SACRAMENTO COUNTY

Co-Applicant Board Required Annual Activities - 2021												
Annual / Periodic Activities	**Jan**	**Feb**	**Mar**	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**
HRSA Grant Application												
Service Area Competition (SAC)*							X	X	X			
Needs Assessment	X	X				X	X					
Other Grant Applications	X	X										
HRSA Grant Awards - Reports												
COVID Supplemental Award	X			X			X					
HRSA CARES	X			X			X					
Enhancing Capacity for Testing	X			X			X					
Main grant report								X	X			
Budget												
HRSA Program & County		X					X					
Updates			X			X					X	
Sliding Fee Discount												
Adopt new SFSL				X								
Audit												
Summary of Program Fiscal Audit				X								
Quality Improvement (QI)												
QI Plan Review	X		X				X			X		
QI Data Reports**	X			X			X			X		
UDS Report		X						X				
Patient Grievances and Safety Review								X			X	
Patient Feedback Survey Findings	X			X			X					
Long-Range Planning												
Adopt Strategic Plan*					X	X						
Review Strategic Plan	X								X			X
Select Services and Hours												
Services Provided			X				X					X
Service Sites						X	X					X

SACRAMENTO COUNTY

Co-Applicant Board Required Annual Activities – 2020 - CONTINUED												
Annual Activities	**Jan**	**Feb**	**Mar**	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**
Governance												
Review & Revise Bylaws		X	X									
Review Co-Applicant Agreement		X	X			X						
Review Sub-Committee Structure						X						X
Review Membership Applications	TBD											
Review Key Policies		X	X						X	X	X	
Project Director												
Approve Selection /Dismissal										X		
Performance Evaluation										X		
Board Member Development												
Elect Chair and Co-Chair											X	
Approve CAB Member Recruitment Plan								X				
Approve new Members	TBD											

* Every 3 years

** Every 3 Months

SACRAMENTO COUNTY

Co-Applicant Board Required Policies and Procedures for Adoption			
Governance	**Policy and Procedure**	**Latest Revision Date**	**Latest CAB Adoption Date**
Board Authority (CH: 19)	01-02 Co-Applicant Board Authority	07/17/20	07/17/20
Board Composition (CH: 20)	01-04 Co-Applicant Board Member Recruitment & Retention	05/22/20	05/22/20
Services	**Policy and Procedure**	**Latest Revision Date**	**Latest CAB Adoption Date**
Scope of Service and Service Site Location(s) (CH: 4, 6, 12, 19)	01-05 Medical Home Program Design	10/06/20	10/16/20
Hours of Operation (CH: 6, 7, 19)	01-05 Medical Home Program Design	10/06/20	10/16/20
Patient Satisfaction (CH: 10, 19)	04-12 Patient Satisfaction Survey	06/19/20	06/19/20
Patient Grievances (CH:10, 19)	02-05 Variance Reporting	22/06/20	11/20/20
Patient Safety and Adverse Events (CH: 10, 19)	03-03 Incident Reporting	10/13/20	11/20/20
Quality Improvement Policy (CH:10, 19)	01-01 Quality Improvement *	06/25/20	07/17/20
QI Plan (CH:10, 19)	2020 Quality Improvement Plan *(annual)*	06/25/20	07/17/20
Quality Improvement Policy (CH:10, 19)	01-09 Clinical Performance Management*	07/09/20	07/17/20
Credentialing and Privileges (CH: 5)	07-05 Credentialing and Privileges	05/05/20	05/17/19
Management and Finance	**Policy and Procedure**	**Latest Revision Date**	**Latest CAB Adoption Date**
Personnel and Conflict of Interest (CH: 13, 19)	01-03 Co-Applicant Board Conflict of Interest	05/07/20	05/22/20
Billing and Collections (CH: 16, 19)	11-02 Billing and Collections *	10/05/20	10/16/20
Emergency Preparedness and Management Plan (PIN 2007-15)	06-10 Emergency Training and Response	09/07/20	09/18/20
Sliding Fee Discount Program/Schedule (CH: 9, 19)	11-01 Sliding Fee Discount *	10/01/20	10/16/20

CH = HRSA Compliance Manual Chapter

PIN = HRSA Policy Information Notice

* = The CAB adopts, evaluates at least once every three years, and, as needed, approves updates to policies in these areas

PROPOSED STRUCTURE: KEY MANAGEMENT ROLES AND REPORTING RELATIONSHIPS

Co-Applicant Board

Jim Hunt
Interim Dir. Health Services

Sumi Mishra, MD
CEO/Medical Director
HRSA Project Director

Sandy Damiano, Ph.D.
Deputy Director

Sharon Hutchins
HRSA/Health Program Mgr.
Quality, Compliance, & Grants

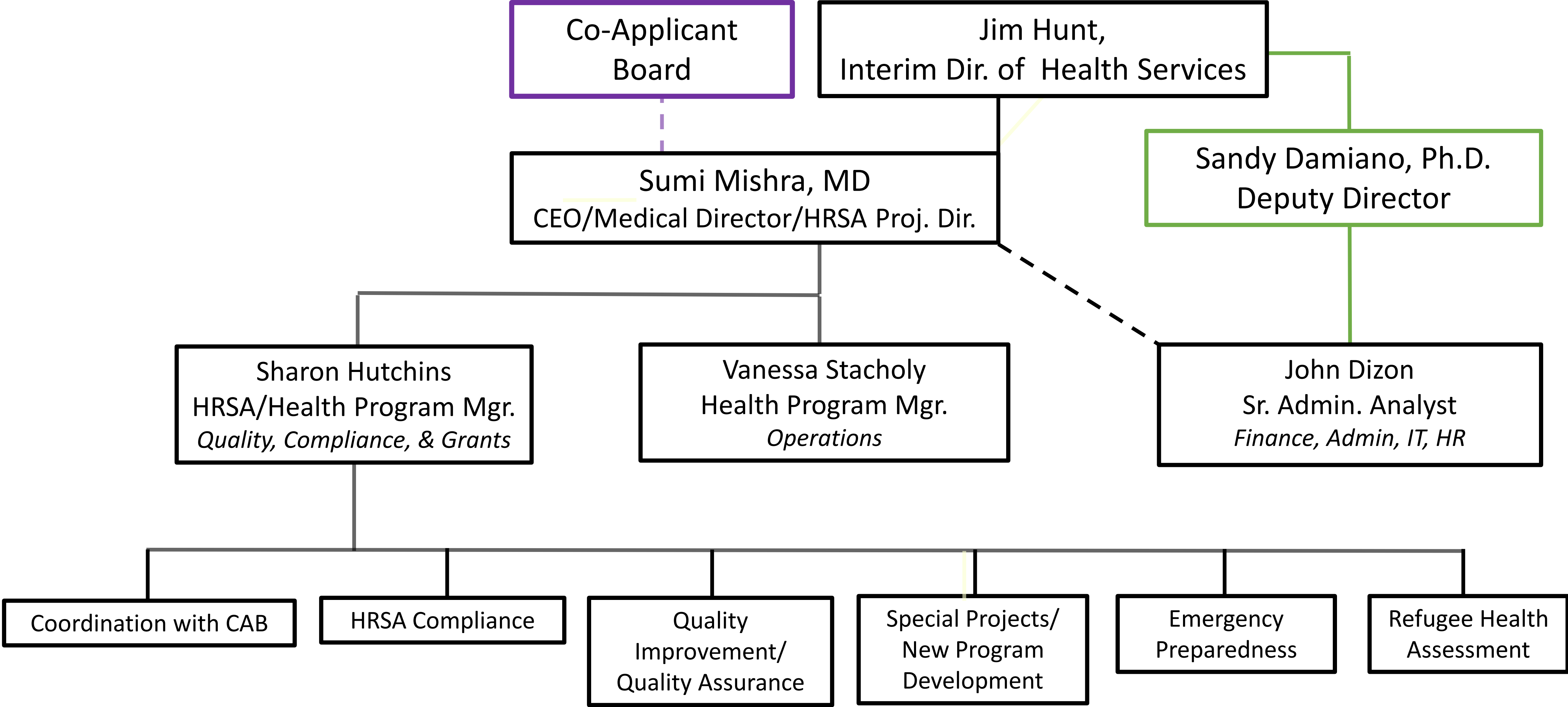
Vanessa Stacholy
Health Program Mgr.
Operations ("COO")

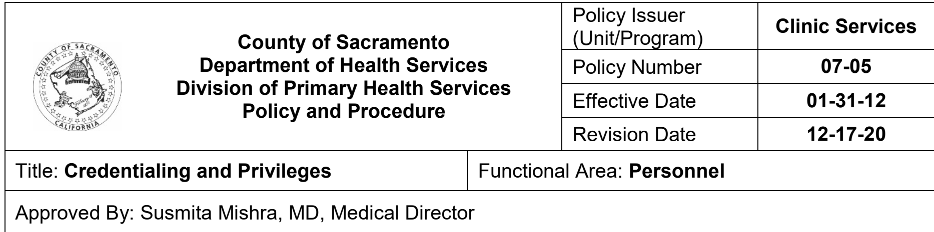
John Dizon
Sr. Admin. Analyst *("CFO")*
Finance, Admin, IT, HR

Deborah Burow
Administrative Services Officer III *(HR)*

PROPOSED STRUCTURE, II

SACRAMENTO COUNTY





County of Sacramento Department of Health 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	**12-17-20**
Title: **Credentialing and Privileges**	Functional Area: **Personnel**		
Approved By: Susmita Mishra, MD, Medical Director			

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.

Licensed providers working under contract from the University of California, Davis are credentialed by the University per contractual agreement:

- Department of Internal Medicine
- Department of Psychiatry
- Department of Pediatrics
- Department of Family Medicine
- Department of Radiology
- School of Medicine
- School of Nursing

Clinical staff provided by temporary medical staffing (“registry”) services are credentialed by the registry.

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, and other clinical staff are both qualified and competent.

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

Definitions:

A. **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. This category includes physicians, nurse practitioners, physician assistants, and Registered Dental Hygenists in Alternative Practice (RDHAPs).

B. **Other Licensed or Certified Practitioners (OLCP):** An individual who is licensed, registered, or certified but is not permitted by law to provide patient care services without

direction or supervision. This category includes nurses, licensed clinical social workers, and licensed marriage and family therapists.

C. Other Clinical Staff (OCS): An individual who is not licensed, registered, or certified, but is permitted per clinical policy to provide patient care services under direct supervision. Sacramento County Health Center has defined OCS as the following classifications. This category included medical assistants.

D. Volunteers and Trainees: There are two types of volunteers at the Sacramento County Health Center.

a) An individual permitted by law to provide care and services without direct direction or supervision, within the scope of the individual's license and consistent with individually granted clinical privileges and as listed in the contract**,** i.e**.** SPIRIT Volunteers. These volunteers undergo the same credentialing and privileging processes as County-employeed LIPs.

b) An individual who is not licensed, registered, or certified but is permitted by Clinical policy to provide patient support services under direction of the Clinical Staff, i.e. Volunteer Medical Assistants through County Volunteer Office. These volunteers would be undergo the same credentialing and privileging processes County-employed OCSs.

c) An individual participating in a recognized academic program with which SCHC has a a formal relationship, may provide direct clinical services as a learner under the supervision of SCHC clinical staff and their preceptor within a specifically defined scope of duties. The verification of the credentials of these learners' is the responsibility of their academic program and explained in the contract between the program and SCHC. These learners include medical residents (LIPs), nurse practitioner residents (LIPs), medical students (OLCPS), nursing students (OLCPs), and MA candidates (OSCs), among others.

E. 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, depending on the staff category:

1. LIPs (including volunteers in this category)
   a) Current licensure (verification on BREEZE website may serve as primary verification of licensure)
   a) may serve as primary verification of licensure)
   b) Relevant education, training, or experience as pertaining to the classification or licensing boards
   c) Current competence, based on the following criteria:
      I. Appropriate clinical care
      II. Timely documentation
      III. Attendance record
      IV. Lack of repetitive patient grievances
   d) Health fitness

2. OLCPs
   a) Current licensure (verification on BREEZE website may serve as primary verification of licensure)
   b) Relevant education, training, or experience as pertaining to the classification or licensing boards

Commented [A1]: What does this mean? How to goes into the next section

e) Current competence, based on the following criteria:
   I. Appropriate clinical care
   II. Timely documentation
   III. Attendance record
   IV. Lack of repetitive patient grievances

c) Health fitness

3. OSCs
   a) Relevant education, training, or experience as pertaining to the classification
   b) Current competence (skills, knowledge, experience and attendance record as provided by professional references); and
   c) Health fitness

4. Volunteers and Learners
   a) Each is classified as an LIP, OLCP, or OSC and then treated as described for that category.
   b) Learners' credentials are verified by their academic program.

F. 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:

1. LIPs
   a) Government issued picture identification
   b) Drug Enforcement Administration (DEA) (as applicable)
   c) Hospital Admitting Privileges (as applicable)
   d) Immunization such as current flu shot and Hepatitis B Vaccine
   e) Tuberculosis clearance
   f) Life Support Training (as applicable)
   g) National Practitioner Data Bank Query (NPDB) (as applicable)

2. OLCP
   a) Government issued picture identification
   b) Immunization such as current flu shot and Hepatitis B Vaccine
   c) Tuberculosis clearance
   d) Life Support Training (as applicable)
   e) National Practitioner Data Bank Query (NPDB) (as applicable)

3. OSCs
   a) Government issued picture identification
   b) Immunization such as current flu shot and Hepatitis B Vaccine
   c) Tuberculosis clearance
   d) Life Support Training (as applicable)

4. Volunteers and Learners
   a) Each is classified as an LIP, OLCP, or OSC and then treated as described for that category.
   b) The verification of the credentials for these learners' credentials is the responsibility of their academic program and explained in the contract between the program and SCHC.

Commented [A2]: What does this mean? How to goes into the next section

Commented [A3]: Is this not looked up on the DEA database- would that not be primary?

Commented [A4]: Do they need this?

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 Vocational Nurses, Physician Assistants, Licensed Clinical Social Workers, Marriage and Family Therapists, Registered Radiology Technologists, Registered Dental Hygienist in Alternate Practice, and Certified Medical Assistants) are included in the attachment labeled "Credentialing Verification Instructions."

Credentialing verification will also be performed for other Clinical Staff (OCS) by XYZ.

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 (LIPs):

▪ Current License ▪ Curriculum Vitae ▪ Relevant education or training (review the highest level attained) ▪ Board Certification or education credits if not board certified ▪ National Practitioner Data Bank (NPDB) query	▪ Current DEA ▪ Government Issued Picture ID ▪ Life Support Training certification ▪ Malpractice Insurance Documentation ▪ Health Fitness ▪ PPD and Immunization status

2. The items reviewed for verification for all other disciplines are included in the "Credentialing Verification Instructions" document.

B. Responsibilities

1. The Co-Applicant Board delegates the responsibility of credentialing and privileging to the Clinic Services Medical Director.
2. Licensure: The Primary Health Services Medical Director is responsible for credentialing and privileging all licensed medical staff. The Medical Director designates an administrative services officer who collects and verifies credentials under the supervision of the Medical Director. The assistant implements and maintains the clinic's specific database for the Credentialing and Privileging program and compiles data for Medical Director review.

   The verification of the credentials for learners is the responsibility of their academic program and explained in the contract between the program and SCHC.

3. Applicants, County, and contracted staff shall have the burden of producing information in a timely manner (at least 90 days prior to start date) for an adequate evaluation of the qualifications and suitability of clinical privileges. The applicant's failure to sustain the burden shall be grounds for denial or termination of privileges.
4. Comptence

Commented [A5]: How do we do this? Do we look it up? Do we administer a test? Look at resumes? Look up complaints? Needs more detail.

a. Supervisors will perform core competencies for staff in their respective programs. The data will be provided to the designated credentialing staff.

b. The Peer Review Committee (PRC) which includes the Medical Director and at least one licensed physician will assess clinical competency for licensed health care providers (LIPs and OLCPs), according to the Peer Review Policy.

C. Approval Process for Initial Hire

1. Once employed, each practitioner (LIP or OLCP) must submit an "Application for Clinical Privileges" to request Core and Special Request Privileges.
2. Based on the "Application for Clinical Privileges" and the supporting documentation of education, training, current experience and demonstrated performance, the Medical Director issues hire approval to practitioners who meet the standard verification within their scope of practice.
   a. If the applicant has a complete, clean application and has been hired by the County either as on-call or permanent staff, the Medical Director reviews materials and in consultation with the Program Manager, grants or denies privileges.
3. Within 90 days of hire, Medical Director will assess clinical competency to determine whether to maintain the approved privileges.

D. Adverse Determination Process

1. Based on Medical Director recommendations, a 60-day corrective action plan is given when a licensed provider has not met performance measures.
2. If there is not sufficient improvement within 60 days, the Medical Director will consult with the Program Manager and follow the County of Sacramento Department of Health Services (DHS) Human Resources Discipline Manual or the contractual requirements for contracted staff.
3. Personnel actions for county staff may be appealed per applicable County Human Resources guidelines and applicable represented labor groups approved contracts.

E. Re-Credentialing and Privileging

1. Medical Director reviews credentials and privileges of LIPs and OLCPs at least every two years.
2. Medical Director and Program manager renew privileges of practitioners based on maintainance of credentials and Peer Review Committee recommendations.

F. Adverse Determination Process-Re-Credentialing and Privileging

1. Based on Medical Director recommendations, a 60-day corrective action plan is given when a licensed provider has not met performance measures.

2. If there is not sufficient improvement within 60 days, the Medical Director will consult with the Program Manager and follow the County of Sacramento Department of Health Services (DHS) Human Resources Discipline Manual or the contractual requirements for contracted staff

3. Personnel actions for county staff may be appealed per applicable County Human Resources guidelines and applicable represented labor groups approved contracts.

G. Confidentiality

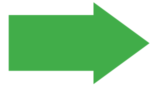
1. All credentialing and privileging proceedings, deliberation, records, related activities, and information shall be confidential, and not subject to discovery, to the fullest extent permitted by law. Disclosure of such proceedings and records shall be made only as required by law, or as needed to fulfill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

Attachments:
Credentialing Verification Instructions
Application for Clinical Privileges-all providers
Application for Clinical Privileges-Radiology Technologists
Application for Clinical Privileges-Dental Hygienists

References:
N/A

Contact:
Diana Barney, ASO I

Co-Applicant Board Approval Date: 12/18/20



Threats

- What obstacles do you face?
- What are your competitors doing?
- Are quality standards changing in ways that will be difficult for you to meet?
- Will changes in the state or national policy environment negatively affect you?
- Is changing technology threatening your position?
- Is your financial position weak?
- Could any of your weaknesses seriously threaten your sustainability?

SWOT Analysis

Strengths	Weaknesses
Opportunities	**Threats**

S W
O T

2020 QI Plan Monitoring

AIM: Patient Experience

Operational Definition: *Patients feel that SCHC cares about & works to improve their well-being, safety & experience in a respectful way*

Goal 1 Promote a respectful environment.

Objective 1-1 ***Minimally achieve 75% "very good or good" score on identified key elements of twice annual patient survey.***

Question	Target	Value (Aug-Sep 2020)	Source
Front desk staff are friendly and helpful	75% good or very good	96.1%	Patient feedback survey
Nurses and medical assistants listen		96.2%	
Nurses and medical assistants are friendly & helpful		96.4%	
Providers listen		96.0%	
Providers are friendly & helpful		95.2%	
Providers give information patients can understand		94.8%	
Providers consider personal or family beliefs		95.0%	

Goal 2 Improve access to care

Objective 2-1 ***Ensure availability of major appointment types (urgent care, new patients, follow-up) to meet the needs of patients and adjust schedules and templates as needed, by minimally achieving 75% "very good or good" score on identified key elements of twice annual patient survey.***

Question	Target	Value (Aug-Sep 2020)	Source
Able to get appointments for checkups	75% good or very good	84.5%	Patient feedback survey
Able to make same day appointment when sick or hurt		59.6%	
Length of time waiting at the clinic		79.7%	

Objective 2-2 ***Abide by managed care timely access requirements for appointment wait times, for specified items.***

Item	Target	Value (Q3 2020)	Source
Urgent care with no prior authorization	48 hrs		
Urgent referral to specialist	4 days		
Request for non-urgent primary care	10 days		
Request for non-urgent specialist	15 days		
Frst prenatal visit	10 days		
New patient appointment	10 days		

Objective 2-3 ***Improve access by telephone during and after hours.***

Item	Baseline	Current	Source
Average waiting time in call center	TBD	TBD	Cisco System Report

Item	Target	Value (Q3 2020)	Source
Phone calls get through easily	75% good or very good	68.8%	Patient feedback survey
I get called back quickly		62.6%	
Able to get medical advice when office is closed		46.9%	

2020 QI Plan Monitoring

AIM: **Population Health Outcomes**

Operational Definition: ***Reducing health inequities & assisting patients in achieving better health outcomes through best practice and/or evidence-based guidelines***

Category **CARE COORDINATION**

Goal 1 **Improve care coordination of members with high service utilization, or who require services across systems.**

Objective 1-1 ***Designate care management team***

Status
Care team designated.
Workflow developed.
Workflow implemented.

Category **CLINICAL PERFORMANCE MEASURES**

Goal 1 **Improve performance on select UDS and HEDIS quality measures (focused on that signal a healthy start in life and those focused on secondary prevention of health issues prevalent among SCHC patients) and tackle racial and ethnic disparities in such measures.**

Objective 1-1 ***Improve chronic disease management and outcomes by achieving at least minimal performance level (MPL) for the following***

Condition	HEDIS Metric	Target	Value (Aug-Sep 2020)	Source
Hypertension	Controlling high blood pressure	62%	3.70%	Latest HEDIS values from IPAs (Nov-Dec)
Diabetes melitus	HbA1c Poor Control (>9.0%)	< 38%	71.50%	
	Had HbA1c Test	89%	47.40%	
	Had Retinal Eye Exam	39%	69.6%	

Objective 1-2 ***Ensure that children have a healthy start in life by achieving at least minimal performance level (MPL) for the following HEDIS***

HEDIS Metric	Target	Value (Aug-Sep 2020)	Source
Initiation of prenatal care	84%	84.90%	Latest HEDIS values from IPAs (Nov-Dec)
Postpartum care	66%	60.40%	
Well-Child Visits 0-15 (W15)	66%	28.60%	
Well-Child Visits 3-6 (W34)	73%	17.80%	
CIS (Two yearr olds up-to-date)	35%	32.20%	

Objective 1-3 ***Reduce racial and ethnic health disparities in UDS and chosen HEDIS measures in 2020 compared to baseline for 2019.***

Quality Metric	2019	2020	Source