Sacramento County Department of Health Services
Health Center Co-Applicant Board (CAB)

Meeting Agenda

November 17, 2023 / 9:30 AM to 11:00 AM

Meeting Location

Community Room 2020 at 4600 Broadway / Sacramento, CA

- Community Room 2020 is accessible without staff/security needing to let you in. The room is located on the 2nd floor at the top of the back stairs (near the Broadway entrance).

Public comment will be taken after each agenda item and at the end of the meeting.

Topic
Opening Remarks and Introductions – *Jan Winbigler, Chair* • Roll Call and welcoming of members and guests • *Review and approval of 10/20/23 CAB meeting minutes • Public Comment
Brief Announcements – *All* •
Officer Elections for 2024
Leadership Updates – *Drs. Mendonsa and Mishra* • Health Resources and Services Agency (HRSA) Project Director Update -*Dr. Mendonsa* • HRSA Medical Director Reports – *Dr. Mishra* • Public Comment
Quality Improvement – *Dr. Hutchins* • Patient Feedback Survey Findings – Mental Health Services Portion • Summary of Patient Grievances & Safety Concerns • Public Comment
CAB Governance • Committees Updates to CAB – *Committee Chairs* ○ Clinical Operations Committee – *Chair Gallo* ▪ Review of Policies and Procedures ➢ *PP-CS-01-01: Quality Improvement* ➢ *PP-CS-03-01: Telephone Protocol* ➢ *PP-CS-03-04: Emergency Medical Response Team* ○ *Finance Committee – *Laurine Bohamera* ▪ October *Financial Status Report* ▪ Initial discussion of growth requests for FY 24-25 budget ○ *Governance Committee – *Chair Winbigler*

This agenda, the minutes (once prepared and approved) and handouts for this meeting can be found on the CAB website: https://dhs.saccounty.net/PRI/Pages/Health%20Center/Co-Applicant%20Board/County-Health-Center-Co-Applicant-Board.aspx

▪ *Proposal to amend Bylaws to align conflict of interest definition with policy and procedure document ▪ Update on recruitment ▪ Update on training

December Monthly Meeting Items – *All*
• HRSA Project Director Report
• HRSA Medical Director Report
• Committee Updates
  ○ Policy and Procedure Review
  ○ November Financial Status Report
  ○ Recruitment and Training Updates
• Public Comment

Public Comment Period – *Ms. Fryer, Vice-Chair*
Closing Remarks and Adjourn – *Jan Winbigler, Chair*

Next Meeting: Special Training Meeting: November 17, 2023 / 11:00 to 12:00 – Brown Act
Monthly Meeting: Friday, December 15, 2023 / 9:30-11:00 AM

*Items that require a quorum of CAB members and vote.

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Sacramento County Department of Health Services
Health Center Co-Applicant Board (CAB)

Meeting Minutes

October 20, 2023 / 9:30 AM to 11:00 AM

Meeting Attendees

CAB Members: Elise Bluemel, Laurine Bohamera, Vince Gallo, Areta Guthrey, Nicole Miller, Suhmer Fryer (late), Jan Winbigler
SCHC Leadership: Sharon Hutchins, Andrew Mendonsa, Sumi Mishra, Vanessa Stacholy, Noel Vargas
SCHC Staff: Robyn Alongi
Community Members: None

Closed Session 9:30-10:00
Topic
HRSA Project Director evaluation – *Jan Winbigler, Chair* • CAB met with the HRSA Project Director to go over their annual evaluation.
Open Session 10:00-11:00
Topic

Opening Remarks and Introductions – *Jan Winbigler, Chair*
• Roll call and welcoming of members and guests
  ○ Roll was taken by Jan Winbigler and she welcomed attendees.
• *Review and approval of 09/15/23 CAB meeting minutes
  ○ Laurine Bohamera made a motion to approve the September 15 minutes as written. Elise Bluemel seconded the motion. A vote was taken.
  ▪ Yes votes: Laurine Bohamera, Vince Gallo, Nicole Miller, Elise Bluemel, Jan Winbigler
  ▪ No votes: None
  ▪ The motion passed.
• Public Comment – *None.*

Brief Announcements – *All* • Artea Guthrey has been ratified by the Board of Supervisors (BOS). She has started completing the requirements and should be a voting member by the November meeting. • Vanessa Stacholy announced that today is her last day at the Health Center. She accepted a position as Director of California Children's Services at Sacramento County Public Health. • Senator Pan is touring the Health Center today with Sacramento City Councilmember Caity Maple.
Leadership Updates – *Drs. Mendonsa and Mishra*

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Sacramento County Department of Health Services
Health Center Co-Applicant Board (CAB)

- Health Resources and Services Agency (HRSA) Project Director Update
  - Health Resources and Services Administration (HRSA) / Sacramento County Office of Education (SCOE) School Based Mental Health Updates.
    - The Health Center is still awaiting communication from HRSA regarding our School Based Mental Health satellite sites' pending applications and regarding sites which became inactive.
  - HRSA and Medi-Cal Audits / Facility Site Reviews
    - The Health Center has started preparing for site visits and audits expected to occur in the first half of next year. Dr. Hutchins formed ongoing workgroups to tackle various subject areas.
  - Sacramento County Health Center Receives a Prestigious Award
    - The Health Center was recognized by River City Medical Group and received an award of excellence. Only a handful of providers received awards. The Health Center was specifically called out during opening remarks by the River City CEO for our innovative weekend and evenings clinics which have reduced gaps in care. The award, River City's Chief Medical Officer's Excellence in Community Health and Preventative Care, was bestowed to the Health Center because of our pioneering care within the community, approaches to decreasing gaps in care, and improving the care we provide to our patients.
  - Street Medicine Program
    - The Health Center is in the process of bringing a County on-call nurse practitioner to an additional half day of street medicine service. A direct contract with HealthNet has been greenlighted and is moving through the contract process. Dr. Mishra is working internally with staff on the details.
  - Improved Access and Provider Services
    - The Health Center continues to work to increase specialty access. We are in talks with two gastroenterology physicians interested in volunteering/expanding their volunteer scope at the Health Center. The SPIRIT organization found a urologist and an additional dermatologist group in Davis for our Healthy Partner patients.
    - We continue to offer extra-hours clinics aimed at expanding access and meeting gaps in care.
    - Saturday, November 18, is the next scheduled clinic. Well-child visits, fluoride, and immunizations will be offered. Appointments and walk-ins for immunizations will be offered.
  - Health Center Growth / Staffing
    - Management continues to fill the positions from the FY23-24 growth request.
    - Robin Skalsky, LCSW is the acting-Health Program Manager to assist with Vanessa's departure.
    - A new Human Services Planner will start in early November.
    - Filling current vacant positions and converting temp and on-call staff to permanent positions.
  - Space/Staffing Updates
    - Some of the space maximizing projects such as double desks in offices and measuring to determine how best to use space have been completed. Other projects are still pending HRSA approval or waiting for the project to be assigned to a County work team.
    - New Health Center signage remains in process. The new signs allow growth so that we don't have to replace them as things change. Signage includes braille.
    - We are working to come into compliance on gender neutral restrooms.
  - Referral Department Improvements
    - The Executive Team continues to focus on improving referrals; a workgroup has been formed and has met twice.

- The workgroup is exploring the idea of bringing in between 7-10 temp medical assistants and housing them in the old Admin area to work on the backlog. We have a backlog of about 3,600 referrals that likely include duplicate referrals. Many are old and withdrawn. Dr. Mishra is ensuring work on the urgent referrals.
- We are developing a standard workflow and once finalized, we will train staff and make sure that all staff uses it.

- We have asked providers not to classify referrals as urgent unless they meet the definition of that term, as they will be denied causing delays in processing.
- Dr. Mishra has been talking with consultants regarding other ideas to address challenges in referrals.
  - Do we have patient input on this process?
    - We have records of patient complaints and grievances, but we are not systematically collecting data on this issue. Our patient satisfaction survey does not cover referrals. We use it because it is a standard survey used by may peer clinics across the nation and gives us comparison information. We are working on how to distribute short patient surveys to ask questions specific to other concerns of the Health Center.
    - Qualtrax is an option for patient surveys under consideration.
- We are working with consultants on productivity targets, meaning the number of referrals each staff member can be expected to process per unit of time for different types of referrals.
- We are considering implementing care teams in which referrals team members are embedded in the clinical program to be able to work more closely with providers and staff in the program.

- CAB Proclamation
  - We received the BOS Proclamation honoring CAB Member Nora Aaron Washington. We have contact information for Aaron's sister and will be mailing the proclamation to her.
- New Initiatives and Miscellaneous
  - We are pursuing student placements from various universities. California State University Stanislaus wants to work with SCHC.
  - Contracts for consultants and SCOE are going through the standard routing process.

- **HRSA Medical Director Reports – *Dr. Mishra***
  - Staff and Access
    - We are in the process of hiring a County on call nurse practitioner (NP) for Street Medicine and an on call physician for same day access/urgent care. This person will handle discharges from hospitals, jails, etc. to see the patients, review and renew medication and provide other care they need.
    - Interviews for a permanent NP to improve primary care access are complete. The next step is a reference check.
    - Volunteer GI doctor, Cara Torruellas will start in November.
    - The Senior Radiology Tech is retiring at the end of October. We will begin recruitment for that position.
  - Services
    - Street Medicine
      - We added psychiatry evaluation/services for Street Medicine. The Tuesday team has an Addiction Medicine Fellow, Dr. Cara Eberhardt; the Friday team has Psychiatry NP Ashley King.
      - We have expanded dispensed medication to include prescription medications. Dispensing protocols follow Board of Pharmacy regulations. Last week we dispensed blood pressure medications.

- Mental Health and Substance Use
  - We are collaborating with UCD on a National Institutes of Health grant to improve patient adherence to treatment for opioid use disorder that starts in the emergency room.
  - CallPsych - We have purchased a subscription for 15 clinicians to pilot an online app that provides treatment options for adult mental health disorders based on a risk calculator.
  - Dr. Mishra recently learned about the UCSF Child and Adolescent Psychiatric Portal (CAPP), a free service for synchronous and asynchronous child psychiatry consultations and social work care coordination services. Education for school based mental health clinicians is also provided through Project Echo. Management needs to figure out if the Health Center needs approval from the Board of Supervisors.
- School-Based Mental Health
  - Chart reviews to improve documentation and billing have begun.
- Extra hours and ad hoc clinics to close performance measure care gaps continue.

- Vaccines
  - Flu clinics are ongoing.
  - COVID-19 boosters for children have arrived and we have begun administration. We are awaiting COVID -19 boosters for adults.
  - Respiratory Syncytial Virus (RSV) - due to increased morbidity and mortality caused by RSV, we will be offering this vaccine. We have received RSV for children (Beyfortus) and adults age 60+ (Arexvy) and will be purchasing the formulation for pregnant women (Abrysvo).
- Referrals Program
  - Work continues to decrease the amount of time it takes to process referrals and to schedule appointments with specialists and imaging centers.
  - Focus areas include:
    - Creating a standard workflow and training all staff.
    - Enhance staffing and allowing them to work at the highest level of their license.
    - Utilizing our electronic medical record system to streamline the process.
- Policies and Procedures
  - Dr. Hutchins and Robyn Alongi created a P&P committee resulting in a more organized forum to edit and update policies.

- Public Comment – *None.*

Quality Improvement

- 2023 QI Plan: Monitoring Report for Quarter 3 – *Dr. Hutchins*
  - The data dashboard was presented to show how we are doing. Our HRSA goal is to see at least 11,000 patients and we have seen over 16,000.
  - Our no show rate is important. We are trying to keep it under 20% and for pediatrics under 15%. We are still seeing high no shows in pediatrics.
  - Clinical Performance measures: The QI RN has been analyzing data to make sure we are putting our efforts where we are likely to meet the measure.
  - The denominators expand and contact based on assignment of new patients.
  - Lead screenings will increase with the use of our two point of care testing devices.
- Patient Feedback Survey Findings – *Dr. Hutchins*
  - Patient surveys are distributed by OAs to patients twice a year at in person appointments. The last survey was answered by about 400 people.

- Access to care is an identified issue and our clinic hours were rated lower than in years past.
  - The data presented are not official DHCS numbers and we know we are out of compliance. We are hiring a physician to increase access to same day appointments.
- We had trouble mailing the surveys to the organization that analyzes them. The behavioral and mental health services survey results will be presented at a future meeting.

- Public Comment – *None.*

CAB Governance

- Committees Updates to CAB – *Committee Chairs*
  - Clinical Operations Committee – Chair Gallo. This item was not discussed due to time.
    - Review of Policies and Procedures
      - *PP-CS 01-01: Quality Improvement*
      - *CS-03-01: Telephone Protocol*
    - Program Review: Refugee Program
  - *Finance Committee – N/A – the committee did not meet
  - *Governance Committee – Chair Winbigler
    - Officer nominations for 2024
      - Chair nominations: Jan is on term limits and cannot serve as the Chair again. We would have to change the bylaws and she could not be elected in November.
      - Nomination ballots were handed out and collected. Staff compiled the nominations and asked those nominated if they accepted the nomination. The following nominated candidates accepted the nomination:
        - Chair: Suhmer Fryer, Jan Winbigler (Since Jan is term-limited, Dr Hutchins will consult County Counsel whether her name can be included on the ballot at the November meeting).
        - Vice-Chair: Laurine Bohamera, Jan Winbigler
    - *Proposal to amend Bylaws to align conflict of interest definition with policy and procedure document
      - There is a discrepancy between how a conflict of interest is defined in the 2021 Bylaws and the Conflict of Interest Policy & Procedure more recently approved by CAB. The Governance Committee proposes to align the language in the two documents and use the more specific language the Policy and Procedure document.
      - The vote was postponed due to technical difficulties and the inability to show the documents.
      - The documents were not shared in this meeting packet but were shared in the September meeting packet. It will be sent after the meeting.
    - Update on recruitment – No new applications have been received.
    - Update on training – County Counsel Jackson will conduct Brown Act training for CAB members from 11 am -12 pm on 11/17/23 in Community Room 2020, following the end of the CAB meeting.

- Public Comment – *None.*

November Monthly Meeting Items – *All*

- Elections for officer positions for 2024
- HRSA Project Director Report
- HRSA Medical Director Report
- Committee Updates
  - Policy and Procedure Review

- *PP-CS: 01-01 Quality Improvement*
- *CS-03-01: Telephone-Protocol*
- *PP-CS-03-04: Emergency Medical Response Team*
- *PP-CS-03-02: Incident Reporting*
- *PP-CS-02-05: Variance Reporting*
- *07-05: Credentialing and Privileging*
- **Proposal to amend Bylaws to align with the conflict of interest definition with the policy and procedure document

  - October Financial Status Report
  - Recruitment and Training Updates

- Public Comment – *None.*

Public Comment Period – *Ms. Fryer, Vice-Chair*

- No public comment was made.

Closing Remarks and Adjourn – *Jan Winbigler, Chair*

- Chair Winbigler adjourned the meeting at 11:08 am.

Next Meeting: Friday, November 17, 2023 / 9:30-11:00 AM

*Items that require a quorum of CAB members and vote.
**Amending the CAB Bylaws requires a quorum, and a two-thirds vote of members present and voting.

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HRSA Project Director Updates

November 17, 2023 CAB Meeting

1. **Health Resources and Services Administration (HRSA) / Sacramento County Office of Education (SCOE) School Based Mental Health Updates**
    - The Health Center met with HRSA. The pending applications for expansion within the School-Based Mental Health satellites have all been disallowed.

2. **HRSA and Medi-Cal Audits / Facility Site Reviews**
    - The Health Center has started preparation for site visits and audits expected to occur in the first quarter of next year. Dr. Hutchins has formed ongoing workgroups to tackle various subject areas.

3. **Sacramento County Health Center Receives HRSA Badges**
    - The Sacramento County Health Center was awarded three Health Resources and Services Administration (HRSA) Community Health Quality Badges, a significant achievement that reflects our commitment to providing high-quality healthcare services to our community. These prestigious recognitions from HRSA acknowledge our dedication to excellence in healthcare delivery, patient-centered services, and continuous improvement. The awards reflect the hard work, dedication, and unwavering commitment of our entire team to ensure that our patients receive the best possible care. In 2022 we received only one Badge, so these awards truly highlight the advances we have made to increase access, better our operation, and improve quality care.

4. **Street Medicine Program**
    - The Health Center is in the process of bringing a County On-Call Nurse Practitioner to an additional half day of street medicine service. A direct contract with a health plan has been greenlighted and moving through the contract process. Dr. Mishra is working internally with staff to iron out details and will provide additional updates during her report.

5. **Improved Access and Provider Services**
    - The Health Center continues to work to increase specialty access.
    - We continue to offer extra-hours clinics aimed at expanding access and meeting Gaps in Care (GICs).

6. **Health Center Growth / Staffing**
    - Management continues to fill the positions from FY23-24 Growth Request.
    - Leadership will begin to discuss growth concepts for the FY24-25 budget.
    - Staffing update related to medical providers is deferred to Dr. Mishra.

7. **Space/Building Updates**
    - Some of the space maximizing projects (e.g., double desks in an office, measurements to determine how to use space) have been completed. Other projects are still pending either due to HRSA approval or awaiting the project to be assigned to a county work team.
    - New Health Center signage to be in place by 12/31/23.

8. **Referral Department Improvements**
    - Referrals remain a focus for the Executive Team. A workgroup has been formed and met twice.
    - Exploring bringing in between 7-10 temp medical assistants and housing them in the old Admin area to work on backlog.

9. New Initiatives and Miscellaneous

- Pursuing student placements from various universities.
- Contracts such as consultants and SCOE are going through the standard routing process.

10. Health Center's Workforce Well-being Survey Results

- Last year the Health Center participated in HRSAs national Workforce Well-being Survey. This survey aligns with our Strategic Plan around ensuring workforce health and improvement.
- Overall, the results were positive. It highlighted several areas in which we could improve and compared SCHC to similar FQHCs across the country. In the category of 'Supportive Health Center Processes' we surpassed the national average.
- The Executive Team will be doing a deep dive into the results and identifying interventions and projects to improve our scores in critical areas.
- A summary of the results was included in the meeting packet.

Workforce Well-Being Survey Results

Earlier this year, Health Center staff was given the opportunity to complete a workforce survey conducted by the Health Resources and Services Administration (HRSA). The survey was anonymous and about 23% of staff completed it. Attached are the Health Center's survey results compared with similar health centers across the U.S. You will see that our results were similar to the national average, but I want to acknowledge the areas in which we rated above or below average and to share my thoughts and plans for improvement.

The survey had seven sections and each section contained a series of questions that staff rated on a scale from 1 – 6: strongly disagree to strongly agree. The averages of each section are shown in the attached document.

Areas SCHC Exceeded The National Average

- **Supportive Health Center Processes** (Administrative responsibilities, quality of care, workflows and policies)
- **Moral Distress** (Work situations that conflict with one's beliefs and values)

What We Did Not Do As Well As The National Average

- **Positive Workplace Culture** (Support of staff well-being, diversity, and inclusion, nondiscrimination, and patient and staff engagement)
- **Recognition** (Formal and informal workplace appreciation)
- **Adequate Resources** (Staffing, supplies, infrastructure, procedures, and ability to respond to changes and crises)
- **Training Provided** (job training and preparation supported by the health center)
- **Leadership** (Guidance, engagement, and motivation from senior leaders)
- **Work Life Balance** (Work demands and level of control indicate overwork)
- **Compensation and Benefits** (Satisfaction with pay and fringe benefits)

The Sacramento County Health Center is proud of the diversity of our staff and those we serve. The results confirmed what we know about staff morale and having adequate resources; we have reported such issues to CAB many times. During the past two years, leadership has been working on improvements including improved workflows, hiring more staff, soliciting staff input and feedback, and communicating more frequently with staff on a wider range of topics to increase transparency.

We are working on a job training program to support new employees. A new provider manual was developed in 2023 to educate new providers on what a FQHC is and what that means for providers. The manual details the Health Centers programs and quality improvement projects among other things.

Because the Health Center is a government entity, compensation for some categories of staff are higher than the private sector and some are lower. The benefit package offered by the County is comprehensive and extremely competitive. The County also offers financial support to employees for schooling which can help with career advancement.

The Health Center will continue to work towards improving the workplace culture and on solutions to better support the work life balance of staff.

Sacramento County Health Center
Co-Applicant Board

Medical Director Report to CAB
November 17, 2023

1. **All Programs**
   - Covid-19 vaccines available for all ages- We are streamlining tasks amongst staff regarding who conducts and documents the screening questions and where it should be housed in the EMR.
   - RSV- We have all formulations (Adults, Children, Pregnant). Adult (Arexvy) and Pregnant (Abrysvo) formulations are very expensive; Pediatric (Beyfortus)formulation- only allow us to order 5 doses per age group. These are challenges to maintaining a steady supply.
   - Regarding Abrysvo and Beyfortus- next steps include adding these immunizations to EMR; educating staff on the storage, handling, and administration; educating providers regarding those who are at high risk and any contraindications.

2. **Adult Medicine**
   - County On-call doctor- Dr. Theresa Manaloto started 11/14;20 hours a week (16 clinical hours, 4 Admin). She will provide additional access for Same Day and urgent appointments with a 1 month ramp up schedule.
   - Permanent NP position- very few candidates interested; Consideration to reopen the list.
   - UCD contracted Dr. Melody Tran on maternity leave; NP Roslyn Seitz covering for her with a 1 month ramp up schedule.
   - The goal is to have additional access by the end of the year.

3. **Pediatrics**
   The US Surgeon General has hired RAND corporation to reach out to health centers which conduct a large amount of Adverse Childhood Events (ACEs) screenings. We were identified as one of the locations. Dr. Ratanasen and I participated in a call with RAND and learned that the focus is a financial one. The Surgeon General is gathering information regarding financial reimbursement of screenings and identifying any unique utilization of funds.

4. **Family Medicine**
   - We are one of a few health care systems with clinicians comfortable with Medication Assisted Therapy for substance use in adolescents AND where there is good follow up. An additional resource is now available to us via the FM program through June 2024: UCD FM doc who is going through her Addiction Medicine Fellowship providing evaluation and treatment for the Street Med team (Tuesdays) and Family Medicine (Fridays).
   - Goal- create a MAT hub (within Sacramento County Health Center and Adult Correctional Health/ Juvenile Medical) for Medi-Cal clients who also are in need of primary care and establishing themselves in a medical home.

5. **Street Medicine**
   - County On-call NP- hire still in process.

- Sharp increase in number of patients seen in Miller Park; challenge that surfaced due to surge in clients is insufficient time to register and complete eligibility documentation; Primary Health and Public Health are in discussion to add support staff to the teams.
- Data regarding all clients seen from 1/1/23-10/31/23 for street medicine and Loaves and Fishes sent securely to the health plans last week to review. The goal is for health plans to offer mechanisms for us to capture eligibility data more easily which would be a win-win for both the plans and the clinic.

Policies and Procedures-

- Revising Patient Discharge policy (again) to incorporate Patient Rights and Responsibilities.

Client Experience Survey (Behavioral/Mental Health)

June-July 2023

Question	Facility	June-July 2023		
Access to Care		**Excellent/ Good**	**Fair/ Poor**	**Not Applicable**
Able to get appointment	Agg Data	91.0%	8.8%	0.0%
	SCHC	86.9%	13.0%	0.0%
Convenient hours of operation	Agg Data	93.3%	6.5%	0.2%
	SCHC	100.0%	0.0%	0.0%
Easily accessible by telephone	Agg Data	85.7%	11.8%	2.4%
	SCHC	60.9%	21.7%	17.4%
Calls quickly returned	Agg Data	81.5%	13.8%	4.7%
	SCHC	45.5%	9.0%	22.7%
Explanation of fees	Agg Data	74.7%	9.4%	17.3%
	SCHC	45.5%	9.0%	45.5%
Facility		**Excellent/ Good**	**Fair/ Poor**	**Not Applicable**
Neat, clean and comfortable building	Agg Data	97.6%	1.8%	0.6%
	SCHC	95.7%	0.0%	4.3%
Handicap accessibility	Agg Data	79.9%	1.8%	16.5%
	SCHC	72.7%	0.0%	27.3%
Provides a safe environment	Agg Data	96.8%	2.0%	1.2%
	SCHC	100.0%	0.0%	0.0%
Reception		**Excellent/ Good**	**Fair/ Poor**	**Not Applicable**
Respectful and helpful to you	Agg Data	96.2%	3.2%	0.6%
	SCHC	100.0%	0.0%	0.0%
	QI Goal	75.0%		
Amount of time spent in waiting room	Agg Data	89.7%		1.2%
	SCHC	81.8%	18.2%	0.0%
Amount of time spent in checkout	Agg Data	91.6%	3.9%	4.6%
	SCHC	77.3%	9.1%	13.6%
Counselor/ Therapist/ Case Manager		**Excellent/ Good**	**Fair/ Poor**	**Not Applicable**
Listens to you	Agg Data	93.8%	3.0%	3.2%
	SCHC	95.4%	4.5%	0.0%
Answers your questions	Agg Data	93.9%	2.8%	3.4%
	SCHC	95.3%	4.8%	0.0%
Respectful to you	Agg Data	94.6%	2.2%	3.1%
	SCHC	95.4%	4.5%	0.0%
Helps you meet your treatment goals	Agg Data	92.6%	3.3%	4.1%
	SCHC	95.0%	5.0%	0.0%
Overall, how would you describe your relationship with your counselor/therapist/case manager?	Agg Data	92.9%	3.5%	3.6%
	SCHC	95.3%	4.8%	0.0%

Client Experience Survey (Behavioral/Mental Health)

June-July 2023

Question	Facility	June-July 2023		
Nurses		**Excellent/ Good**	**Fair/ Poor**	**Not Applicable**
Respectful to you	Agg Data	86.1%	2.1%	11.8%
	SCHC	84.2%	0.0%	15.8%
Helpful to you	Agg Data	86.2%	2.1%	11.7%
	SCHC	82.3%	0.0%	17.6%
Nursing Aids/Medical Assistants		**Excellent/ Good**	**Fair/ Poor**	**Not Applicable**
Respectful to you	Agg Data	84.5%	1.5%	14.0%
	SCHC	84.2%	0.0%	15.8%
Helpful to you	Agg Data	84.2%	1.7%	14.1%
	SCHC	83.4%	0.0%	16.7%
Medical Physicians		**Excellent/ Good**	**Fair/ Poor**	**Not Applicable**
Repectful to you	Agg Data	80.1%	1.9%	18.1%
	SCHC	89.4%	0.0%	10.5%
Answers your questions	Agg Data	79.2%	2.5%	18.3%
	SCHC	88.3%	0.0%	11.8%
Helpful to you	Agg Data	79.5%	2.4%	18.1%
	SCHC	89.4%	0.0%	10.5%
Understands your problem	Agg Data	77.4%	4.2%	18.4%
	SCHC	88.2%	0.0%	11.8%
Education received on medical condition and medications prescribed (e.g. side effects or purpose)	Agg	78.0%	3.5%	18.6%
	SCHC	83.3%	0.0%	16.7%
Psychiatrist		**Excellent/ Good**	**Fair/ Poor**	**Not Applicable**
Repectful to you	Agg Data	79.9%	1.9%	18.2%
	SCHC	72.3%	0.0%	27.8%
Answers your questions	Agg Data	79.0%	2.6%	18.4%
	SCHC	72.2%	0.0%	27.8%
Helpful to you	Agg Data	78.5%	3.2%	18.3%
	SCHC	72.3%	0.0%	27.8%
Understands your problem	Agg Data	77.2%	4.3%	18.5%
	SCHC	72.2%	0.0%	27.8%
Education received on medical condition and medications prescribed (e.g. side effects or purpose)	Agg	76.3%	3.9%	19.8%
	SCHC	64.7%	0.0%	35.3%

Client Experience Survey (Behavioral/Mental Health)

June-July 2023

Question	Facility	June-July 2023		
Groups		**Excellent/ Good**	**Fair/ Poor**	**Not Applicable**
Your participation has been helpful to your recovery	Agg	42.8%	3.0%	54.3%
	SCHC	27.8%	5.6%	66.7%
Rate the skills taught and information presented to you	Agg	43.1%	2.6%	54.3%
	SCHC	23.5%	11.8%	64.7%
Discharge Planning		**Yes**	**No**	**Not Applicable**
You have been involved in the planning of your transition from this program	Agg	29.7%	9.0%	61.3%
	SCHC	29.4%	17.6%	52.9%
Your discharge plan will support your recovery	Agg	31.0%	3.0%	66.0%
	SCHC	26.7%	0.0%	73.3%
General		**Yes**	**No**	**Not Applicable**
Would you recommend our programs to your friends/relatives if they need our services?	Agg	93.4%	1.4%	5.1%
	SCHC	100.0%	0.0%	0.0%
Are you confident that personal information will be kept confidential by staff?	Agg	94.9%	1.8%	3.4%
	SCHC	100.0%	0.0%	0.0%
Are staff respectful of your cultural, ethnic, and spiritual needs?	Agg	90.8%	0.9%	8.3%
	SCHC	83.3%	5.6%	11.1%
Do you participate in planning your treatment?	Agg	85.6%	3.2%	11.1%
	SCHC	94.1%	0.0%	5.9%
Did staff meet your request for family involvement?	Agg	62.3%	3.7%	34.0%
	SCHC	44.4%	11.1%	44.4%
Did you have opportunities to learn daily living skills?	Agg	67.3%	3.9%	28.7%
	SCHC	58.8%	11.8%	29.4%
Have you used the health center website?	Agg	34.9%	46.4%	18.7%
	SCHC	52.9%	35.3%	11.8%
Do you have someone besides the agency staff to call during times when you are feeling helpless, hopeless, or	Agg	85.1%	14.9%	
	SCHC	81.3%	18.8%	
		< once per week	**at least once per week**	**2 or more times per week**
How often do you socialize with your support network?	Agg	26.0%	29.4%	44.6%
	SCHC	26.7%	53.3%	20.0%
		Excellent/ Good	**Fair/ Poor**	**Not Applicable**
Overall, rate the progress you are making meeting your treatment goals.	Agg	87.4%	9.6%	3.0%
	SCHC	88.3%	11.8%	0.0%

Client Experience Survey (Behavioral/Mental Health)

June-July 2023

Client Experience Survey (Behavioral/Mental Health)

June-July 2023

Client Experience Survey (Behavioral/Mental Health)

June-July 2023

Q2-Q3: 2023 Summary of Patient Grievances

<u>Grievances</u> (from Health Plans or Independent Practitioner Organizations)

Category	Description	Examples	Number
Level I	Access challenges	Complaints about call center wait times; difficulty making an appointment	6
Level II	Disrespectful behavior or failure to follow clinical, operational or fiscal P&P	Delayed prescription refills; patient billed in error; unprofessional or disrespectful treatment of patients	7
Level III	Issues impacting patient safety, violating privacy laws, and/or involving possible litigation	Medication error; Needle stick/exposure; severe allergic reaction; HIPAA breach; severe bodily harm	1
Other	Concern does not directly involve the health center		4

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	**09/22/2023**
Title: **Quality Improvement**	Functional Area: **Organization**		
Approved By: Andrew Mendonsa, HRSA Project Director			

Policy:

Sacramento County Health Services (SCHC) is committed to improving services for our patients. To evaluate performance, under guidance from the Co-Applicant Board, the Quality Improvement Committee selects or creates indicators to monitor and analyze. Clinic operations are adjusted to enhance service provision in areas revealed to need improvement.

Procedures:

A. Quality Improvement (QI) Plan

1. A QI Plan will be approved annually by the Health Center Management Team, the Quality Improvement Committee (QIC), and the Co-Applicant Board.
2. See attachment A, Quality Improvement Plan.

B. QIC

1. The SCHC QIC will be comprised of the following:
   a. HRSA Project Director
   b. HRSA Project Manager
   c. Medical Director
   d. Pharmacy Director
   e. Physician Representative(s)
   f. Nursing Supervisor Representative
   g. Nursing Program Representative
   h. Program Planner
   i. Administrative Services Officer (Data Reports)
   j. Others as indicated.
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 patient care and service, provide policy decisions, review, and make recommendations regarding the annual Quality Improvement Plan. These policy decisions and directions will be relayed to the Operations Team to develop workflows and manage the logistics of executing the policy decisions.
3. The QIC will meet monthly or not less than ten (10) times per year.

4. A Quality Improvement Report will be provided to the Co-Applicant Board at least quarterly by the designated Project Director or designee.
5. See QI Plan for additional details.

C. Operations Team

1. The Operations Team will develop workflows to execute the QI policy decisions made by QIC and/or CAB.

References:
HRSA Health Center Program Compliance Manual, Chapter 10: Quality Improvement/Assurance

Attachments:
Annual Quality Improvement Plan

Contact:
Sharon Hutchins, HRSA Project Manager

Co-Applicant Board Approval Date

10/20/2023

Sacramento County Health Center

Quality Improvement Plan

2023

Department of Health Services
Primary Health Division
Approved by CAB on 03/17/2023

OVERVIEW

Sacramento County Health Center (SCHC) has a systematic approach to quality measurement and quality improvement. The Quality Improvement (QI) Plan outlines the process that includes methods to monitor performance and implement changes in practice, when necessary, with follow up measurement to determine whether new practices positively affected performance.

Review of data is essential to the QI process. Data can include but is not limited to performance indicators, satisfaction surveys, member concerns (complaints, grievances), service utilization, medication errors, chart review, etc. Compliance and risk management are also integral to quality management. The Health Center is a public entity and has separate units or departments for Compliance (HIPAA), risk management, contracts, fiscal, safety, information management, and legal counsel.

Health Center Vision

- To be an exceptional health care center valued by the communities we serve and our team.

Health Center Mission

- To provide high quality, patient-focused, equitable healthcare for the underserved in Sacramento County, while providing training for the next generation of local health care providers.

Values

- Accountability
- Diversity
- Excellence
- Respect
- Compassion
- Equity
- Education

Goals

- Reducing health inequities and assisting patients in achieving better health outcomes through best practice and/or evidenced based guidelines;
- Patients feel that the SCHC cares about and works to improve their well-being, safety and experience in a respectful way;
- Care Team members understand and believe in their role and are supported to carry it out in a positive environment; and
- Responsible management of funds to ensure economic sustainability of health center.

Guiding Principles for Service Provision

- Access to care for routine, same day, and new member appointments;
- Respect, sensitivity, and competency for populations served;
- A safe and attractive environment for clients, visitors and staff;
- A work culture that acknowledges all team members provide essential high quality services;
- Effective communication and information sharing;
- Effective and efficient use of resources to sustain the mission;
- Implementation of data-informed practices; and
- Continuous improvement.

PROGRAM STRUCTURE

Quality Improvement Committee (QIC)

1. The QIC provides operational leadership and accountability for clinical continuous quality improvement activities.
2. QIC meets at least monthly or not less than ten (10) times per year.
3. The QIC represent different disciplines and service areas within the Health Center. This includes the Division Manager, Medical Director, Pharmacy Director, QI Director, designated Administrative Services Officer (reports), and representatives for clinics, physicians, and nursing.
4. QIC responsibilities include:
    a. Develop the annual QI Plan that includes a specific approach to Continuous Quality Improvement (CQI) based on the Quadruple Aim, and present it to the Co-Applicant Board (CAB) for adoption.
    b. Establish measurable objectives and indicators of quality based upon identified priorities.
    c. Monitor data indicating progress toward clinical goals related to Patient Experience and Population Health Outcomes.
    d. For clinical indicators out of target range, develop actions and strategies for Health Center Management Team implementation.
    e. Report to the CAB on clinical quality improvement activities on a regular basis.
5. Management Team responsibilities include:
    a. Implement strategies and provide education to staff on clinical quality standards and metrics.
    b. Monitor data indicating progress toward the goals related to Reducing Costs and Care Team Well-Being.
    c. For economic and personnel indicators out of target range, develop actions and strategies for Health Center Management Team implementation.
    d. Report to the CAB on non-clinical quality improvement activities on a regular basis.
    e. Report back to the QIC.
6. Health Center Co-Applicant Board (CAB) role includes:
    a. Authorities outlined in Clinic Services *PP 01-02: Co-Applicant Board Authority*.
    b. Delegate authority and responsibility for the QI Program to the QIC.
    c. Review, evaluate, and approve the Quality Improvement Plan annually and receive quarterly reports on identified quality indicators.

PERFORMANCE INDICATORS & ANALYSIS

Performance Indicators are identified and measured as part of the quality improvement initiatives. They:

- Have defined data elements;
- Have a numerator (who/what was changed) and denominator (of what eligible group) available for measurement; and
- Can detect changes in performance over time and allow for a comparison over time.

Outcomes / Process Measurements are those that:

- Identify measurable indicators to monitor the process or outcome;
- Collect data for specified time period, or ongoing;
- Are compared to a performance threshold or target; and
- Evaluate the effectiveness of defined action(s).

Data Analysis establishes:

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

Continuous Quality Improvement (CQI) -- Clinic Services frequently utilizes the Plan–Do–Study–Act (PDSA) method for focused intervention. See PDSA Work Sheet.

PLAN	Identify area target not met. 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	Recommend further study / action. May need to abort, adapt or adopt. This decision depends upon results of the analysis. If the proposed solution was effective, decisions are made regarding broader implementation including the development of a communication plan, etc. If the solution was not effective, QI team returns to planning step.

COMMUNICATION AND COORDINATION

Communication

Problems may be identified from data, staff or management experience, concerns, audits, or agency feedback. Managers are responsible for:

1. Sharing the plan including indicators and targets with staff at all levels;
2. Including multidisciplinary staff from all areas of operations in problem identification; developing strategies, implementing interventions, and review of data analysis;
3. Providing information alerts or policy and procedure guidance; and
4. Imbedding key priorities into Health Center policies, training, and other core materials.

CONFIDENTIALITY AND PRIVACY OF PERSONAL HEALTH INFORMATION

All data and recommendations associated with quality management activities are solely for the improvement of patient experience, patient care, economic sustainability, or the well-being of the care team. All material related to patient care is confidential and 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 clinical quality management process which involves peer review shall be held in strictest confidence and considered peer review protected.

The Health Center 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 the CAB meeting minutes.

Personal health information obtained because 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 password protected and only accessible to those who need access.

Clinic Services Policies & Procedures Manual and the County Office of Compliance have extensive policies and procedures for health information management and protected health information.

2023 QUALITY IMPROVEMENT GOALS AND OBJECTIVES

Annually, the Health Center selects Quality Improvement goals and objectives for each part of the Quadruple Aim. The Quality Improvement Committee (QIC) is responsible for oversight of two of the Aims: Patient Experience and Population Health Outcomes. The Management Team is responsible for the remaining two Aims: Reducing Costs and Care Team Well-Being.

Patient Experience ***(Patients feel that the SCHC cares about and works to improve their well-being, safety and experience in a respectful way)***

Goal 1: Improve Access to Care

- Objective 1-1: Improve Access by Telephone During and After Hours
  - Reduce the amount of time patients spend on the phone by:
    - Increasing the percentage of calls answered within Service Level each month from a baseline of 72% to 80% by December 2023.
    - Reduce the Longest Queue time to less than 1 hour each month.
  - Track above metrics by number of call center personnel hours on shift.
- Objective 1-2: Reduce No Shows
  - Reduce No Shows by 5% for each program.
  - Track the no-show rate for each provider.
  - Track appointment reminders to see how many are completed (i.e. patient responds by confirming or canceling the appointment).

- Objective 1-3: Increase Appointment Access
  - Increase availability of appointments after regular business hours by conducting a minimum of 12 after hours (Saturdays &/or evening) clinics.
  - Track provider and schedule utilization, average lead time and time lost to no shows.
  - Track the percentage of new members who get new member appointments within 120 days of assignment to SCHC and how many of these are completed (e.g. have all components including SHA).
- Objective 1-4: Reduce Time from Referral/Order to Appointment
  - Process at least 25% of referrals within the DHCS timely access requirements.
  - Track time from order to schedule and then to visit.

Goal 2: Improve Customer Service

- Objective 2-1: Improve Continuity of Care
  - Track percentage of PCP empaneled patients.
  - Track the number of non-urgent appointments that are with the patient's PCP as a measure of continuity of care.
- Objective 2-2: Improve Pre-Visit Planning
  - Document pre-visit planning workflows for patient registration in Family Medicine, Adult Medicine, Behavioral Health and Pediatrics.
  - Track pre-visit (e.g. checks of health maintenance section prior to patient visits.

Goal 3: Improve Patient Engagement

- Objective 3-1: Improve Patient Outreach
  - Increase the percentage of active adult patients with activated My Chart from 31% to 35% by end of 2023.
  - Ensure contact by visit or outreach (call/letter/text) with all empaneled patients at least once per calendar year.
  - Document outreach workflows and ensure consistency (e.g. script) among all
- Objective 3-2: Improve Supports for Health Literacy and Patient Education
  - Ensure 10 most common forms or handouts for each program are available in the languages (other than English) spoken by at least 3,000 English-limited residents of Sacramento County (Cantonese, Dari, Farsi, Hmong, Mandarin, Pashto, Spanish, Russian, Ukrainian, Vietnamese).

Population Health Outcomes ***(Reducing health inequities and assisting patients in achieving better health outcomes through best practices and/or evidence-based guidelines)***

Care Coordination

Goal 4: Improve Care Coordination of Patients with High Service Utilization or Who Require Services Across Systems

- Objective 4-1: Increase rate of patients receiving follow up after ED visit or hospitalization within 30

days to 50%

- Objective 4-2: Ensure utilization of Hypertension & Diabetes in-clinic program services is 95% of program capacity.
- Objective 4-3: Ensure the number of multi-visit patients participating in Complex Care Management (CCM) is 95 % of program capacity.
- Objective 4-4: Track number of patients 1) referred to and 2) receiving care coordination services from other organizations (plans/providers).

Clinical Performance Measures

Goal 5: Achieve Minimum Performance Level (MPL) on Select Uniform Data System (UDS) and Healthcare Effectiveness Data and Information Set (HEDIS) Quality Measures Focused on Those That Signal a Healthy Start in Life

- Objectives:
  - Prenatal/Postpartum care
  - Lead Screening
  - Childhood Immunization (CIS)
  - Adolescent Immunization (IMA)
  - Well-Child Visits for children 0-30 months of age (WCV-30)
  - Well-Child Visits for those 3-21 years of age (WCV 3-21)

Goal 6a: Achieve MPL on Select UDS and HEDIS Quality Measures Focused on Secondary Prevention of Health Issues Prevalent Among SCHC Patients

- Objectives:
  - Breast Cancer Screening (BCS)
  - Cervical Cancer Screening (CCS)
  - Colorectal Cancer Screening (CRCS)
  - Flu Immunizations
  - Tobacco Cessation

Goal 6b: Achieve High Performance Level (HPL) for HEDIS Quality Measures Focused on Secondary Prevention of Health Issues Prevalent Among SCHC Patients

- Objectives:
  - Chlamydia Screening
  - Hypertension Management: BP Control

Goal 7: Achieve MPL Performance on Select UDS and HEDIS Quality Measures Focused on Care Coordination and Treatment for Chronic Conditions Prevalent Among SCHC Patients

- Objectives:
  - Diabetes Management: A1c Testing & Control
  - Diabetes Management: Vison Check
  - Diabetes Management: Nephropathy

- Diabetes Management: Neuropathy
- Cardiovascular Disease (CVD): Statin Therapy
- HIV: Viral Suppression

Goal 8: Improve Performance on Select UDS and HEDIS Quality Measures Focused on Diagnosis and Treatment of Mental, Behavioral Health and Substance Use Related Conditions Among SCHC Patients

- Objectives:
  - Depression Screening and Follow Up
  - Depression Remission at 12-Months
  - Follow-up after Emergency Department visit or Hospitalization for Alcohol and Drug Use
  - Follow-up after Emergency Department visit or Hospitalization for Mental Health

Goal 9: Improve QI Support and Infrastructure

- Objective 9-1: Track staff effort and financial impact of QI projects to help build the QI program.
- Objective 9-2: Develop Standards for the Content of Quality Improvement Plans
  - Ensure Program QI Plans include the following components:
    - List of Key Performance Indicators
      Based on above requirements
    - List of key stakeholders and their role
    - Initial QI relevant Program SWOT analysis
    - Outline of proposed improvement activities and prospective timeline
- Objective 9-3: Develop Standards For Accountability For Program Quality Performance
  - Each Program will have an assigned Quality Coach from the Quality Department
  - Each Program will assign a designated Quality Lead and an alternate/assistant
    Leads may be either staff or providers. If Quality Lead is not the program medical director or program manager, a standard for communication of quality plan activities must be outlined.
  - Program Quality Leads and/or Program leadership will be required to report on performance of Program Quality Plan quarterly to the QIC.
- Objective 9-4: Develop Standards For Reporting Program Quality Performance
  - Set tiered performance targets for all goals that align with MPL and include stretch goals
  - Develop Program Quality Dashboards *(analog in 2023; digital in 2024)*
  - Dashboards will be updated monthly and posted/provided to QIC.
  - QIC will have a monthly opportunity for any program to report/address significant barriers to improvement projects.
  - Programs will provide structured report-out quarterly at QIC meeting.
  - Develop Program level Project Plans to address goals that include operational standard deliverables (SOPs, Workflows, Job Descriptions, EMR tools).

Goal 10: Address Racial and Ethnic Disparities Identified in Select UDS and HEDIS Quality Measures

- Objective 10-1: Reduce Racial and Ethnic Health Disparities in the Control of Diabetes and Hypertension

- Compare data for three-year intervals from pre-pandemic (2016-2018), pandemic (2019-2022), and post-pandemic (2023-2025) to account for temporal trends that have had differential impacts on racial and ethnic groups.
- Use the results to direct focus of quality improvement to health outcomes and groups with the greatest disparities and health burden.
- Work with UC Davis experts on the effective measurement of health inequities and effective strategies to reduce them.

Reducing Costs ***(Responsible management of funds to ensure economic sustainability of health center)***

Goal 1: Health Center staff will develop a dashboard of indicators to monitor the relative costs and revenues associated with specific programs and practices.

- Objective 1: At least semi-annually, produce calculations of the number of visits and total revenue per
  - Clinical department/program (i.e. Adult Medicine, Behavioral Health Services, Dental Services. Family Medicine, Homeless Services, Mobile Services, Pediatrics, Refugee, School-Based Mental Health, Specialty Services)
  - Provider type
  - Provider FTE
  - Medium (i.e. video, phone, and in person appointments)

Care Team Well-Being ***(Staff members understand and believe in their role and are supported to carry it out in a positive environment)***

Goal 1: Identify barriers and obstacles to long-term retention for County staff.

- Objective 1: Review findings from HRSA survey and identify one or more actionable strategies to improve employee retention.

Goal 2: Improve morale and retention of the Care Team.

- Objective 1: Review the results of the personnel survey and identify one to three areas for action to improve care-team well-being for action by December 2023.
- Objective 2: Review institutional policies and practices to determine if changes can be made to aid retention efforts.

2023 QUALITY IMPROVEMENT PROJECTS

For the 2023 plan, SCHC is distinguishing among four categories of Quality Improvement Projects and introducing increased infrastructure to support these.

1. The first category projects affect all or the majority of clinical programs at SCHC to which most programs can and should contribute. SCHC clinical programs are Adult Medicine, Family Medicine, Integrated Behavioral Health, Pediatric Preventive Dental Services, Pediatrics, Radiology, Refugee Health Assessment, and School-Based Mental Health.

2. The second category projects affect all or the majority of clinical programs at SCHC and will be led by clinical support programs staff. Administration, Quality Improvement, Registration, Member Services, and Referrals are examples of clinical support programs.

3. The third category projects are those that affect more than one clinical program area, but which will be led by a single clinical program.

4. The fourth category projects are specific to and led by a single clinical or non-clinical program area.

SCHC will begin 2023 working on specified projects to address the specific measures outlined below. Additional projects may be proposed to or by the QIC as the need arises, such as not being on course to achieve the objectives (see previous section) or converting tracking objectives to targeted objectives. QI projects may be proposed to QIC using the standard form and process by any provider or program representative. QIC will evaluate proposals and incorporate approved projects into the overall QI plan and schedule.

Category 1 Projects: Clinic-Wide Projects to Which Most Programs Contribute

Initial Projects
Reduce No Shows
Lead: QIC

Increase Appointment Access
Lead: QIC

Category 2 Projects: Clinic-Wide Projects Led by Support Programs

Initial Projects
New Patient Outreach and Initial Health Appointment
Lead: Member Services

Depression Screening and Follow Up
Lead: QI Team

Breast Cancer Screening
Lead: QI Team

Colorectal Cancer Screening
Lead: QI Team

Reduce Wait Times in the Call Center
Lead: Call Center

Conduct Pre-Visit Planning
Lead: Registration

Reduce Processing Time for Non-Urgent Referrals
Lead: Referrals

Category 3 Projects: Projects Affecting More than One Clinical Program Led by Single Clinical Program

Initial Projects
Reduce Repeat Calls to Call Center
Lead: Adult Medicine

Cervical Cancer Screening
Lead: Adult Medicine

Follow Up After ED Visit or Hospitalization for Mental Health
Lead: Integrated Behavioral Health

Follow Up After ED Visit or Hospitalization for Substance Use
Lead: Integrated Behavioral Health

Well-Child Visits 0-30 Months (including required immunizations)
Lead: Pediatrics

Well-Child Visits 3-21 Years (including required immunizations)
Lead: Pediatrics/Family Medicine

Lead Screening by 2 Years
Lead: Family Medicine

Increase the Percentage of Diabetic Patients with Controlled Blood Sugar
Lead: Adult Medicine/Diabetes Clinic

Increase the Percentage of Hypertensive Patients with Controlled Blood Pressure
Lead: Adult Medicine/Hypertension Clinic

Category 4 Projects: Projects Affecting a Single Clinical Program Led by that Clinical Program

Initial Projects
Timely Entry (1st Trimester) into Prenatal Care
Lead: Family Medicine

Complete Post-Partum Visit during set window
Lead: Family Medicine, Pediatrics, and Adult Medicine

ATTACHMENT A: QI Project Idea Submission and Approval Form

Sacramento County Health Center **Quality Improvement Project Proposal**	Name	
	Department/Program	
	Faculty Advisor Name (for Learner)	
	Submitted Date	
	QIC Review Date	

Quality Improvement Project Title:
Background: Relevant historical data and information. Explain why the current process or system needs improvement. What is the impact this is having on our organization, our patients? (limit of 400 characters with spaces)
What SCHC goals and objectives does the project address? *Mission and values, and/or Quality Improvement Plan and/or HEDIS or HRSA measures.* (limit of 200 characters with spaces)
Improvement Goal: What outcome are you hoping to achieve? (limit of 200 characters with spaces)
Ease of Project: Does SCHC currently collect the relevant data needed for your project? YES NO Does the literature support the ability for an ambulatory facility to intervene to improve the outcome? YES NO Is there a source of funding? YES NO What are the resources you need (time, staff, funding, equipment, space, etc.). (limit of 400 characters with spaces)

SCHC Quality Improvement Committee			
Review Date:	Decision Date:	Approved? YES	NO
Recommendations/Next Steps:			

ATTACHMENT B: QI Project Description A3

Project Name:	Program Owner:	Start Date:	Projected End Date:

Project Team

Role/Title	Name	Department	Prefered Contact Method
Project Lead			
Project Manager			
PM Support			

Background

Why do we care? What is the impact on patients? Who are the stakeholders?

Gap Analysis

Identify what is causing or contributing to the problem. Which cause has the largest impact?

What is the gap b/w actual & desired outputs of process?

References

Research,standards, guidelines

Risks & Barriers

Brief description of Risks /to Project Success/Completion

Initial State / Baseline

Define current reality. Base info here on observations, process mapping, and data. Include baseline metrics.

AIM

What are we trying to accomplish. SMART

MEASURES

Type	Metric(s)	Measure-ment	Base line	Target	Long Term
Outcome					
Process					
Barrier					

DELIVERABLES

ACTION PLAN

Priority	Action	Owner	Start Date	Due Date	Level of Effort (H/M/L)	Potential Impact (H/M/L)
1						
2						
3						
4						
5						

RESOURCE NEEDS

Check boxes?

COMPLETION & ROLLOVER EXPECTATIONS

Estimated time to completion. Area with ongoing oversite after project completion.

ATTACHMENT C: QI Project Charter

Date:	**Sponsor (clinical lead):**
Project Name:	
Team Clinical Chairperson (Drive the project, give provider perspective, get provider buy-in): **Team Administration Chairperson (Drive project, give admin/line staff perspective, get staff buy-in):**	
Team Members (contribute your experience and perspective to the project, input ideas and help test ideas and administer change): 1. Name (Role/Responsibility) Line Staff 2. Name (Role/Responsibility) Clinician 3. Name (Role/Responsibility) Outside eyes 4. Name (Learner?) 5. Name (Coach to help guide process)	
Meeting Schedule (Meet at least monthly, possibly more at the beginning)**:**	

1 **Background**

Relevant historical data and information. Explain why the current process or system needs improvement. What is the impact this is having on our organization, our patients? Why now?

2 Current Condition

Detailed description of the current situation, process, trend chart, what is the problem we are trying to solve?

3 Goal Statement

Where do we want to go? Specific goal to address the gap for future state from the current states. What outcome are we hoping to achieve? Set SMART goals (Specific, Measurable, Acheivable, Revelant, Timebound).

Scope and Barriers

- Whose input and support will this project require? How will you engage these key stakeholders?
- What barriers do you predict to your success? How will you overcome these barriers?
- List any guidelines for the team, including project constraints, rules or procedures, technology considerations, what is out of scope, etc.

This worksheet walks you through the process of testing changes for improvement. Discuss and jot down ideas for each of the four questions and use the tips to guide you through each discussion.

Discussion questions	Discussion tips
Aim setting: What are we focusing on now, and what is our goal?	• Set aims from the point of view of our patients (i.e., what would they want you to work on?). • Set your aims high ("stretch goal") – even halfway there would be a substantial improvement. • Look to make substantial progress in a matter of weeks.
Measurement: How will we know if we are making it better?	• Provide feedback on performance and change using data. • Collect data pre- and post-change. • Avoid long baseline studies that postpone getting to the change. • Keep it simple. • Choose practical measurement over perfect measurement. • Keep the time between intervention (action) and measurement to a minimum.
Idea generation: What changes do we think will make it better?	• Think about the rules and mental constructs that underlie the current way of doing things. This is the "box" that our current thinking is in. Get outside the box by asking: "Does it have to be that way?" "What would it be like if we were prohibited from following that rule?" "If we broke those rules, would that be so bad after all?" • Turn needed behavioral changes into specific techniques that people can learn. • Always generate multiple ideas for change. There may be legitimate reasons why a certain idea cannot be tested. If that is your only idea, then momentum is stopped.
Testing: How will we carry out progressive trials of our ideas?	• People are more likely to go along with a test of change if they are involved in the planning of it. • Don't get attached to any one way of implementing an idea. Stay at the change-concept level and allow others the joy of developing the specifics to fit their situation. • Start small and work initially with those willing to work with you. Use the success of these few to approach others. • Improvement is always a "work in progress"; it is not a one-time event. Work to keep the momentum going. Take the biggest step you can take, but don't worry that you are not doing it all. One step leads to another.

	• Be sure to allocate time to reflect on the results of every test of change and its implications for the next test. • Integrate improvement into regular work. For example, allocate office meeting time for this. Always be testing a change and letting everyone know about it. • Anticipate the impact of the change on other players in the system. Keep them informed – no surprises. Don't let the unwilling stop you from testing a change with those who are willing, but don't do anything behind anyone's back. • Communicate, communicate, communicate … repeat. • Don't lose sight of the whole system as you work on a small piece of it. Don't let analysis interfere with synthesis.

ATTACHMENT D: QI Project Monthly Status Report

PROJECT STATUS REPORT			
Project Title:			
Start Date:		Workgroup	
Projected End Date:			
Sponsor/Lead:			
Project Manager:			

Narrative Status Summary

Progress Chart(s)

Active Subtasks			
Phase	Subtask	Barriers/Questions	Target Date

Next Steps			
Phase	Subtask	Barriers/Questions	Target Date

ATTACHMENT E: Program Quarterly Report Schedule

QIC 2023 Report Out Schedule

Program	January	February	March	April	May	June	July	August	Sept	Oct	Nov	Dec
Member Services		QI Team Training	1			2			3			4
Call Center				1			2			3		
Referrrals	N				1			2			3	
Registration			1			2			3			4
Quality			1			2			3			4
Adult Med	N			1			2			3		
Pediatrics					2			3			4	
Family Med					1			2			3	
IBH	N			1			2			3		

Standard PowerPoint presentation template will be used for Program Quarterly Report Outs

Prospective QI Team Activities

Program	January	February	March	April	May	June	July
Member Services		Introduction to Principles of Quality Project Management	G3:O1 Initiation/Analysis	G3:O1 Design/Develop	G3:O1 Test/Impliment	G2:O1 Initiation/Analysis*	G3:O1 Maintenance G2:O1 Design
Call Center	G1:O1 Initiation/Analysis		G1:O1 Design/Develop	G1:O1 PDSA	G1:O1 PDSA	G1:O1 PDSA	G1:O2 Initiation
Referrals	G1:O4 Initiation/Analysis		G1:O4 Design/Develop	G1:O4 PDSA	G1:O4 PDSA	G1:O4 PDSA	G1:O4 Maintenance
Registration	G2:O2 Initiation/Analysis		G2:O2 Design/Develop	G2:O2 Impliment	G2:O2 Maintenance	G2:O2 Phase 2 Initiation/Analysis	G2:O2 Phase 2 Design/Develop
Quality	CMS2 Develop BCS Initiation/Analysis		CMS2 Test BCS Design/Develop	CMS2 Impliment BCS Test	CMS2 Maintenance BCS Impliment	BCS Maintenance CRCS Analysis	CRCS Design/Develop
Adult Med			CDC Analysis	CDC Design/Develop	CDC PDSA	CDC-PDSA	CDC-PDSA
Pediatrics	WCV-Outreach Initiation/Analysis		WCV-Outreach Develop	WCV-Outreach Test/Impliment	WCV+-Workflow Initiation/Analysis	WCV+ Review Design/Develop	WCV+-Workflow Impliment
Family Med			PPC Initiation	PPC Analysis	PPC Design/Develop	PPC Test	PPC Impliment
IBH			FUA/FUM Workflows Analysis/Design	FUA/FUM Workflows Devleop/Test	FUA/FUM Workflows Impliment	DRR Initiate/Analysis	DRR Design/Develop
QIC/Leadership *Goal setting, develop guidelines, set expectations, remove barriers.*	2023 QI Plan	G1:O3 Increase Appts Develop Guidelines	G2:O1 Appt w/PCP G1:O2 Reminders Research	G2:O1 Appt w/PCP G1:O2 Reminders Develop Guidelines		G2:O2 Phase 2 Establish Priorities	

ATTACHMENT F: QIC Monthly Meeting Agenda

	Topic	Owner	Time
1	Announcements	Sharon	5 min
2	Clinic Wide Measure Status Update	Sharon	5 Min
3	Report Out A	Program/Project Lead	10 Min
4	Report Out B	Program/Project Lead	10 Min
5	Report Out C	Program/Project Lead	10 Min
6	Questions/Discussion of Monthly Status Project Reports *Monthly status reports provided to QIC one week prior to meeting*	QIC	10 Min
7	Action Item Recap	Sharon	5 min

	County of Sacramento **Department of Health Services** **Division of Primary Health** **Policy and Procedure**	Policy Issuer (Unit/Program)	**Clinic Services**
		Policy Number	**03-01**
		Effective Date	**09-30-10**
		Revision Date	**10-03-23**
Title: **Telephone Protocol**		Functional Area: **Clinic Operations**	
Approved By: Andrew Mendonsa, Psy.D., MBA / Division Manager			

Policy:

The Sacramento County Health Center is committed to excellent customer service by assisting individuals by phone promptly, respectfully, and sensitively.

Procedures:

A. General guidelines for staff assigned to phones

1. Answer the phone in a professional and courteous manner and identify yourself. e.g., “Thank you for calling the Sacramento County Health Center. This is NAME. How may I help you today?”
2. Update the patient contact information at every encounter (address, phone numbers, and emergency contact) in the Electronic Health Record (EHR).
3. Verify eligibility while assisting the patient.
4. Refer to Policy and Procedures (PP) 03-08 Appointment Scheduling if scheduling an appointment.
5. If the caller is upset, respond in a calm, understanding, and professional manner. Request assistance from a colleague or supervisor as needed.
6. Before placing a caller on hold, ask the caller “May I place you on a brief hold?” Allow the caller to respond before placing them on hold.
7. For non-English speaking and hearing impaired callers, ask the caller to hold for an interpreter. Document primary language and the need for an interpreter in the EHR.
    a. From the main toolbar open the registration tab.
    b. Select the “Additional Pat Info” radio button on the left side.
    c. Document the patient’s language needs (e.g., Female Dari interpreter needed).

B. Management and direction of calls:

1. If the caller wants to make, change, or get information about an appointment, proceed with the call per PP 03-08 Appointment Scheduling.
2. All other requests:
    a. Give the caller the correct department’s phone number and other pertinent information, then transfer the call and provide a warm handoff (e.g., “I have the Patient Name on the line, and he needs to…”).

Department	Phone	Reason to Transfer Call
Behavioral Health Clinician of the Day	(916) 539-8340	• Suicide and homicide ideation ○ Keep the caller on the line and have a colleague call the Behavioral Health Clinician for assistance
Main Pharmacy	(916) 874-9642	Outside pharmacy calls
Pediatric and Adolescent Primary Care	(916) 876-5437	• Make, change, and reschedule appointments • Request for same-day/urgent appointment • Leave a message for a pediatrician • Speak to a pediatric nurse
Referrals Team	(916) 874-9334	• Referral questions • Any calls with referral and specialist questions • Healthy Partners (HP) Diagnostic Questions
Registered Nurse		
Pediatric Dept	Send Telephone Encounter	• Callers report an urgent medical problem • Medical questions • Medication reaction • Patient requesting an urgent appointment, and no appts. are available within 48 hours • Providers & other professionals • Hospital discharge and no available appointments within 10 days • Quest (or other professional) calling with critical labs
Adult Medicine	Ashley: 4-1093 Farzam: 4-9246 Ana: 5-3054 Diana: 4-3359	
Family Medicine	Erica: 5-0754	
Send Telephone Encounter		Send a telephone encounter for • Urgent medical question or issue • Checking on forms/letters • Medical question regarding visits • Lab results • Checking on will-call and forms/letters that can't be located • Patient requesting sooner (not urgent) appt. • Non-medical questions or concerns
Department Routing Guide		
Medical Records Request		(916) 874-9298
Member Services Team/Healthy Partners		(916) 874-1805
Refugee Health Assessment Program		(916) 874-9227
Pediatric Clinic		(916) 876-5437
Radiology Appointment or Questions		(916) 874-9522
Employment Verification for DHS employees		Dept of Health Services, Human Resources (916) 875-1300
Department of Human Assistance		(916) 874-3100

C. Creating and sending a telephone encounter message from the caller EHR:

1. Messages must be professionally written, accurate, complete, and prompt. Slang is unacceptable.
2. If the patient indicates s/he has an urgent medical problem or question, send an urgent telephone encounter to the triage nurse pool. The encounter must include the reason for the urgent medical issue/request, the patient's eligibility and medical home assignment, and the phone number where the patient can be reached. Do not keep the member on the line while typing the telephone encounter.
3. Review "Patient Encounter Selection" if there is a recent encounter regarding the same issue. Select the encounter. Edit the note per the patient's request. Save and route the encounter.
4. If the patient calls with a new concern, request, or question:
    a. Click "New Encounter" to create a telephone encounter.
    b. Select the date
    c. Enter the PCP
    d. Click accept (this action will open a new encounter)
    e. Complete the following section:
        i. Contact Section: Incoming call, outgoing, other
        ii. Reason for call (select from the drop-down menu)
        iii. Routing (see the department Message Routing Guide)
        iv. My Note: type the message per the caller's request
        v. On the left side, "Close the Workspace"
        vi. Select "Accept" below the note to save the information
5. The designated medical staff will respond or consult the provider and respond to the message within two working days.
6. Per provider directive, the designated medical staff (medical assistant, registered nurse, or pharmacist) will contact the caller and document the action taken utilizing the same encounter.
    a. The designated staff can **edit the note** to document what actions were taken or they can create a **new note** in the same encounter.
    b. To save the documentation, click the radio buttons,"**Close the Workspace**" and "**Accept**."

References:
PP 02-02 Interpreter for Patient Care
PP 03-08 Appointment Scheduling
PP 04-01 Urgent Services
PP 05-01 Pharmacy Refill Procedure

Attachments:
Call Center Call Routing – Primary Care Workflow

Contact: Health Program Manager for Operations

Co-Applicant Board Approval:

	County of Sacramento **Department of Health Services** **Division of Primary Health Services** **Policy and Procedure**	Policy Issuer (Unit/Program)	**Clinic Services**
		Policy Number	**03-04**
		Effective Date	**03-07-12**
		Revision Date	~~**9/6/10-23-2023~~06/09/21**
Title: **Emergency Medical Response Team**		Functional Area: **Clinic Operations**	
Approved By: Susmita Mishra, MD, Medical Director			

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Policy

Sacramento County Health Center (SCHC) has a team response to medical emergencies within the Primary Care Center building (PCC). The Emergency Medical Response Team (EMRT) consists of employees trained to respond to medical emergencies. Assigned EMRT responds to all clinic area emergencies and stays with the patient until paramedics arrive. -The County p~~P~~harmacy, ~~and the~~ Public Health Laboratory, and clinics within the PCC are included.

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Procedures

A. Requesting Medical Emergency Response

1. An individual requiring immediate medical attention may be identified by any person including those affiliated with ~~the Sacramento County Health Center (~~SCHC~~)~~, Public Health (PH), Pharmacy, and/or building Security.
2. SCHC, Pharmacy, and-~~/~~or PH Staff will use the identified phones to ~~do the~~engage the -overhead paging system to call the EMRT~~response team~~. To access the paging system, please use one of the phones identified with the colored dots or refer to Attachment A: Paging System Phones to locate the nearest p~~P~~aging phone, dial 76, enter #10, state announcement, and press end call.

B. Staff must state "Adult Emergency Response Team to [location]" if adult patient emergency. If pediatric emergency, state "Pediatric Emergency Response Team to [location]." ~~S~~if applicable, staff must also state "Quest" or "PH Lab" ~~in order~~ to ~~help~~ identify at which lab the EMRT ~~response~~ is ~~required~~needed.

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C. Emergency Response Team Restrictions

The EMRT shall not:

1. Provide medical treatment other than basic lifesaving procedures.
2. Move patient unless directed by a provider.
3. Put the safety of themselves or others at risk.

D. Required Training for EMRT

1. Basic Life Support (BLS) – all c~~C~~linical staff
2. Overhead paging system – all staff
3. Competency in use of oxygen, ambu bag and Automated External Defibrillator (AED) – c~~C~~linical staff only

E. EMRT Schedule

1. Team assignments are rotated, ~~and~~ are the responsibility of the designated ~~manager and~~manager and are reviewed by ~~the~~ SCHC's Medical Director.

2. EMRT schedule and corresponding activities are posted on the white board located across from the MA work areas on both floors.

~~G.~~F. EMRT Composition and Roles

TEAM MEMBER	RESPONSIBILITY
Staff person who is witness to or informed of event	1. Use overhead paging system to call EMRT to location of emergency. 2. Press 76 to access paging system. 3. At steady tone, enter # 10, announce "Adult Emergency Medical Response Team to [location]" if adult patient; if it is a child, announce "Pediatric Emergency Medical Response Team to [location]." ~~S~~if applicable, staff must also state "Quest" or "PH Lab" ~~in order~~ to ~~help~~ identify at which lab the EMRT ~~response~~ is ~~required~~needed. 4. If an interpreter is needed, request required language (if possible) in the announcement, such as "Spanish interpreter or Spanish speaking staff needed."
Senior Office Assistant/Clerical Supervisor	1. Notify Security (874-2575) of the location of emergency and ask an officer to respond to clear the scene of bystanders. 2. Print insurance information, last progress note, recent labs, medication list, known allergies, health conditions, current or history of acute or reoccurring symptoms, label(s) and emergency contact information. 3. Provide individual's information to First Responders if indicated.
Provider (MD, NP)	1. Responsible for coordination of the emergency response – assume lead role at the scene. 2. Determine whether 911 intervention~~, if~~ is necessary. 3. Remain with the patient until secure handoff to first responders or patient status is no longer emergent. 4. If the patient is a member of the health center, provider will document intervention in the electronic medical record.
Primary Registered Nurse (RN	1. Provide emergency assessment. ~~2.~~ Obtain emergency response bag (PINK bag for pediatrics). See Section F, Number 4 for emergency response bag supplies. 2. Replace emergency supplies within 1 business day after the emergency ~~within 1 business day~~. 3.
Secondary RN Supervising RN	1. Record details of the event and pertinent medical information during Primary RN assessment. 2. Secondary RN will complete the Incident Report and give it to the ~~-~~Supervising RN to compile final report. 3. Supervising RN will ensure accuracy and timely completion

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	of Incident Report and will give it to HPM for review.
Medical Assistant (MA)	1. Bring AED and oOxygen to the scene. 2. Dial 911, at pProviders direction. 3. Assist RN and pProvider as directed.
Security Officer on Scene	1. 1. Inform Security desk of impending ambulance arrival, if applicable. 2. Control crowd, allow the EMRT access and room space to work. Direct other personnel back to their workstations.

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2. Control crowd, allow the ERT access and room to work. Direct other personnel back to their workstations.

H.G. Emergency Response Bag Contents and Maintenance

1. First fFloor emergency response bags are located in the Medication Room.
2. Second fFloor emergency response bags are located in 2244-supply room in the Pediatric s suite (Pediatrics – Pink pediatric bag) and 2140-Medication room (Suite 2100-Blue- adult bag).
3. The emergency response bag contains the following emergency medications:

Emergency Response Bag Medication Contents	
ADULTS	**PEDIATRICS**
Epi Pen 0.3mg (1:1000)	Epinephrine 0.3mg
Glucagon 1mg/1ui IM	Epi Jr. 0.15mg
Nitrostat 0.4mg SL (25 tablets/bottle)	Diphenhydramine HCl 50mg/ml
Tube Fast Acting Glucose Gel (24g carbohydrate)	Diphenhydramine HCl 25mg/cap
Ammonia Inhalants Amp (0.33mL= alcohol 35% - Ammonia 15%/1)	Benadryl (chew) 12.5mg/tab 20tabs
Diphenhydramine 50mg/mL IM (1 ml pre-filled syringe)	Children's Acetaminophen 160mg/5 ml
Diphenhydramine 25mg Capsules	Proventil, spacer Ammonia Inhalant
Aspirin 325mg Tablets	Glucagon ER response bag
Naloxone 0.4mg/ml (vial)	
Ondansetron 4mg/2ml (vial) Ammonia Inhalants Amp(0.33mL= alcohol 35% - Ammonia 15%/1) Diphenhydramine 50mg/mL IM (1 ml pre-filled syringe)	Children's Acetaminophen 160mg/5ml
	Proventil, spacer Ammonia Inhalant
Diphenhydramine 25mg Capsules	Glucagon ER response bag
Aspirin 325mg Tablets	
Naloxone 0.4mg/ml (vial)	
Ondansetron 4mg/2ml (vial)	

16.4. The emergency response bag contains items sized appropriately for either adults or children:

a. Ambu Bag w/mask

b. High Concentration Oxygen Mask

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c. Thermometer
d. Bite Block
e. EKG Tab Electrode
~~e.~~
f. Multifunction Defibrillator Electrode Pedi.Padz®
g. Instant Cold General Purpose 4 X 6 Inch

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h. Blood Pressure Cuff And Stethoscope

i. Glucometer With Lancets And Strips

j. Pulse Oximeter

k. Airways

l. Nasal Cannula Or Oxygen Face Mask (I.E., Ambu Bag)

m. Personal Protective Equipment (PPE)

~~17.~~5. Assigned RN will monitor and check emergency equipment weekly.

~~18.~~6. Assigned RN provides monthly routine maintenance using the Automated External Defibrillator (AED)/ Oxygen (O2) Monthly Log and Maintenance Checklist.

~~19.~~7. Oxygen is supplied in tanks with a capacity of 2,200 pounds per square inch (PSI). When oxygen levels fall below one-half as indicated on the dial, designated staff will notify "Life Save" for servicing. An additional portable oxygen tank is available ~~in~~in the Health Center observation area for immediate use, if necessary.

~~I.~~H. **Mutual Aid Agreement with Chest Clinic, Public Health Laboratory (PHL), and Sexual Health Clinic (SHC) (Division of Public Health)**

Chest Clinic, PHL, ~~-~~and/or SHC Office Assistants (OA) or other staff: ~~will~~

1. Will c~~c~~all for EMRT~~ERT~~. May use Security for overhead page.
2. ~~Chest Clinic, PHL, and/or SHC clinical personnel~~W ~~w~~ill initiate AED if appropriate while ~~a~~waiting the EMRT ~~ERT~~ arrival.
3. ~~Chest Clinic, PHL, and/or SHC clinical personnel or OA~~ M~~m~~ay take a role with the E~~R~~MRT as noted above in EMRT ~~ERT~~ Composition and Roles.
4. ~~Chest Clinic, PHL, and/or SHC personnel~~W ~~w~~ill identify themselves and their role to responding provider.
5. All personnel without assigned roles will return to their workstations.

~~5.~~6. PHL will not call the EMRT ~~schedule~~ for any exposure to biological agents.

References:
N/A

Attachments:
Attachment A: Paging Systems Phones
Attachment B: Clinic Services Incident Report
Attachment C: EMRT Schedule

Contact:
~~Laurie Haugen, BSN, RN, Supervising Registered Nurse~~
Ainur Sapargaliyeva, RN, Supervising Registered Nurse
Robin Skalsky, ~~Vanessa Stacholy, Health Program Manager~~Health Program Manager for Operations

Co-Applicant Board Approval:
~~06/18/21~~

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Program Summary: Refugee Health

Name of Program	Description
Summary and purpose	The Refugee Health Program serves legal immigrants with eligibility determined by the federal Office of Refugee Resettlement. The purpose is to ensure new arrivals are healthy enough to become self-sustaining, contributing members of the community.
When did the program start?	Many decades ago
Is our purpose still relevant?	Yes
Description of current scope and activities. Which types of patients are served? At which sites? What are the hours?	There are two foci for the Refugee Health Program. The first is Refugee Health Assessment, in which providers and staff review overseas medical records, conduct a thorough health assessment, and order relevant tests and vaccines. The second is Linkage, in which new arrivals with significant medical or mental health needs are linked to appropriate care in the US health care system, including making appointments and assisting patients to attend them.
Current staffing levels	Health Assessment (RHAP Program) • 24 staff (including on call, temporary and registry staff) • 4 providers (1 full time, the others part-time) Linkage (RHPP Programs) • 12 staff, including on call and temporary staff
Financing and Budget	Health Assessment (RHAP Program) $1,197,161 Linkage (3 RHPP Programs) $439,927
How effective are we being (and how do we know)? *List specific metrics if possible.*	Pending final 2022 Audit results 1a) Exceeded: Ensure that 90% of all arriving refugees start the health assessment process. 1b) Exceeded: Ensure that 60% of all [arrivals of other statuses]… start the health assessment process 2) Not met: Ensure that 60% of all arriving refugees [and arrivals of other statuses]… have completed health assessments within 90 days from date of arrival, date parole status is granted [or other relevant date]. *CDPH will assist us in processing waiver requests. They understand most delays are due to 1) challenges with Quest appointments, 2) people coming into the clinic late, and other waivable reasons.* 3) Met: Assess immunization status of 95% of children and adults who have started a health assessment 4) Not met: Ensure that 90% of individuals identified as eligible to receive scheduled immunizations at the time of the health assessment are either immunized or referred to an appropriate provider. *This is a documentation issue, not a performance issue. See more discussion in point # 2 in the next section.* 5) Exceeded: Ensure that 95% of individuals identified with a health

	condition needing further medical evaluation are referred to a health care provider. 6) Exceeded: Ensure that 95% of arrivals who completed health assessment are evaluated for TB infection or disease…. 7) Objective not Met: Ensure that 90% of individuals diagnosed with Class II LTBI start LBTI treatment according to CDPH Guidelines *Data coordination issue with Sacramento Co Public Health* 8) Objective not Met: Ensure that 70% of those commencing LTBI treatment complete the recommended course of therapy. *See comment above.*
Are we meeting our patient satisfaction and quality goals with this program? *List specific metrics if possible.*	NA -need to develop them specific metrics this federal fiscal year

Period	**4**
Current Month	**October**
Percentage of Year	**33%**

CAB Financial Report

Line Item	Budget	Current Month	Year to date	*Encumbrance*	*Total* *(YTD+Encumbrance)*	YTD Percentage (Total/Budget)	Notes
Revenue							
Inter/Intrafund Reimbursements	$ 12,284,581	$ 1,009,698	$ 1,525,663	$ -	*$ 1,525,663*	12%	Typically a lag due to Fiscal processes
Intergovernmental Revenue	$ 21,712,340	$ 1,623,616	$ 7,622,601	$ -	*$ 7,622,601*	35%	Medi-Cal revenue, HRSA & Refugee grants
Charges for Services	$ 18,000	$ 1,500	$ 3,250	$ -	*$ 3,250*	18%	CMISP old pre-2014 service charges
Miscellaneous Revenue	$ -	$ -	$ -	$ -	*$ -*	0%	
Total Revenue	**$ 34,014,921**	**$ 2,634,813**	**$ 9,151,514**	**$ -**	***$ 9,151,514***	**27%**	
Expenses							
Personnel	$ 15,782,496	$ 1,001,504	$ 3,987,533	$ -	*$ 3,987,533*	25%	Low due to vacancies (currently 28.0 FTE)
Services & Supplies	$ 19,071,205	$ 970,408	$ 1,192,437	$ 6,570,414	*$ 7,762,851*	41%	Low due to SCOE invoices and accruals not being paid yet. Multiple FY 23-24 Contracts have just been executed. This will start to catch up
Other Charges	$ 1,060,633	$ 3,037	$ 5,997	$ 130,387	*$ 136,384*	13%	All accruals have not been paid.
Equipment	$ -	$ -	$ -	$ -	*$ -*	0%	
Intrafund Charges (Allocation costs)	$ 3,007,297	$ 318,969	$ 581,725	$ 14,577	*$ 596,302*	20%	
Total Expenses	**$ 38,921,631**	**$ 2,293,918**	**$ 5,767,691**	**$ 6,715,378**	***$ 12,483,070***	**32%**	
GRAND TOTAL							
(Net County Cost)	**$ (4,906,710)**	**$ 340,896**	**$ 3,383,822**	**$ (6,715,378)**	**$ (3,331,556)**		Coming in roughly 1.5m below budget at this time

GRANT SUMMARY

HRSA	Grant Year Start	Grand Year End	Total Grant	Available to Claim 7/1/23-6/30/24	YTD Claimed	Remaining	Notes
HRSA Homeless (Main)	3/1/2023	2/28/2024	$ 1,386,602	$ 1,386,602	$ 636,551	$ 750,051	Spending on track
HRSA ARP CAP	9/15/2021	9/14/2024	$ 619,603	$ -	$ -	$ -	Contruction timeline not yet determined
HRSA HIV	9/1/2022	8/31/2025	$ 975,000	$ 325,000	$ 212,369	$ 112,631	Spending slow to start. Will carryover funds
Refugee						$ -	
RHAP	10/1/2022	9/30/2023	$ 1,789,062	$ 1,789,062	$ 1,727,171	$ 61,891	61k left over after FFY ended - due to staff vacancies
RHPP	10/1/2022	9/30/2023	$ 82,014	$ 82,014	$ 54,471	$ 27,543	
RHPP Multi-Year	10/1/2022	9/30/2023	$ 153,000	$ 153,000	$ 24,626	$ 128,374	Spending slow due to vacancies -2 HSA vacant, 1 MA vacant
RHPP AHP	10/1/2022	9/30/2023	$ 200,000	$ 200,000	$ 22,327	$ 177,673	Spending slow due to vacancies - 1 OA vacant
Miscellaneous						$ -	
County ARPA - 1 (H4)	1/1/2022	12/31/2024	$ 2,451,919	$ 2,451,919	$ 999,990	$ 1,451,929	Spending on track, increased April 2023 when HRSA ARPA expired
County ARPA - 2 (H18)	1/1/2022	12/31/2024	$ 500,000	$ 500,000	$ 8,774	$ 491,226	Telehealth Equipment Award
County ARPA - 2 (H19)	7/1/2022	12/31/2024	$ 815,000	$ 815,000	$ 41,705	$ 773,295	New award, spending slow to start

Sacramento County Health Center
Co-Applicant Board

BOARD BYLAWS

Revision Date: April 16, 2021

Table of Contents

Introduction

This body shall be known as the Sacramento County Health Center Co-Applicant Board, and shall be hereafter referred to as "CAB". The CAB is also known as "Board" under Health Resources and Services Administration (HRSA). The CAB shall serve as the independent local co-applicant governing board pursuant to the Public Health Services Act and its implementing regulations. The County of Sacramento, a public entity and political subdivision of the State of California, shall act as co-applicant with the CAB.

Article I: Purpose

The CAB is the community-based governing board mandated by the Health Resources Services Administration's ("HRSA") Bureau of Primary Health Care ("BPHC") to set health center policy and provide oversight of the County's Federally Qualified Health Center ("FQHC"), which shall be hereafter referred to as "Health Center".

The CAB shall work cooperatively with the County of Sacramento acting in its role as co-applicant, to support and guide the Health Center in its mission:

Vision: Unparalleled experience as a trusted partner in health care for our Sacramento County community.

Mission: Provide high-quality, caring, and comprehensive healthcare services for our diverse Sacramento County community through partnering with patients, academic institutions, and community-based organizations.

Values: Respect, Compassion, Learning, Excellence, Efficiency, Accountability

Article II: Responsibilities

The CAB has specific responsibilities to meet the governance expectations of HRSA, while day-to-day operational and management authority reside with Sacramento County, Department of Health Services (DHS), Primary Health Services Division staff.

The CAB's responsibilities include providing advice, leadership, and governance in support of the Health Center's mission. .

The CAB shall have the following responsibilities:

A. Hold final authority on all areas assigned to the Health Center's HRSA scope of project, including services and supports provided through HRSA grant funds, program income, and all appropriated funds;

B. Hold monthly meetings and maintain a record of all official actions;

C. Approve the annual Health Center budget;

D. Identification, consultation and selection of services beyond those required in law to be provided, as well as the location, mode of delivery of those services and the hours of operation;

E. Adopt policies necessary and proper for the efficient and effective operation of the Health Center;

F. Periodic evaluation of the effectiveness of the Health Center in making services accessible to County residents, particularly those experiencing homelessness;

G. Develop and implement a procedure for hearing and resolving patient grievances; Approve quality of care protocols and audits;

H. Delegate credentialing and privileging of providers to the Medical Director of the Health Center, as referenced in the PP CS 07-05 Credentialing and Privileging;

I. Ensure compliance with federal, state, and local laws and regulations;

J. Adopt Bylaws;

K. Approve the selection, performance evaluation, retention, and dismissal of the Health Center's Project Director;

L. Approve Health Center Sliding Fee Discount policy;

M. Long-term strategic planning, which would include regular updating of the Health Center's mission, goals, and plans, as appropriate;

N. Approve HRSA applications related to the Health Center, including grants/designation application and other HRSA requests regarding scope of project;

O. Ensure new board members are oriented and trained regarding the duties and responsibilities of being a board member of an organization subject to FQHC requirements and satisfying the educational and training needs of existing members; and

P. Officially, accept the annual audit report and management letter performed by an independent auditor in accordance with federal audit requirements.

NOTE: No individual member shall act or speak for the CAB except as may be specifically authorized by the CAB. Members (other than the Health Center Chief Executive Officer/Project Director) shall refrain from giving personal advice or directives to any staff of the Health Center.

Article III: Limitations of Authority

The Board of Supervisors shall maintain the authority to set general policy on fiscal and personnel matters pertaining to the Health Center, including financial management practices, charges and rate setting, and labor relations and conditions of employment. The CAB may not adopt any policy or practice, or take any action, which is inconsistent with the County Code, or which alters the scope of any policy of the Board of Supervisors regarding fiscal or personnel issues. All policies and practices must adhere to California law, Brown Act requirements, and are subject to the Public Records Act.

The COUNTY through its DHS in consultation with the CAB, shall be solely responsible for the management of the financial affairs of the Health Center, including capital and operating borrowing; for the development and implementation of financial policies and controls related to the Health Center; and receive, manage, allocate, and disburse, as applicable, revenues necessary for the operation of the Health Center.

Article IV: Members

Section 1: Membership

There shall be between nine (9) and thirteen (13) at large voting members of the CAB and one (1) ex-officio non-voting member.

A. Membership categories:

1. Board Members - Consumers:

    a. A majority of members of the board shall be individuals who are served by the Health Center. This means an individual who is a currently registered patient who has accessed Health Center services in the past 24 months and received at least one service.

    b. As a group, patient members of the board reasonably represent individuals who are served by the Health Center in terms of demographic factors such as race, ethnicity gender, socioeconomic status, and age.

    c. At least one representative on the board will be from each targeted population serviced by the Health Center including homelessness, as specifically defined under the section 330 grant.

    d. A legal guardian of a patient who is a dependent child or adult, or a legal sponsor of an immigrant, may also be considered a patient for purposes of board representation.

2. Board Members - Community Members:

    a. Members of the board have a broad range of skills, expertise and perspectives representing the community served by the Health Center.

    b. Members shall be individuals from differing segments of the County with expertise in community affairs, finance, legal affairs, business or other commercial concerns.

    c. Members may be an advocate who has personally experienced being a member of or represent, or have expertise in or work closely with the special population such as individuals experiencing homelessness.

3. The HRSA Project Director, or designee, shall serve as an ex-officio non-voting member of the CAB.

Section 2: Membership Qualifications

A. No more than half of the Community members may receive more than ten percent (10%) of his or her annual income from the health care industry (health care industry is understood to mean any community clinic or hospital providing health services to low income residents of Sacramento).

B. All members must work, reside in, or be associated with, Sacramento County. No member of the CAB shall be an employee or an immediate family member (i.e., spouse, child, parent, or sibling, [related by blood, adoption, or marriage]) to such an employee of the Department of Health Services of the County of Sacramento, or CAB officer. No member shall have a financial interest, which would constitute a conflict of interest.

Section 3: Member Recruitment, Selection, and Ratification

A. Establishment of CAB

The initial voting members of the CAB were nominated and appointed by the Board of Supervisors.

B. Continuation of CAB

1. Member Recruitment

The CAB (or a sub-committee appointed for this purpose) develops a recruitment plan each year, to identify and recruit potential members that help fill existing and forecasted gaps in CAB membership including regarding

a. Member classifications,

b. Populations represented on the CAB,

c. Member skills, experience and perspectives; and

d. Segments of the community about which members have expertise.

The recruitment plan includes strategies designed to effectively reach targeted groups or classes of individuals.

Expiring Terms

a. Terms end in January. Recruitment for soon to be expiring terms will begin in September so that candidate members can be considered and a new CAB member approved prior to the end of the term.

Vacancies during Terms

a. The recruitment plan may designate a period during which membership applications will be accepted and reviewed

2. Application Review

The application for CAB membership and instructions for completing and submitting it—as well as information about the Health Center, the CAB, and its role, as well as open seats and deadlines for application—are made widely available to possible members, including on the Health Center website.

a. Nominations for voting membership on the CAB may be submitted by anyone so long as the nominee meets the membership requirements of these Bylaws.

b. Nominated individuals must submit an application to provide required information and to verify their interest and ability to serve as CAB members.

c. Applications are submitted to Health Center staff designated by the HRSA Project Director. Staff verify that applicants meet CAB membership requirements. The names of all applicants who meet the membership requirements are presented to the Governance Committee.

d. The Governance Committee of the CAB reviews the membership

applications and talk with possible candidates.

3. Approval of CAB members

   The CAB (or a designated Committee or staff member) interviews prospective members that meet membership requirements and review their skills, experience, perspectives, and other possible contributions to the CAB. The CAB votes on prospective members.

4. Ratification of CAB members

   a. As outlined in the Co-Applicant Agreement between the CAB and the Sacramento County Board of Supervisors, Once approved by the CAB, Health Center staff provides the names of approved CAB members to the Clerk of the Board or designee.

   b. The Clerk of the Board, or designee, reviews materials and submits for ratification by the Board of Supervisors.

   c. The Clerk of the Board notifies the designated Health Center staff of BOS actions related to CAB members and sends a ratification letter to each new ratified CAB member.

B. Verification of Eligibility of Existing CAB members

   1. By December 31st of each calendar year, Health Center staff will verify existing CAB member eligibility. Each CAB member will complete the Co-Applicant Board Member Secondary Attestation Form attesting to their eligibility (in October).

Section 4: Responsibilities and Rights of Members

A. All members must:

   1. Attend all CAB meetings, unless excused by the Chair.

   2. Be subject to the conflict of interest rules applicable to the Board of Supervisors of the County of Sacramento and the laws of the State of California.

B. Members shall be entitled to receive agendas, minutes, and all other materials related to the CAB, may vote at meetings of the CAB, and may hold office and may chair CAB committees.

Article V: Term of Office

The term of office for CAB members shall be for four (4) years. A member shall be limited to no more than four (4) consecutive terms of membership. The effective date of membership corresponds to the date of appointment.

Any elected member who has served four (4) consecutive, four (4) year terms shall not be eligible for re-election until one (1) year after the end of his or her fourth term. Election to fill a vacancy for less than three (3) years shall not be counted as service of a four (4) year term for this purpose. Unless terminated earlier in accordance with the Bylaws, members shall serve their designated term until their successors are elected and qualified.

Article VI: Removal

Any member may be removed whenever the best interests of the Health Center or the CAB will be served. The member whose removal is placed in issue shall be given prior notice of his/her proposed removal, and a reasonable opportunity to appear and be heard at a meeting of the CAB. A member may be removed pursuant to this section by a vote of two-thirds (2/3) of the total number of members then serving on the CAB.

Continuous and frequent absences from the CAB meetings, without reasonable excuse, shall be among the causes for removal. In the event that any member is, absent without acceptable excuse from three (3) consecutive CAB meetings or from four (4) meetings within a period of six (6) months, the CAB shall automatically consider the removal of such person from the CAB in accordance with the procedures outlined in this Article.

The CAB will accept a written or emailed resignation of a CAB member, or a verbal resignation if given during a full CAB meeting. The CAB Chair or designee will send an email or letter to the CAB member confirming the resignation. Following seven (7) days of receipt of the letter by the CAB, the resignation is accepted.

Article VII: Conflict of Interest

A conflict of interest is a transaction with the Health Center in which a CAB member has a direct or indirect economic or financial interest. Conflict of interest or the appearance of conflict of interest by CAB members, employees, consultants and those who furnish goods or services to the Health Center must be declared. CAB members are required to declare any potential conflicts of interest by completing a *Conflict of Interest: Disclosure and Attestation Statement* per County of Sacramento policy for members appointed to advisory boards (see Appendix A) as well as annually complete the *Co-Applicant Board Conflict of Interest: Disclosure and Attestation Statement* (see Appendix B), in which they attest that they are not,

- An employee of the Sacramento County Health Center; nor
- An immediate family member (i.e., spouses, children, parents, or siblings [through blood, adoption, or marriage]) of an employee or CAB officer.

In situations when a conflict of interest may exist for a member, the member shall declare and explain the conflict of interest. No member of the CAB shall engage in discussion about or vote on a topic where a personal conflict of interest exists for that member. In addition to the requirements imposed by these Bylaws, CAB members shall also be subject to all applicable state and federal conflict of interest laws.

Article VIII: Compensation

Members of the CAB shall serve without compensation from the Health Center. Travel and meal expenses when traveling out of Sacramento County for CAB business shall be approved in advance by the CAB.

Article IX: Meetings

Section 1: Regular Meetings

The CAB shall meet monthly and maintain records/minutes that verify and document the Board is functioning. Where geography or other circumstances make monthly, in-person participation in board meetings burdensome, monthly meetings may be conducted by telephone or other means of electronic communication where all parties can both listen and speak to all other parties.

Section 2: Conduct of Meeting

The meeting shall be conducted in accordance with the most recent edition of The Sturgis Standard Code of Parliamentary Procedure unless otherwise specified by these Bylaws.

Section 3: Open and Public

All meetings will be conducted in accordance with the provisions of the Ralph M. Brown Act, open public meeting law, as amended.

Section 4: Notice, Agenda and Supportive Materials

A. Written notice of each regular meeting of the CAB, specifying the time, place and agenda items, shall be sent to each member not less than seventy-two (72) hours prior to the meeting except as permitted by the Ralph M. Brown Act. Preparation of the agenda shall be the responsibility of the Chair in conjunction with the Project Director, or his or her designee.

B. The agenda of each regular meeting shall be posted at the Health Center and on the Health Center's website: https://dhs.saccounty.net/PRI/Pages/Health%20Center/Co-Applicant%20Board/County-Health-Center-Co-Applicant-Board.aspx.

C. Supportive materials for policy decisions to be voted upon shall be distributed to all members along with the agenda. If, on a rare occasion, such prior submission is precluded by time pressures, and if the urgency of a CAB vote is established by the Chair of the CAB, an item may be placed on the agenda although supporting materials are not available in time to be distributed. However, such material shall be available at the meeting.

D. Items, which qualify as an emergency, can be added to the agenda pursuant to the Ralph M. Brown Act.

Section 5: Special Meetings

A. To hold a special meeting, advance notice of such meeting shall be given.

B. The CAB shall hold an annual meeting during November, at such time and place as is established by the Board upon proper notice, for election of new members and officers, and for the transaction of such other businesses as may properly come before the CAB. The annual meeting shall serve as the regular meeting for that month. Notice of the annual meeting shall be given in writing by the Project Director or his or her designee to each member not less than thirty (30) nor more than sixty (60) days prior to the date of such meeting.

Section 6: Quorum and Voting Requirements

A. A quorum is necessary to conduct business, make recommendations, or approve items. A quorum shall be constituted by the presence of a majority of the appointed members of the CAB.

B. A majority vote of those CAB members present and voting is required to take any action.

C. Each member shall be entitled to one (1) vote. Voting must be in person or telephonically; no proxy votes will be accepted.

D. CAB member attendance at all meetings shall be recorded. Members are responsible for signing the attendance sheet or informing the Chair of their participation by telephone or teleconference software. The names of members attending shall be recorded in the official minutes. Where geography or other circumstances make monthly, in-person participation in board meetings burdensome, monthly meetings may be conducted by telephone or other means of electronic communication where all parties can both listen and speak to all other parties. Attendance will be recorded by the Project Director or his or her designee with a roll call and participation recorded in the official minutes.

E. The Project Director shall have direct administrative responsibility for the operation of the Health Center and shall attend, or assign a delegate in his/her absence to all meetings of the CAB, but shall not be entitled to vote.

Article X: Officers

Section 1: Eligibility

The Chair and Vice-Chair shall be chosen from among the voting members of the CAB. Members of the CAB shall not be eligible for an officer position until they have served for at least six (6) months with the CAB as an active member. An active member is defined as a member who has attended all meetings, with the exception of up to two (2) excused absences, in the past six months.

Section 2: Nomination and Election

Initial selection of officers upon creation of the CAB transpired at the same CAB Board meeting following the adoption of these Bylaws.

Henceforth, nominations for officers shall be made at the regular October meeting. A nominee may decline nomination.

Officers shall be elected annually by a majority vote of those members present and voting, as the first order of business at the November meeting of the CAB.

Section 3: Appointment of Chair and Vice-Chair

Only members who have been an active member of the CAB for at least six (6) months are eligible to be appointed and serve as officers.

Officers shall be elected for a term of one (1) year, or any portion of an unexpired term thereof. A person shall be limited to no more than four (4) consecutive terms of office. Any elected officer who has served four (4) consecutive, one (1) year terms of office shall not be eligible for re-election until one (1) year after the end of his or her second term of office.

This limitation of consecutive terms may be waived by a majority vote of the CAB (with the officer in question recusing him or herself from the vote) if no other CAB member is willing to serve in that office. A term of office for an officer shall start January 1, and shall terminate December 31, of the same year; however, an officer may serve after his or her term ends until a successor is elected.

Section 4: Vacancies

Vacancies created during the term of an officer shall be filled for the remaining portion of the term by special election by the CAB, at a regular or special meeting in accordance with this Article.

Section 5: Responsibilities

The officers shall have such powers and shall perform such duties as from time to time shall be specified in these Bylaws or other directives of the CAB.

A. Chair

The Chair shall preside over meetings of the CAB, shall serve as Chair of the Executive Committee, and shall perform the other specific duties prescribed by these Bylaws or that may from time to time be prescribed by the CAB.

B. Vice-Chair

The Vice-Chair shall perform the duties of the Chair in the latter's absence and shall provide additional duties that may from time to time be prescribed by the CAB.

Article XI: Amendments and Dissolution

A. Amendments

The Bylaws may be repealed or amended, or new Bylaws may be adopted at any meeting of the CAB at which a quorum is present, by two-thirds (2/3) of those present and voting. At least fourteen (14) days written notice must be given to each member of the intention as to alter, amend, repeal, or to adopt new Bylaws at such meetings, as well as the written alteration, amendment or substitution proposed. Any revisions and amendments must be approved by the CAB. County Board of Supervisors must approve any change that alters or conflicts with their action establishing CAB.

B. Dissolution

Dissolution of the CAB shall only be by affirmative vote of the CAB and County Board of Supervisors at duly scheduled meetings.

Certification

These Bylaws were approved at a meeting of the board by a two-thirds (2/3) majority vote on December 15, 2017.

These Bylaws were amended at a meeting of the board by a two-third (2/3) majority vote on September 15, 2023.

Signed copies available upon request,

Jan Winbigler, CAB Chair September 15, 2023

Appendix A

Sacramento County Health Center Co-Applicant Board Conflict of Interest: *Disclosure and Attestation Statement*

Conflict of Interest: Defined as an actual or perceived interest by a Board member in an action which results, or has the appearance of resulting, in personal, organizational, or professional gain. A financial interest is a type of conflict of interest.

Duty of Loyalty: CAB members shall be faithful to the organization and can never use information obtained in his/her position as a CAB member for personal gain.

Responsibilities of CAB Members:

A. A CAB member must declare and explain any potential conflicts of interest related to:
   1. Using her/his CAB appointment in any way to obtain financial gain for the member's household or family, or for any business with which the CAB member or a CAB member's household or family is associated; and/or
   2. Taking any action on behalf of the CAB, the effect of which would be to the member's household or family's, private financial gain or loss.

B. No member of the CAB shall vote in a situation where a personal conflict of interest exists for that member.

C. No voting member of the CAB shall be an employee or an immediate family member of an employee of the Health Center; however, a member may otherwise be an employee of the County or Department of Health Services.

D. No CAB member shall be an employee or an immediate family member of an employee of a Federally Qualified Health Center.

E. Any member may challenge any other member(s) as having a conflict of interest by the procedures outlined in the CAB's Bylaws, Article IX.

As a CAB member, my signature below acknowledges that I have received, read, had an opportunity to ask clarifying questions regarding these conflict of interest requirements and the CAB Conflict of Interest Policy and that I understand the contents of this policy as it relates to my membership and responsibilities as a CAB member in capacity of officer, expert volunteer, advocate, consumer, or County staff member. I understand that any violation of these requirements may be grounds for removal from CAB membership. I further understand that I may be subject to all other applicable state and federal conflict of interest requirements in addition to the provisions set forth in these Bylaws.

I declare that the above statement is true and accurate to the best of my knowledge and hereby attest to the fact that I am not,

_____ A Sacramento County Health Center employee; nor
INITIALS

_____ An immediate family member (defined as a spouse, child, parent, or sibling [by blood, adoption, or marriage] of
INITIALS

_____ A Sacramento County Health Center employee; nor
INITIALS

_____ A Sacramento County Health Center Co-Applicant Board Officer.
INITIALS

_____ _____
PRINTED NAME *SEAT NUMBER*

Appendix A

Sacramento County Health Center Co-Applicant Board Conflict of Interest: *Disclosure and Attestation Statement*

_____ _____

SIGNATURE *DATE*