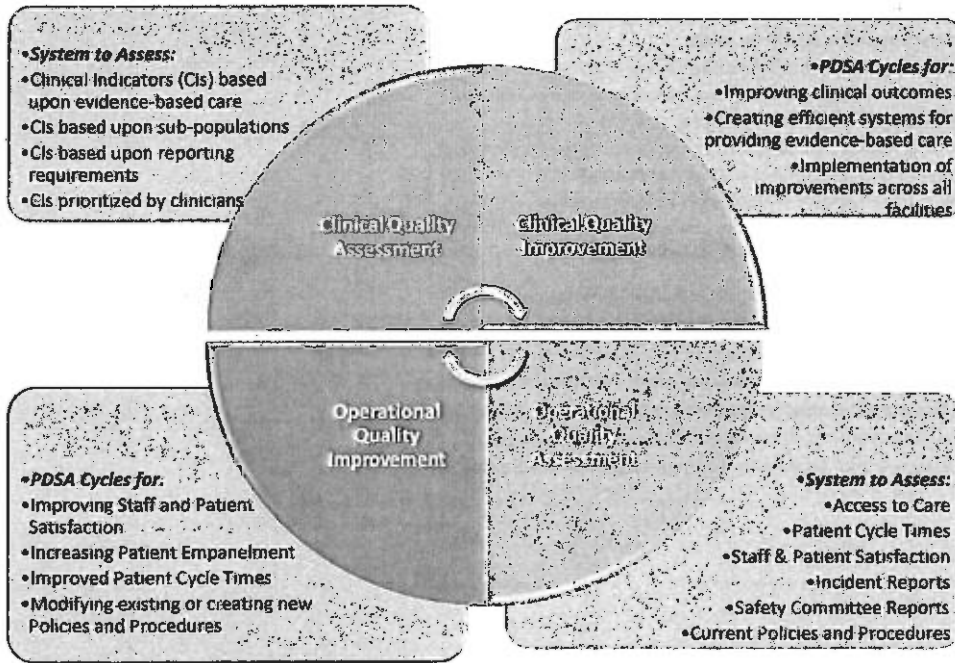
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² Quality of Care: A process for making strategic choices in health systems. World Health Organization, 2006

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.



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 Team² 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.

² Adapted from Institute for Healthcare Improvement
<http://www.ihl.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 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.

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 thereat."

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.

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 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.

	EFFICIENT ACTIVITIES	PROVIDE AND IMPROVE CLINICAL OUTCOMES FOR PATIENTS	DATA COLLECTION METHODS	IMPROVE PDSA	QUALITY IMPROVEMENT STRATEGIES
PATIENT SATISFACTION					
STAFF SATISFACTION					
CLINICAL CARE					
CLINICAL OPERATIONS					

	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 9:30 am
Meeting Location:	
Leader:	
Facilitator/Transcriber:	
Attending:	
Guest(s):	

Persistent Focus on Excellence in Patient Care in a Compassionate Environment

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

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

Next Meeting

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