Sacramento County Primary Health Services

Healthcare for the Homeless Co-Applicant Board (HCHCAB)

Special Meeting Agenda

December 12, 2014 / 1:00 PM – 2:00 PM

Phone Conference Call*

Dial-in Number: (712) 432-1212
Meeting ID: 928-248-836 #

Teleconference Locations**

7001-A East Parkway
Sacramento, CA 95823

1300 North C Street
Sacramento, CA 95823

3131 Palmer Street
Sacramento, CA 95815

4410 Power Inn Road
Sacramento, CA 95826

400 Bannon Street
Sacramento, CA 95814

Focal Point: HCH Policies and Procedures

Topic	Time	Action or Discussion
Welcome, Introductions – *Paula Lomazzi*, Chair	1:00 – 1:10	Discussion
Standing Items		
Policies and Procedures (P&Ps) review and develop recommendations for meeting scheduled January 16, 2014. • Healthcare for the Homeless Co-Applicant Board Authority 01-02 • Performance Improvement 01-01 • Credentialing and Privileges 07-05	1:10 – 1:50	Discussion Recommendations
Comments		
▪ Public Comment - *Paula Lomazzi* ▪ Closing Remarks and Adjourn	1:50 – 2:00	Discussion

*To access the conference call, dial the number a few minutes before the meeting starts. Then when prompted, enter the ID number and the #.

** For public and members, if you would like to attend the conference call, but don't have access to a phone, the conference call will be made available at 7001-A East Parkway, Sacramento, CA 95823.

Next Meeting: January 16, 2015 / 9:30 AM – 10:30 AM

County of Sacramento **Department of Health and Human Services** **Division of Primary Health Services** **Policy and Procedure**	Policy Issuer (Unit/Program)	**Clinic Services**
	Policy Number	**01-01**
	Effective Date	**09-29-10**
	Revision Date	**11-21-14**
Title: **Performance Improvement**	Functional Area: **Organization**	
Approved By: Nancy Gilberti, Division Manager		

Policy

Clinic Services leadership is committed to improving services for our members. In order to evaluate improvement, performance indicators are created, monitored, analyzed, and adjusted in order to enhance service provision.

Procedures:

A. Quality Improvement (QI) Plan

1. A QI Plan will be drafted, reviewed, and approved on an annual basis by the Quality Improvement Council and the Health Care for the Homeless Co-Applicant Board.
2. See attached QI Plan.

B. Quality Improvement Council (QIC)

1. Clinic Services QIC will be comprised of the following:
    a. Division Manager
    b. Clinic Services Medical Director
    c. Pharmacy Director
    d. Designated Health Program Manager
    e. May include a designated Registered Nurse (RN) or a LCSW/MFT.
2. The scope and responsibilities include developing performance indicators, analyzing data and making recommendations for change. The QIC will review trended quality performance data, identify opportunities to improve client care and service, provide policy decisions, review, and make recommendations regarding the annual Quality Improvement Plan.
3. The Quality Council will meet at least monthly or not less than ten (10) times per year.
4. Indicators will be reviewed and revised annually or as indicated.
5. See QI Plan for additional details.

References:

Clinic Services Policy & Procedure Manual
http://inside.dhhs.saccounty.net/PRI/Pages/GI-PRI-Policy-and-Procedure-Manual.aspx
http://www.dhhs.saccounty.net/PRI/Pages/Sacramento-Medi-Cal-Managed-Care-Stakeholder-Advisory-Committee/BC-MCMC.aspx

County Office of Compliance (HIPAA resources)
http://inside.compliance.saccounty.net/default.htm

Attachments:
PDSA Worksheet
Quality Improvement Plan

Contact:
Susmita Mishra, MD, Medical Director

Sacramento County
DHHS Primary Health Services Division
Clinic Services

Quality Improvement Plan
FY 2014-2015

FINAL DRAFT 10/10/14

Reviewed and Approved		
Signature	**Title**	**Date**
	Program Manager	
	Medical Director	
	Co-Applicant Board Chair	

OVERVIEW

Clinic Services shall demonstrate through its Quality Improvement Program a systematic, organization-wide approach to provide high quality, culturally sensitive patient centered care and services to clients. Through this systematic approach, the Quality Improvement / Assurance Plan provides a process and methods to survey performance, implement changes in practice and measure performance levels.

Guiding Principles for Service Provision

- Customer service focused
- Patient-centered, recovery oriented
- Culturally competent and sensitive
- Treats individuals with dignity and respect
- Safe and attractive environment for clients, visitors and staff
- Team work required to optimize service provision and coordination of care
- Effective communication and information sharing
- Data informed practices
- Continuous improvement

PROGRAM STRUCTURE

Quality Improvement Committee (QIC)

The QIC is multidisciplinary with participants representing different disciplines and service areas within Clinic Services. The key to the success of the QI process is leadership commitment and accountability.

The QIC provides ongoing operational leadership of continuous quality improvement activities. It meets at least monthly or not less than ten (10) times per year and consists of the following committee members:

Medical Director – Chair of the QIC, clinical lead

Pharmacy Director – Functions as a Committee participant and leads efforts related to review of medications, protocols or formulary changes.

Program Manager, Integrated Behavioral Health (IBH) Medical Home / Health for the Homeless – Leads efforts related to managed care, HRSA, fiscal and key liaison to the Co-Applicant Board.

Division Manager – oversight functions of clinical operations including EMR

Other committee members may include but are not limited to a designated Registered Nurse (RN) and LCSW/MFT in order to ensure full multi-disciplinary involvement.

QIC responsibilities include:

- Developing and approving the QI Plan.
- As part of the Plan, establishing measureable objectives based upon priorities identified through the use of established criteria for improving the quality and safety of clinic services.
- Developing indicators of quality on a priority basis.
- Periodically assessing and supporting quality improvement indicators.
- Reporting to the Co-Applicant Board on quality improvement activities on a regular basis.
- Formally adopting a specific approach to Continuous Quality Improvement (CQI).

Health Care for the Homeless (HCH) Co-Applicant Board ("Co-Applicant Board)

The HCH Co-Applicant Board Authorities are outlined in Clinic Services P&P 01-02.

The Co-Applicant Board delegates authority and responsibility for all matters relative to the Quality Improvement Program to the QIC.

This Board reviews, evaluates and approves the Quality Improvement Plan annually.

QUALITY IMPROVEMENT METHODOLOGY

Goals and Objectives

QIC identifies and defines goals and specific objectives to be accomplished each year. These goals include training of clinical and support staff regarding Continuous Quality Improvement (CQI) principles and specific QI initiatives.

The following are the long-term goals and specific objectives for accomplishing these goals for the year of FY 14-15.

- To fully implement and maximize use of the QI Process: The QIC will ensure the QI process is understood and utilized by development of the plan, tools, methods and use of appropriate communication vehicles such as staff trainings.

- To implement quality improvement activities designed to improve HRSA clinical measures or HEDIS measures: QIC will select 1 – 2 measures for analysis and focused intervention utilizing the QI process.

- To regularly monitor key areas of clinic utilization: QIC to select metrics for service access and patient satisfaction, review data and methodically intervene and re-measure.

- To implement quantitative measurement to assess key processes or outcomes: The average number of "no shows" will be reduced overall by x% from its current average within the next (6) months.

Performance Indicators

Performance indicators are identified and measured part of the quality improvement initiatives. Appropriate indicators are those that:

- Have defined data elements
- Have a numerator and denominator available for measurement
- Can detect changes in performance over time and allows for a comparison over time.

Outcomes / Process Measurement

Performance monitoring is system-wide and focused at a particular service or population focused. Measures need:

- Identification of measureable indicators to monitor the process or outcome
- Collection of data for specified time period, or ongoing
- Evaluation against a threshold or target
- Evaluation of the effectiveness of defined action(s)

Data Analysis

Data must be reviewed and assessed in order to establish:

- Priorities for improvement
- Actions necessary for improvement
- Whether process changes resulted in improvement
- Performance of existing key processes

CQI

Clinic Services utilizes a Plan–Do–Study–Act (PDSA) for focused intervention. *See PDSA Work Sheet.*

PLAN	- Problem identification and desired outcomes - Identify most likely cause(s) through data review - Identify potential solution(s) and data needed for evaluation
DO	- Implement solution(s) and collect data needed to evaluate the solution(s)
STUDY	- Analyze the data and develop conclusions
ACT	- Recommendations for further study / action. This depends upon results of the analysis. If the proposed solution was effective, decisions should be made regarding broader implementation including the development of a communication plan, etc. If the solution was not effective, will return to return to planning section.

COMMUNICATION AND COORDINATION

Communication

Leaders support QI activities through the planned coordination and communication of problem identification, interventions and results of measurement activities related to QI activities with the overall efforts to improve the quality of care provided. The sharing of QI data and information is an important and ongoing leadership function. Leaders, through a planned and shared communication approach, ensure the staff and the Co-Applicant Board have knowledge of and input into ongoing QI initiatives as the core function of CQI.

Planned communication may take place through the following methods:

- QI Committee members reporting back to respective staff
- Discussion in regular or ad hoc staff team meetings
- Handouts, information alerts or policy and procedure guidance
- Story boards or posters displayed in common areas
- Co-Applicant Board presentation

Key priorities should be imbedded in the architecture of Clinic Services policies, training and other core materials including data collection.

CONFIDENTIALITY AND PRIVACY OF PERSONAL HEALTH INFORMATION

- All data and recommendations associated with quality management activities are solely for the improvement of client care. As such, all material is confidential and is accessible only to those parties responsible for assessing quality of care and service. All proceedings, records, data, reports, information and any other material used in the quality management process which involves peer review shall be held in strictest confidence and considered peer review protected.
- Clinic Services will minimize use of identifiable protected health information for quality measurement to protect it from inappropriate disclosure. Reports for committee review regarding data analysis and trending shall not disclosure a client's protected health information. Use of aggregate data or reports will be maintained in minutes.
- Personal Health Information obtained as a result of a client complaint or appeal is kept in a secure area and is only made available to those who have a need to know. Computer access to personal health information about a client's complaint or appeal is limited by a pass code for only those who need access.
- Clinic Services Policies and the County Office of Compliance have extensive policies and procedures related for health information management and protected health information.

County of Sacramento **Department of Health and Human Services** **Division of Primary Health Services** **Policy and Procedure**	Policy Issuer (Unit/Program)	**Clinic Services**
	Policy Number	**01-02**
	Effective Date	**01-31-13**
	Revision Date	**07-21-14**
Title: **Health Care for the Homeless Co-Applicant Board - Authority**	Functional Area: **Organization**	
Approved By: Marcia Jo, JD, MPA, Health Program Manager		

Policy

Sacramento County Primary Health conforms to the Health Services and Resource Administration (HRSA) requirement to have a consumer and community-oriented Co-Applicant Board whose role is to provide guidance and oversight of the Program funded by HRSA.

Procedures

A. Meetings and Notices

1. Healthcare for the Homeless Program Coordinator will convene the Co-Applicant Board per the attached Bylaws.
2. Senior Office Assistant will provide minutes and administrative support.
3. Brown Act rules for posting agendas will be followed. Agendas will be posted at the following locations:
    a. Mercy Clinic Loaves and Fishes (MCLF) Clinic
    b. Loaves and Fishes Friendship park posting boards
    c. Union Gospel Mission
4. Minutes will be approved by Health Program Manager and posted by Administrative Secretary within 10 days of the meeting.
5. A binder of all agendas and minutes will be available at each meeting for members and guests to use as reference.

B. Member Support

1. Each new member will have an orientation meeting with the Program Coordinator and review their binder that contains:
    a. Health Care for the Homeless program background, including history, intent, and function.
    b. Mission and bylaws.
    c. Current strategic plan.
    d. HRSA board requirements.
    e. Current narrative, budget, and organizational chart.
    f. Board member roster including constituency.
2. Available on the website:
    a. Annual calendar
    b. Roster of members
    c. Bylaws
3. Consumer members who miss a meeting will be contacted and updated by the Homeless Program Coordinator or designee.
4. If more than two meetings occur without a quorum, the Homeless Program Coordinator and Health Program Manager will meet to review retention strategies.

C. Consumer members

1. HRSA requires that 51% (4 individuals under current Bylaws) are active patients of Primary Care and have received services within the approved scope, in the prior 24 months.
2. Consumer recruitment will be a topic at every Board meeting, with new strategies attempted to attract and retain consumer members that meet HRSA qualifications.
3. Former consumers are also welcome within the restrictions noted in the bylaws.

D. Activities and Reports

1. Committees: Co-Applicant Board committees are formed as needed to research topics, complete assessments, evaluate homeless program staff, and undertake other projects as necessary.
2. Evaluations: The Co-Applicant Board evaluates the Program Coordinator every two years. They may also review the evaluations of outreach staff submitted by partner agencies.
3. Reports: Co-Applicant Board will review the following reports at least annually:
    a. Numbers of homeless serviced by the program compared to prior years.
    b. Results of the annual needs assessments.
    c. HCH progress reports or grant applications.

References:
N/A

Attachments:
Co-Applicant Board Bylaws

Contact:
Victoria Deloney, MBA, BSN, Sr. Health Program Coordinator

County of Sacramento **Department of Health and Human Services** **Division of Primary Health Services** **Policy and Procedure**	Policy Issuer (Unit/Program)	**Clinic Services**
	Policy Number	07-05
	Effective Date	01-31-12
	Revision Date	07-18-14
Title: **Credentialing and Privileges**	Functional Area: **Personnel**	
Approved By: Nancy Gilberti, Division Manager		

Policy

Credentialing policies and procedures shall address the process for appointments and reappointments of Medical Staff and licensed contracted staff for Primary Health Clinical Services.

Credentialing standards and criteria are established commensurate with those of the National Council for Quality. Credentialing and privileging shall be conducted without regard to race, ethnicity, national origin, color, gender, age, sexual orientation, or religious preference.

Purpose

Credentialing and privileging are processes of verification of education training and experience as well as formal recognition and attestation that independent licensed practitioners or other licensed or certified staff are both qualified and competent.

Credentialing verifies that the staff meets standards as determined by a credentialing committee or other appropriate reviewing source by reviewing such items as the individual's license, experience, certification, education, training, malpractice and adverse clinical occurrences, clinical judgment and character by investigation and observation, as applicable.

Privileging provides permission for an independent licensed practitioner's scope of practice and the clinical services he or she may provide.

Definitions:

Licensed Independent Practitioner (LIP): An individual permitted by law to provide care and services without direction or supervision, within the scope of the individual's license and consistent with individually granted clinical privileges.

Other Licensed or Certified Practitioners: An individual who is licensed, registered, or certified but is not permitted by law to provide patient care services without direction or supervision.

Primary Source Verification (PSV): Verification by the original source of a specific credential to determine the accuracy of a qualification reported by an individual health care practitioner. Please refer to the Credentialing Checklist for PSV verification sources. PSV is completed, at a minimum, for the following:

- Current licensure
- Relevant education, training, or experience
- Current competence; and
- Health fitness

Secondary Source Verification (SSV): Uses methods to verify credentials when PSV is not required. Please refer to the Credentialing Checklist for SSV verification sources. SSV is completed for the following:

- Government issued picture identification
- Drug Enforcement Administration (as applicable)
- Hospital Admitting Privileges (as applicable)
- Immunization and PPD status; and
- Life Support Training (as applicable)

Procedures

Credentialing verification will occur by obtaining Primary source or Secondary source verification in accordance with accepted national verification sites. Credentialing documents requiring verification and the verification sites for licensed staff (physicians, dentists, Nurse Practitioners, Registered Nurses, Licensed Clinical Social Worker, Marriage and Family Therapists, Registered Radiology technologists and certified Medical Assistants) are included in the attachment labeled Credentialing Verification Instructions.

All contracted staff will have credentials maintained by Contractor. Contractor must provide credentials to the Medical Director or designated Clinic Services personnel upon request. This includes contracted specialists and hospital academic programs. The Medical Director will grant privileges to contracted staff.

All County employees, acting within the scope of their licensure and employment, are insured, protected, and defended for their actions by the County.

A. Document Review

1. The following items are reviewed and verified as part of the credentialing and privileging process for County and contracted licensed independent practitioners:

▪ Application ▪ License ▪ Curriculum Vitae ▪ Relevant education or training (review the highest level attained) ▪ Board Certification (CME documentation if not board certified) ▪ National Provider Data Bank (NPDB) query	▪ Current DEA ▪ Government Issued Picture ID ▪ ACLS/CPR certification ▪ Malpractice Insurance Documentation ▪ Hospital Privileges ▪ Health Fitness ▪ PPD and Immunization status ▪ Peer Review Data (competency and Quality Improvement).

2. The items for verification review for all other disciplines are included in the Credentialing Verification Instructions Document.

B. Responsibilities

1. The Primary Health Services Medical Director is responsible for credentialing and privileging all licensed medical staff. The Medical Director designates a Senior Office Assistant (SOA) who collects and verifies credentials under the supervision of the Medical Director. The SOA implements and maintains the clinic specific database for the Credentialing and Privileging program and compiles data for Medical Director Review.
2. The Peer Review Committee (PRC), which includes the Medical Director and at least one other licensed physician, will review credentials, professional

competence, health status, and grant and/or renew privileges of all Licensed Independent Practitioners before hire and every two years thereafter.

3. The Credentialing and Privileging Committee (CPC) which includes the Medical Director, and at least one primary care physician, a psychiatrist, and a RN will review all material and recommendations made by the PRC and make further recommendations regarding continuation, termination or suspension of privileges. The CPC shall be a confidential multidisciplinary body of professional peers and shall meet no less than annually. All members shall be licensed in their respective disciplines and be in good standing with their respective licensing boards.
4. All committee decisions are reported to the Quality Improvement Council for reviewing adherence to this policy.
5. Applicants and County and contracted staff shall have the burden of producing information in a timely manner for an adequate evaluation of the qualifications and suitability of clinical privileges. The applicant's failure to sustain this burden shall be grounds for denial or termination of privileges.

C. Approval Process for Initial Hire

1. Once employed, each practitioner must submit a Privilege Approval form to request Core and Special Request Privileges.
2. Based on the employment application and Privilege Approval form, the CPC authorizes the Medical Director to issue final hire approval to practitioners who meet the standard verification within their scope of practice.
3. If applicant has a complete, clean application and has been hired by, the County either as on-call or permanent staff, the Medical Director grants initial privileges for 120 days while waiting for CPC review and recommendations.
    a. During the 120 days, the PRC will evaluate the new practitioner's work performance and professional competence utilizing the Clinician Performance Evaluation tool.
    b. If satisfactory review determines practitioner has meet all performance standards as they relate to credentialing and continuing education, attendance, customer service, productivity, and professional standards as applied to patient assessment, care and treatment plans, privileges will be approved and reassessed at the next CPC meeting..

D. Adverse Determination Process

1. Based on CPC recommendations when a clinician has not met performance measures, a corrective action plan will be developed and discussed by the medical director.
2. If a clinician has not demonstrated improvement, within 60 days, after orientation, training and corrective action, Medical Director will consult with Division Manager and follow the County of Sacramento DHHS Human Resources Discipline Manual process of counseling, warning letters, reprimand and potential / actual termination.
3. Personnel actions may be appealed per applicable County Human Resources guidelines and applicable represented labor groups approved contracts.

E. Re-Credentialing and Privileging

1. Peer and CPC review of credentials and privileges of current Licensed Independent Practitioners and Other Licensed or Certified Practitioners will occur every two years. This will include the completion of the Privilege Approval form and review of performance data.

F. Confidentiality

1. All credentialing and privileging proceedings, deliberation, records and related activities and information shall be confidential, and not subject to discovery, to the fullest extent permitted by law. Disclosure of such proceedings and records shall be made only as required by law, or as needed to fulfill the credentialing activities within the scope of the policy.

Attachments:
Credentialing Verification Instructions
Privilege Approval Form

References:
N/A

Contact:
Susmita Mishra, MD, Medical Director