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

March 26, 2025 @ 4:00pm - 5:00pm

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

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

1. Welcome/Introductions
2. Oral Communications
3. February 5, 2025, Meeting Minutes – Action Required
4. AB2449 Approval Vote – Action Required
5. Peer Review Policy – Action Required
6. Quality Management Update
7. Financial Update
8. CEO Update

Action Items from Previous Meetings: **Action Item**	**Person(s) Responsible**	**Date Completed**	**Comments**
Proposition 35 passed. Report back next couple of months what does that mean on revenues that will be coming into the clinic system.	Julian		

Next meeting: Wednesday, April 2, 2025, 4:00pm - 5:00pm **Meeting Location: In-Person -** 150 Westridge, Suite 101, Watsonville, Ca 95076 and 1080 Emeline Ave., Bldg. D, Admin Conference Room, Santa Cruz, CA 95060. Commission will connect through Microsoft Teams Meeting or call in (audio only) +1 831-454-2222,191727602# United States, Salinas Phone Conference ID: **191 727 602#**

The County of Santa Cruz Integrated Community Health Center Commission

Minute Taker: Mary Olivares

Minutes of the meeting held March 26, 2025

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

Attendance	
Christina Berberich	
Len Finocchio	Executive Board – Co-Chair
Rahn Garcia	Member
Dinah Phillips	Member
Marco Martinez-Galarce	Member
Maximus Grisso	Member
Michelle Morton	Member
Amy Peeler	County of Santa Cruz, Chief of Clinics
Raquel Ruiz	County of Santa Cruz, Senior Health Services Manager
Julian Wren	County of Santa Cruz, Admin Services Manager
Mary Olivares	County of Santa Cruz, Admin Aide
Meeting Commenced at 4:01 pm and concluded at 5:01 pm	

Excused/Absent:

1. Welcome/Introductions

2. Oral Communications:

Conflict of interest form 700 sent out last week. Commissioners need to sign up for new payroll system to receive commission stipend pay.

3. February 5, 2025, Meeting Minutes – Action Required

Review of February 5, 2025, Meeting Minutes – Recommended for approval. Rahn motioned to accept minutes as presented. Maximus second, and the rest of the members present were all in favor.

4. AB2449 Approval Vote – Action Required

The following members could not attend the commission meeting in person and were present virtually Len, Marco, and Maximus, due to just cause. Rahn moved to motion affirming the presence of the remote commissioners and individuals not able to participate in the conference room in person. Dinah second and the rest of the members present were all in favor

5. Peer Review Policy – Action Required

Raquel presented the Peer Review Policy and recommended it for approval. Raquel reported this policy was recommended when HRSA came for the site visit. Raquel reviewed policy with commissioners. Dinah motioned to accept policy as presented. Michelle second, and the rest of the members present were all in favor.

6. Quality Management Update

Raquel reported that the Emeline Clinic presented their quality improvement project, cervical cancer screening. Raquel reported the AIM statement is to increase cervical cancer screening rates at the Santa Cruz Health Center from 51.17% (Q3 2024 CCAH Data) to 58% by December 31, 2025(Alliance benchmark 57.11%). Raquel reported on the county operational plan objective. Raquel reported by June 30, 2027, to increase unduplicated patient count for individuals at the County-run Federally Qualified Health Centers by 10% from 14,114 (January 1, 2024-December 31, 2024) to 15,525 with a focus on underserved geographical areas who have less access to healthcare. Raquel also reported on the Ryan White (HIV/AIDS Program) They are updating dental, chlamydia and gonorrhea data to capture form in the Electronic Health Record. Lastly Raquel reported on Peer Review & Risk Management. She stated they are working on the Medication Administration and Error form that is to be incorporated in their incident report form, finalizing the chronic pain medication management policy, and they had finalized the Peer Review Policy.

7. Financial Update

Amy presented on behalf of Julian. Amy reported their deficit is $619,854 less than it was last fiscal year, and their revenue is $2,695,164 more than last fiscal year. She reported the charges for services are $3787,328 more than last fiscal year and their grant drawdowns are $1,092,165 less than last fiscal year, and their services and supplies are so much more.

8. CEO Update

Amy reported two new patients have applied today to be on their commission. The question was asked what can we do to keep a quorum going? It would be helpful to send out a survey to commissioners to find out availability. Mary to send out survey.

Next meeting: April 2, 2025, 4:00pm - 5:00pm

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☐ Minutes approved _____ ___/___/___

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

Health Centers Division

Quality Management Report

March 2025

Quality Management Committee

- Quarterly Quality Improvement Presentation- Emeline Cervical Cancer Screening :

  The AIM statement is to increase cervical cancer screening rates at Santa Cruz Health Center from 51.17% (Q3 2024 CCAH Data) to 58% by December 31, 2025(Alliance benchmark 57.11%).

- County Operational Plan Objective Draft (Slide 3)
- Ryan White (HIV/AIDS Program): updating dental, chlamydia and gonorrhea data capture form in the Electronic Health Record.

Countywide Operational Plan Objective DRAFT

By June 30, 2027, Increase unduplicated patient count for individuals at the County-run Federally Qualified Health Centers by 10% from 14,114 (January 1, 2024-December 31, 2024) to 15,525 with a focus on underserved geographical areas who have less access to healthcare.

Peer Review & Risk Management Committee

- Medication Administration and Error form
  - To be incorporated in our Incident Report Form
- Chronic Pain Medication Management Policy
- Control Substance Order Protocol
- Finalized the Peer Review Policy

Questions?

Thank You

SUBJECT:	POLICY NO.:	
Peer Review Policy	**200.03**	
SERIES: 200 Personnel	**EFFECTIVE DATE:** March 26, 2025	COUNTY OF SANTA CRUZ HEALTH SERVICES AGENCY
APPROVED BY: Amy Peeler, Chief of Clinic Services	**REVISED:**	**Clinics and Ancillary Services**

POLICY STATEMENT:

The County of Santa Cruz Health Services Agency Health Centers Division (Health Centers) ensures that it effectively provides, and documents care to its patients. To that end, Health Centers take a proactive approach in applying continuous quality improvement in the provision of clinical patient care services. Health Centers shall have a peer review process to assure quality and regulatory compliance in all aspects of patient care. Peer review and medical chart audits contribute to this goal by monitoring clinical treatments and medical record documentation. Medical chart audits also provide a source of information for clinical and provider privileging. All clinicians, including physicians, nurse practitioners, physician assistants, and Integrated Behavioral Health (IBH) clinicians shall participate in and be subject to the peer review process.

The specific goal of the peer review process will be to emphasize the six core competencies:

1. Patient Care – provide care that is compassionate, appropriate, and effective.
2. Medical/Clinical Knowledge – demonstrate knowledge of biomedical, clinical, and cognate sciences and their application.
3. Practice-Based Learning and Improvement – able to investigate and evaluate their patient care practices, appraise and assimilate evidence to improve their clinical practice.
4. Interpersonal and Communication Skills – demonstrate skills that result in effective information exchange, teaming with patients and families and professional colleagues.
5. Professionalism – demonstrate a commitment to carrying out professional responsibilities, adhere to ethical principles, and sensitivity to diverse patient populations.
6. System-Based – demonstrate awareness and responsiveness to larger context and systems of health care and use system resources to provide optimal care.

REFERENCE:

Health Resources & Services Administration-Health Center Compliance Manual
American Board of Medical Specialties (ABMS)
Physician Assistant Board (PAB)

SUBJECT: Peer Review	POLICY NO.: **200.04**	

American Academy of Nurse Practitioners Certified Board
California Evidence Code section 1157
Business & Professions Code section 805

PROCEDURE:

The peer review process is overseen by the Medical Directors from Watsonville Health Center, Emeline Health Center, the Homeless Persons Health Project, IBH Directors and the Peer Review and Risk Management Committee. The committee will audit the chosen records for completeness and financial factors and will document all findings on the audit form. There are four (4) types of peer review: peer chart review; episodic review; ongoing professional practice evaluation, and focused professional practice review. A high-level report of the peer review process will be presented to Integrated Health Centers Commission quarterly. All Licensed Independent Practitioners (LIPs) will be reviewed as described in the timelines listed below. This policy does not prevent Health Centers from reviewing Other Licensed Practitioners (OLPs) according to their scope of practice.

Peer Review Process

The Peer Review Process will be conducted in the following order:

1. The Health Centers will conduct an independent peer review overseen by the Medical Directors.
2. The Health Centers will form a committee and bring together a group of peers to review and evaluate clinical cases and charts.
3. The charts will be reviewed by providers of the same specialty.
4. The person reviewing the charts will complete a chart review form and report on the chart at the peer review committee meeting.
5. Based on the chart review, the committee will make recommendations if any training or corrective actions are needed.
6. The committee will document findings including a plan for corrective actions when necessary.
7. Peer review may result in a revocation, limitation, or denial of full privileges.
8. The Senior Health Services Manager will give a report to the Integrated Health Center Commission of any Quality Improvement Projects and high-level overview at least quarterly.

SUBJECT: Peer Review	POLICY NO.: 200.04	

Confidentiality, Record Keeping and Conflict of Interest

California Evidence Code section 1157 protects the records and proceedings of peer review committees from being disclosed in civil cases. This protection also does not require a member of the peer committee to testify as to what transpired at the meeting.

1. Peer review and its processes must be handled in a secure and confidential manner to protect patient, employee, and provider rights.

2. Any case reviews, records, documents, and committee minutes must be maintained as confidential.

3. Notes will be taken during the peer review committee meetings. Records of all peer review notes and chart reviews will be kept locked and confidential for at least 7 years.

4. Every attempt will be made to ensure that fair, equitable, and non-biased procedures are utilized in all peer review proceedings. Conflicts stemming from social, political, or business affiliations will be avoided when possible. Individuals involved in peer review activities should be impartial peers and not have a conflict of interest with the subject of the peer review activity.

5. A peer would also exclude individuals with blood relationships, spousal relationships, or other potential conflicts that might prevent the individuals from giving an impartial assessment or give the appearance for the potential of bias for or against the subject of peer review.

Types Of Peer Review And Procedure For Each Type

There will be five (5) types of peer review: onboarding professional practice reviews, individual peer chart review, group topic focused reviews, episodic reviews, and focused professional practice reviews.

Onboarding Professional Practice Reviews

1. Onboarding professional practice reviews, conducted by the Medical Director or Clinical Supervisor of the clinician, will be conducted for all clinician at: one (1) month of hire; three (3) months of hire; six (6) months of hire; twelve (12) months of hire.

2. Each provider will have a minimum of ten 10) charts evaluated in the first month, five (5) charts evaluated at the 3rd, 6th and 12th month of hire.

SUBJECT: Peer Review	POLICY NO.: 200.04	

Individual Assignments (As Needed for IBH)

1. Every other month – 1 chart per clinician

2. Mortality Review (for suicides/as needed)

Group Peer Chart Review Group Activity-pick a topic such as pain management, Health Maintenance, pediatrics, etc.

1. Peer chart review will be conducted once a year (in June) by peers in a group setting at a Peer Review Sub-Committee Meeting. Charts will be pulled based on specific quality improvement topics. Discussions will happen in small groups and then report themes or lessons learned to the rest of the group.

2. Every Health Center clinician provider will participate in both providing review and being reviewed.

3. A maximum of four (4) charts will be pulled for each provider and reviewed. A chart review form will be completed for each chart.

4. If there are any questions about quality of care, the provider whose care is in question will be asked to respond by checking the box on the form to alert the Medical Director to the concern. These concerns will then be brought forward by the Medical Director. The Medical Director will present high level themes to the Peer Review and Risk Management committee.

Episodic

1. Episodic Chart Review (as needed) i.e. Health Center Grievance log or Hospital discharges conducted by the peer review committee. Review will be initiated by a complaint (including but not limited to patients, staff, manager, and/or provider), an office visit that resulted in hospital admission, and/or medical emergencies. The provider being reviewed may be asked to submit an explanation of the case in question and may be invited to attend the peer review. (N/A to IBH)

Focused Professional Practice Reviews (FPPR)

1. FPPR will be implemented by the Medical Director in communication with the Personnel Department when there are concerns regarding the provision of safe, high quality patient care by a current provider, or issues of professionalism. The FPPR process evaluates, for a limited time,

a provider's professional performance or professionalism including quality of care, patient safety, unprofessional behavior, and/or professional performance of privileges.

2. While outcomes can be a trigger for review, the outcome by itself is not a basis of consideration as to whether the standard of care was provided. FPPR is not imposed as a form of discipline, but to assess competency or professionalism and ensure quality care for patients through education or other appropriate measures.

3. Only the professionalism and the privilege(s) in question are the subject of the evaluation. The provider's remaining privileges will remain in good standing during the FPPR period. The Medical Director or designee are responsible for overseeing the evaluation process for their clinical staff.

FPPR can be initiated by the following:

1. The Peer Review and Risk Management Committee requests an FPPR based on Morbidity and Mortality reports, incident trends, or patient complaint trends relating to a particular provider. The Peer Review and Risk Management Committee reserve the right to review and make privileging decisions for egregious or time sensitive cases, bypassing the FPPR process, if warranted.

2. The FPPR process is a 3-month evaluation period including intensive peer and/or in-person chart review consisting of at least five (5) cases per month and education, as assigned.

3. The provider will be notified about FPPR formally in writing and/or in meeting with Medical Director

4. The Medical Director or designee such as the clinical supervisor will conduct a minimum of once per month coaching session with the provider and provide feedback regarding the monthly reviews.

5. The Peer Review and Risk Management Committee will receive a status report on the progress of providers undergoing FPPR and is responsible for any associated privileging status changes or assignments of education, training, or other measures deemed appropriate to the provider and concerns.

6. The Peer Review and Risk Management Committee and Medical Director will be responsible for the assignment of appropriate continuing education courses and their completion deadlines during the FPPR period.

7. The FPPR initiation date is to be determined by the Medical Director and Personnel Department, in partnership with the clinical supervisor that will be responsible for the provider's review.

Information for this evaluation may be derived from the following:

1. Discussion with other individuals involved in the care of each patient (e.g., consulting physician; nursing; administrative personnel);

2. Chart review, review of Ongoing Professional Practice Evaluation (OPPE); and review of malpractice claims;

3. Monitoring clinical practice patterns;

4. Direct observation of provider;

5. In-Person review of cases with provider; and/or

FPPR is complete when the provider completes the required 3-month evaluation period including reviews, education, and coaching and demonstrates maintained improvement in areas of concern with no additional cases where the standard of care was not met.

Cases in which the standard of care is not met may necessitate extension of the FPPR period. Specifically, when there continues to be concerns regarding the provision of safe, high quality patient care by a provider. The FPPR process may continue until the Peer Review and Risk Management Committee agrees that concerns have been sustainably resolved.

SUBJECT: Peer Review	POLICY NO.: **200.04**	

	Onboarding in the first-year professional practice reviews, conducted by the Clinical Supervisor/Medical Director	**Individual (PCP, IBH)**	**Group- topic focused (i.e. diabetes or hypertension) (PCP, IBH)**	**Episodic**	**Focused Professional Practice Reviews (FPPR)**
Number of charts	1st month: 10 3rd month: 5 6th month: 5 12th month: 5	1	4	As needed	5
Frequency	Will be conducted for all providers at: 3 months of hire; 6 months of hire; twelve months of hire and annually thereafter	Every other month	Once a year At a staff meeting	At peer review committee	Based on Morbidity and Mortality reports, incident trends, or patient complaint trends relating to a particular provider. 5 charts per month.
Total charts for the year per provider	25	6	4	Variable	15 over a 3-month period.

SUBJECT: Peer Review	POLICY NO.: 200.04	

Reporting structure: