County of Solano
Community Healthcare Board
Regular Meeting

March 20, 2024
12:00 pm – 2:00 pm
2101 Courage Drive, Fairfield, CA 94533
Room Location: Multi-Purpose Room

AGENDA

1) CALL TO ORDER – 12:00 PM

a) Welcome
b) Roll Call

2) APPROVAL OF THE MARCH 20, 2024 AGENDA

3) PUBLIC COMMENT

This is the opportunity for the Public to address the Board on a matter not listed on the Agenda, but it must be within the subject matter jurisdiction of the Board. If you would like to make a comment, please announce your name and the topic you wish to comment and limit comments to three (3) minutes.

<u>REGULAR CALENDAR</u>

4) APPROVAL OF MINUTES

Approval of the February 21, 2024, draft meeting minutes

5) CLINIC OPERATIONS REPORTS

	Written Report submitted?
a) Staffing Update – Natasha Hamilton	Yes
b) Credentialing Update – Desiree Bodiford	Yes
c) HRSA Grants Update(s) – Noelle Soto	Verbal
d) Grievances/Compliments – Rebecca Cronk	Yes
e) H&SS Compliance – Krista McBride	Yes
f) Finance & Revenue Cycle Management – Nina Delmendo	Verbal
g) Referrals – Cynthia Coutee	Verbal
h) OCHIN EPIC Update(s) – Dona Weissenfels	Yes
i) QI Update – Han Yoon	Verbal
j) FHS Clinic Q-Matic Stats – Noelle Soto	Yes

6) CHB FOLLOW-UP TO CLINIC QUALITY AND OPERATIONAL REPORTS:
Review, Follow-up & Action: CHB will provide feedback on reports, request additional information on quality and clinic operations reports & follow up on these requests.

7) HRSA PROJECT OFFICER REPORT

a) Health Center HRSA Project Officer Update – Dona Weissenfels
 i) Health Center Activities – Internal and External Update
 ii) Strategic Plan Report Update
 iii) Responsibilities Matrix for Co-Applicants

8) BUSINESS GOVERNANCE

a) Review and evaluate the QI/QA Evaluation Report and the performance of the Health Center based on QI/QA Evaluation/Assessment and other information received from the Health Center – Han Yoon
 i) **ACTION ITEM:** The Board will consider approval of the QI/QA Evaluation Report and the performance of the Health Center based on the Quality Evaluation and other Reports received from the Health Center. The Board will request action or follow-up on the Quality Program as appropriate.
b) Review and consider approval of a new FHS Policy; Board Key Management, Policy 900.03.
 i) **ACTION ITEM:** The Board will consider approval of FHS Policy; Board Key Management, Policy 900.03.
c) Review and consider approval of the updated 2024 Community Healthcare Board Calendar, which reflects the changes in the months that the Quarterly Quality Improvement Report will be presented to the Board
 i) **ACTION ITEM:** The Board will consider approval of the updated 2024 Community Healthcare Board Calendar
d) Consider approval to create and name the volunteer Board members on the new Marketing Sub-Committee.
 i) **ACTION ITEM:** The Board will consider approval of creating a Marketing Sub-Committee and ask for volunteer to serve on the committee

9) DISCUSSION

a) Board Member Applications received from Rovina Jones, Seema Mirza and Yalda Mohammad Shafi.
 i) The Executive Committee reviewed three Board Member Applications submitted by Rovina Jones, Seema Mirza and Yalda Mohammad Shafi, and recommends the Board's approval, for all three applicants to be appointed as FHS Community Healthcare Board Members.
 ii) **ACTION ITEM**: The Board will consider Rovina Jones, Seema Mirza and Yalda Mohammad Shafi to be appointed as FHS Community Healthcare Board Members
b) Compliance Training – Krista McBride, H&SS Compliance
c) Sharing information on "Network of Care" – Tracee Stacy

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10) BOARD MEMBER COMMENTS

11) CLOSED SESSION

i) Project Officer/CEO Evaluation

11) ADJOURN: TO THE COMMUNITY HEALTHCARE BOARD MEETING OF:

DATE:	April 17, 2024
TIME:	12:00 pm – 2:00 pm
LOCATION:	Multi-Purpose Room 2201 Courage Drive Fairfield, CA 94533

County of Solano
Community Healthcare Board
DRAFT

REGULAR GOVERNING BOARD MEETING MINUTES

Wednesday, February 21, 2024
In Person Meeting

Members Present:

At Roll Call: Michael Brown, Etta Cooper, Ruth Forney, Charla Griffith, Gerald Hase, Don O'Conner, Sandra Whaley and Brandon Wirth.

Member(s) arrived late: Tracee Stacy

Members Absent: Marbeya Ellis, Deborah Hillman, Anthony Lofton, and Robert Wieda,

Staff Present:

Dr. Michele Leary, Dona Weissenfels, Natasha Hamilton, Cynthia Coutee, Rebecca Cronk, Pierce Leavell, Noelle Soto, Han Yoon, Dr. Ian Bennett, Nina Delmendo, Krista McBride, Cherry Violanda, Kelly Welsh, Kathryn Power (PHC), Danielle Seguerre-Seymour and Patricia Zuñiga.

1) **Call to Order- 12:05 pm**
   a) Welcome
   b) Roll Call

2) **Approval of the February 21, 2024 Agenda**

Discussion: Chair Brandon Wirth requested that Agenda Item 5f) "Finance & Revenue Cycle Management", under "Clinic Operations Reports", be moved to Agenda Item 8a) "Review and consider approval of the FHS Sliding Fee Scale Policy Number: 100.03", under "Business Governance". He was notified by Nina, that she would arrive at 1:00pm.

Motion: To approve the February 21, 2024, Agenda, with the change that Agenda Item 5f), be moved and presented with Agenda Item 8a).

Motion by: Don O'Conner and seconded by Ruth Forney

Ayes: Michael Brown, Etta Cooper, Ruth Forney, Charla Griffith, Gerald Hase, Don O'Conner, and Brandon Wirth.

Nays: None.

Abstain: None.

Motion Carried.

3) Public Comment

- Han Yoon, FHS Planning Analyst, made a request to the Board to change the dates when to present the Quarterly Quality Improvement Reports, so the report could be created in sync when the data is received at the end of the quarters in March, June, September and December. He proposed they be presented April 17, 2024, July 17, 2024, October 16, 2024, and then in January 15, 2025. The report that will be presented on January 15, 2025 would include data collected from October through December 2023.
- Legal Counsel, Kelly Welsh, advised Han that in the future, if he has comments related to his Clinic Operations Reports, like a proposal to update the Calendar, that his comments could be mentioned before he gave his QI Update Report. He acknowledged and thanked Kely.

<u>Regular Calendar</u>

4) Approval of Minutes

Approval of the January 17, 2024 draft Minutes

Discussion: None.

Motion: To approve the January 17, 2024 draft Minutes

Motion by: Don O'Connor and seconded by Ruth Forney

Ayes: Michael Brown, Etta Cooper, Ruth Forney, Charla Griffith, Gerald Hase, Don O'Conner, and Brandon Wirth.

Nays: None.

Abstain: Sandra Whaley

Motion Carried

5) Clinic Operations Reports

a) **Staffing Update** — Natasha Hamilton
- Natasha reviewed the Staffing Update report. *(Please reference the "FHS Staffing Update – February 21, 2024")*
- She mentioned that FHS has been very busy with the onboarding of the recent hires and recruitment for vacant positions. Dr. Leary has been working hard in recruiting providers. There were no questions from the Board.

b) **Credentialing Update** — Cherry Violanda *(Please reference the* "ESU Status Report – February 2024")
- Desiree and Raechel were unavailable, so Cherry Violanda presented the report. There were no questions from the Board. There were no questions from the Board.

c) **HRSA Grants Update(s)** — Noelle Soto
- Noelle notified the Board that they submitted the initial submission of the Unified Data Systems (UDS) Report, which was due the previous week, on February 15, 2024. She gave "Kudos" and thanks to all those that worked on it, such as Fiscal, and the FHS Clinical Team.

- The UDS Report is in the review phase, and were awaiting any questions or comments, if any, from the reviewer. She stated that once it is finalized next month, she will report it to the Board. The Board thanked Noelle for her effort and there were no questions from the Board.

d) **Grievances/Compliments** — Rebecca Cronk *(Please reference the "Grievance" report.)*
- Rebecca presented the graphs for 2023 and 2024 and noted that they were on the same page, to allow for comparison. She mentioned in January the majority of grievances were due to Scheduling and some due to Quality of Care. She noted that all were rated at a Level 1, which meant that staff followed protocol, no significant harm to the patient.
- She mentioned a compliment received from a patient, who said the physicians and staff always provide quality care and was an advocate for the patients. She appreciated what they do for the patients, and that kind of service is not provided at Sutter or Kaiser medical centers in the area. The compliment was well received by the Board and attendees.
- Board Member Tracee Stacy asked for clarification on the category of Quality of Care. Rebecca stated that at the last meeting she included the Category definitions. She stated that Quality of Care can me a number of examples, such as bed side manner, provider-patient interaction. The three (3) that were reported in January 2024, and the patient did not agree with how the provider diagnosed them,

e) **H&SS Compliance** — Krista McBride *(Please reference the "FHS Privacy & Security Incident Report January 1 – 31, 2024" report.)*
- Krista acknowledged that at the last meeting the Board requested a report on the number of incidents of breaches in FHS. She presented the report for January 2024. There were not any privacy or security incidents in January. She informed the Board that the descriptions of any incidents were noted in the report.
- She told the Board that she would present a report each month and include any incidents that were reported to HSS Compliance.
- Chair Brandon Wirth loved the report and mentioned that it was more than was expected, and the Board was pleased with it as well.
- Pierce Leavell, Health Services Clinic Manager of the Fairfield Clinic, noted that the wheelchair that mentioned in the report that was stolen, was returned, but then a different wheelchair was taken from the clinic.
- Board Member asked if there was a program or Social Worker in FHS, helping with Cal-Inc, Medi-Cal, CCS or Partnership, to pay for a medical equipment. Dona noted that FHS does not provide those kinds of services.

f) **Finance & Revenue Cycle Management** — Nina Delmendo *(Please reference the "Revenue Cycle" reports.)*
- *(Note: As approved by the Board, this Agenda Item 5f) will be presented before Agenda Item 8a).*

g) **Referrals** — Cynthia Coutee
- Cynthia informed the Board that the Referrals project is in the final stages of completing the Quality Improvement PDSA (Plan Do Study Act) Cycle. They are in the process of collecting data and on February 27, 2024, it would go to Han. The hope is that a referrals report would be reported at the meeting next month. There were no questions from the Board.

h). **Major Project Updates** —Dona Weissenfels
- Dona mentioned she was working with vendors to come up with a one-page board report that shows the status of the transition from NextGen to EPIC, if we are on target, those areas of concern or those areas we are doing well. She hoped to possibly share it by next month.

- Dona announced the OCHIN EPIC Project officially Kicks Off on February 27, 2024 with both vendors, NetraVine, the IT Project Manager and Facktor Health, Project Management, non IT for FHS. On February 27th, OCHIN gets a hold of the project and the official time clock starts. Dona and FHS Leadership have gotten familiar with the vendors and the soft launch, over the last month, so they understand the needs of FHS. More to come in the future and she will work on the monthly status report, to present next month.
- Dona mentioned this has been planned for about two (2) years and staff is excited and EPIC will go live between September 24-27, 2024, this year.
- Dr. Michele Leary, CMO, mentioned that the providers are excited and that some providers onboarded and in the process of being hired already have EPIC experience. There were no questions from the Board.

i) **QI Update** – Han Yoon – *(Please reference the "Quarterly Quality Improvement Report December 2023".)*

- Han asked to review the CHB 2024 Calendar, and asked that the dates of presenting the QI Report be changed, so that the QI Report would be presented in April instead of March, in July, instead of June, in October instead of September and in January, instead of December. He explained to the Board that the data for the quarters of January to March, for example are not received until April, and so on. The Clerk, Patricia Zuñiga, was asked by the Chair, Brandon Wirth, to prepare a draft 2024 CHB Calendar with the adjustments that Han proposed, and add it to the March Agenda for Board approval.
- Han did a brief review of the Quarterly QI Report. There are 10 measures that were reviewed in the report covering February to December 2023 from all FHS Clinic sites. He reviewed the Blood Pressure Measure with the Board. Dr. Michele Leary mentioned that for now the numbers are flat, but when EPIC is in place, the data will be mor informative.
- Han informed the Board that FHS will be participating in a Mobile Mammogram Van, provided by Alilea Medical Imaging and there was a meeting on February 2, 2024.
- Han also mentioned that from the HRSA OSV Audit, they requested that QI/QA Meeting minutes be taken during the meetings and that they are included in the CHB Agenda Packet for the Board to review. It was also mentioned that any Board Member is welcome to attend the online, virtual QI/QA Meetings, but, Kelly Welsh, Legal Counsel, mentioned that less than a quorum could attend. The Board Members interested in attending were Chair, Brandon Wirth, Vice Chair, Michael Brown and Board Member Tracee Stacy. The board Clerk was asked to ensure that those Board Members be added to the online MS Teams meeting. Legal Counsel, Kelly Welsh, reminded those Board Members that the meeting was an FHS Meeting, and that when they attended, they were to attend as observers and not allowed to participate, ask questions or speak at the meeting. She also mentioned that if the Board Members had a question, while attending the QI/QA Meeting, they could bring the question to the following CHB Meeting and again, she noted that the Board Members could only observe, listen and gather information at the FHS QI/QA Meetings.
- Dona mentioned that she and Dr. Leary met with PHC, the day before, and that the minimum threshold for Quality Improvement Activities was 33%, and that FHS met all the measures, and at the end of December FHS met 37% of the goals. There were no questions from the Board.

j) **FHS Clinic Q-*Matic Stats*** — Noelle Soto *(Please reference the "Q-Matic Stats" report.)*

- Noelle reviewed the Q-Matic stats with the Board. She mentioned that the report shows the stats from March to December of last year, for comparison. There were no questions from the Board.

6) CHB Follow-up to Operational Clinic Reports:

a) Follow-up Action requesting additional information on Quality and other clinic reports.

i) The Board requested a report, of Healthcare breaches that occur within FHS, to be provided at each meeting – HSS Compliance, Krista McBride.

- Krista McBride, H&SS Compliance representative, fulfilled this request and she presented the new *FHS Privacy & Security Incident Report January 1 – 31, 2024" report,* which will be presented each month.

7) HRSA Project Officer Report

a) Health Center HRSA Project Officer Update – Dona Weissenfels

i) Health Center Activities – Internal and External Update

- Dona mentioned that with Natasha onboard as the Health Services Manager, Senior, all members of the Call Center have been moved to the Vallejo Clinic in Vallejo. Previously the Call Center Staff was split at all the clinic locations and now the Call Center is centralized in one location. It was critical to move everyone to Vallejo to work as a team. Kristi Capewell was hired a couple months ago as the new Call Center Supervisor and will be working closely with the Team to set standards and achieve the goals of the Call Center. The Team will be getting familiar with Kristi and each other and will work together in the manner how they talk to our patients and take care of them. She thanked Natasha for her effort.
- Dona gave kudos to Dr. Leary, her QI/QA Team and Han at the end of the year in reaching 37% overall with the Qi/QI Measures and lots of overtime was done to achieve those results, due to short staff.
- Dona stated the primary task at hand are the OCHIN EPIC Projects and the one thing Dona mentioned was that FHS does not do medical coding, where staff is looking at the charts and coding all the diagnosis and circumstances around the patient care that is given. Instead FHS does billing, FHS is unable to tell anyone how sick our patients are or focus on those services that we think our patients need. Starting in April they will be hiring a contractor to come in and train the providers and staff on medical coding. She mentioned there will be more patient data available by the end of the year through this process, will and better define who our patients are population wise in order to make better decisions at the Board and FHS Leadership level. She told the Board that in her entire career, this was the first clinic she encountered where there was no medical coding done.

ii) Strategic Plan Report Update *(Please reference the "Strategic Plan Report – Report Period: January-February 2024, Date of Report: February 21, 2024" provided at the meeting.)*

- Dona reviewed the Strategic Plan Report Update and stated FHS was on target with their goals.
- She pointed out #5, Optimize financial operations, including revenue and expenses, ensure full compliance with HRSA FQHC financial regulations and prepare for transition to APM. She complimented Nina Delmendo and Girlie Jarumay in taking the time in attending the online HRSA Trainings titled, "Bootcamps on Finance" and being more supportive of FHS as an FQHC and in turn educating the Board.
- Board Chair, Brandon Wirth, notified the Board Members that the Strategic Plan Update is an important document and that they follow along and monitor what is being done in the Strategic Plan and in relation to our HRSA Visit.

- Board Member Tracee Stacy asked if the finance part of the Strategic Plan and the high number of overtime hours could justify adding positions in the budget, and justify the positions are needed. Dona responded that the information is being discussed to justify new positions and said that FHS is requesting ten (10) additional Medical Assistant positions and part of that is due to the overtime hours spent on Quality.

iii) Patient Satisfaction Survey – CAHPS (Consumer Assessment of Healthcare Providers Survey) *(Please reference the Patient Satisfaction Surveys – "CAHPS: 2023 Survey for PHC Adult & Child" and "CCS: 2023 Clinician & Group & Patient-Centered Medical Home (PCMH)")*

- Dona told the Board that the patient satisfaction surveys provided, were conducted by PHC. She also noted that the print in the surveys was very small, and asked if anyone wanted and electronic copy, to contact her.
- She mentioned the surveys showed an overall decline in patient satisfaction and experience with access to care, communications, and coordination of care. This was completely understandable due to the shortage of providers and staff.
- Dona noted that due to staff shortage, FHS was not able to do a patient satisfaction survey, which is difficult without a patient portal which is a better way to reach out to the patients, so in the Interim, PHC reaches out to our patients.

8) Business Governance

5f) Clinic Operations Reports-Finance & Revenue Cycle Management – Nina Delmendo *(This agenda item was approved by the Board to be moved with 8a.) (Please reference the following reports: "Expenditure and Revenue as of January 2024", "Total Unbilled Encounters as of February 15, 2024", "Total Encounters as of January 31, 2024", "Total Qualified Encounters (Medical, Dental, Mental Health) FY 2023/24 – July 2023 – January 2024".)*

- Nina notified that she was late in attending because she was attending online Financial HRSA courses.
- Legal Counsel, Kelly Welsh, noted that it was confusing the Board Members which materials were included in the packet and those handed out at the meeting, and she coordinated with Dona and Patricia and there were some reports that were not available at the time the agenda packet was sent out 72 hours in advance of the meeting. She stated that they usually strive to hand in the reports ahead of time, however it is allowable to distribute materials at the meeting, but it does not give a lot of time for the Board to review but it is allowable.
- Nina reviewed the reports with the Board and noted a correction of the date on "Total Encounters Report" should be as of 1/31/2024 and not 12/30/2023.

a) Review and consider approval of the Family Health Services (FHS) Sliding Fee Scale Policy Number: 100.03 — Nina Delmendo *(Please reference the "Memo: Analysis of Sliding Fee Discount Program (SFDP)" and "Sliding Fee Scale Discount Program, Policy Number: 100.03".)*

i) Action item: The Board will consider approval of the Family Health Services (FHS) Sliding Fee Scale Policy Number: 100.03

Discussion: None.

Motion: To approve the Family Health Services (FHS) Sliding Fee Scale Policy Number: 100.03, with the changes that Nina mentioned.

Motion by: Tracee Stacy and seconded by Ruth Forney.

Ayes: Michael Brown, Etta Cooper, Ruth Forney, Charla Griffith, Gerald Hase, Don O'Conner, Sandra Whaley, Brandon Wirth and Tracee Stacy.

Nays: None.

Abstain: None.

Motion not made.

b) Review and consider approval of the Quarterly Quality Improvement Report — Han Yoon *(Please reference the "FHS Quality Assurance/Quality Improvement Committee Meeting Minutes of February 2, 2024")*
   i) **Action item**: The Board will consider approval of the Quarterly Quality Improvement Report

Discussion: None.

Motion: To approve the Quarterly Quality Improvement Report.

Motion by: Don O'Conner and seconded by Mike Brown.

Ayes: Michael Brown, Etta Cooper, Ruth Forney, Charla Griffith, Gerald Hase, Don O'Conner, Sandra Whaley, Brandon Wirth and Tracee Stacy.

Nays: None.

Abstain: None.

Motion carried.

9) Discussion

a. Family Health Services (FHS) Marketing.
   - Discussion ensued about how to begin the marketing process now, before EPIC is in place. Questions about funding, grants and realignment funding was mentioned. Board Member Tracee Stacy asked that a Marketing Sub Committee be put on the agenda at the March meeting to create one and ask for Board Members to volunteer to serve on the committee to plan marketing and rebranding. Nina noted that funding could be added to the budget, but is would not be considered a high priority.
   - Tracee mentioned "Network of Care", but due to time constraints, she was asked to present the information at the next meeting under "Discussion".

b. Brown Act Training – Kelly Welsh *(Please reference the "The Brown Act Presentation".)*
   - Kelly notified the Board that the Brown Act are very important for the Board to understand and know the guidelines in the Brown Act.
   - The Board suggested that the presentation be added to the CHB Binder to reference.

10) Board Member Comments

- Board member Tracee Stacy attended the Suicide Prevention Coalition Meeting and stated that there was one (1) known homeless person who died of overdose and six (6) in Solano County: 1 from Fentanyl; 2 from Poly-Meth; and 3 from Poly-Fentanyl.
- Board Chair acknowledged Dona for advancing the Board Members with knowledge after she came on board.
- Board Members notified the Clerk, Patricia Zuñga that they wanted to be added to the list to attend the MS Teams QI/QA Meeting.

11) Closed Session

i) Project Officer/CEO Evaluation Review

12) Adjourn: To the Community Healthcare Board Meeting of:

DATE: March 20, 2024
TIME: 12:00 p.m. — 2:00 p.m.
Location: Multi-Purpose Room
2101 Courage Drive
Fairfield, CA 94533

The Meeting was adjourned at 3:05 p.m.

Handouts in the Agenda Packet

- CHB 1/17/2023 draft Meeting Minutes
- Clinic Operations Report – FHS Staffing Update – February 21, 2024
- Clinic Operations Report – ESU Status Report – February 2024
- Clinic Operations Report – Grievance Reports - April – December 2023 and January 2024
- Clinic Operations Report – HSS Compliance-FHS Privacy & Security Incident Report – January 2024
- Clinic Operations Report – FHS Clinic Q-Matic Stats Reports – March 2023-December 2023 and January 2024.
- Patient Satisfaction Surveys – CAHPS: 2023 Survey for PHC Adult & Child and CCS: 2023 Clinician & Group & Patient-Centered Medical Home (PCMH)
- Memo: Analysis of Sliding Fee Discount Program (SFDP)
- Sliding Fee Scale Discount Program, Policy Number: 100.03
- Quarterly Quality Improvement Report – December 2023
- The Brown Act Presentation

Documents received at the meeting:

- Strategic Plan Report – Report Period: January-February 2024, Date of Report: February 21, 2024
- FHS Quality Assurance/Quality Improvement Committee Meeting Minutes of February 2, 2024
- FHS Revenue Cycle Reports: Expenditure and Revenue as of January 2024, Total Unbilled Encounters as of February 15, 2024, Total Encounters as of January 31, 2024, Total Qualified Encounters (Medical, Dental, Mental Health) FY 2023/24 – July 2023 – January 2024.

Community Health Care Board

Family Health Services Staffing Update

CHB Meeting Date: March 20, 2024

Number of Active Candidates - County

Clinic Physician (Board Certified) - 1 (UHC Solutions)
Clinic Registered Nurse - VV - 1
Nurse Practitioner - FF Adult 1 (UHC Solutions)

Number of Active Candidates - Touro

Physician Assistant - 1

Number of Active Candidates - Locum Tenens

Number of Active Candidates - Volunteer

Clinic Physician (Board Cert) TB - 1

Open County Vacancies

Clinic Physician (Board Cert) - 1
Clinic Physician (Board Cert) **Extra Help** - 1
Clinic Registered Nurse - 1
Clinic Registered Nurse, Senior - 1
Dental Assistant (Registered) 0.50 FTE - 1
Dental Assistant (Registered) - 1
Health Education Specialist **Extra Help** - 2
Medical Assistant - 3
Medical Assistant Lead - 1
Medical Records Technician, Sr **Extra Help** - 1
Mental Health Clinician (Licensed) - 1
Nurse Practitioner/Physician Assistant - 5
Nurse Practitioner/Physician Assistant **Extra Help** - 1

Interviews in Progress

Medical Assistant - TBD

Expected New Hires + Recently Hired Staff

*Nurse Practitioner - FF Adult - 03/18/2024
*Nurse Practitioner - Locum - FF Adult - 03/18/2024
*Nurse Practitioner - Locum - FF Adult - 03/18/2024

Vacancies/Departures

*Medical Assistant - 03/01/2024
*Clinic Registered Nurse, Senior - 03/15/2024
*Clinic Registered Nurse (P/T) - 05/03/2024

FHS Community Healthcare Board – Status Report March 2024:
FHS Credentialing, Provider Enrollment and Sanction Screening Activities

Excluded Parties/Sanction Screening: 148

Month	Sanction Screening Number Screened/Verified	Sanction Screening Number Ineligible
February 2024 TOURO/LOCUMS	Touro/Locum Providers: 23	Exclusions Found: 0
February 2023 County – H&SS Employees/Candidates	H&SS Employees: 125	Exclusions Found: 0
Totals	TOTAL SCREENED: 148	Exclusions Found: 0

Credentialing: 11 Re-Credentialing: 7

Month	Number of Candidates' Credentials Verifications - (Re-)Started -	Number of Candidates' Partnership Provider Enrollments - Submitted for Partnership Approval -
February 2024 TOURO	Active/Open: 2 Physician Assistant: 1 Clinic Physician: 1	Submitted to Partnership: -0- Approved by Partnership: -0- Pending Submission to Partnership: 1
February 2024 LOCUM	Active/Open: 4 Nurse Practitioner: 4	Submitted to Partnership: -1- Approved by Partnership: -0- Pending Submission to Partnership: 1
February 2024 County H&SS Employees/ Candidates	Active/Open: 12 Dentist Manager: 1 Supervising Physician –1 Clinic Physician – 1 Medical Assistant – 4 Nurse Practitioner – 3 Licensed Vocational Nurse - 1 CMO – 1	Submitted to Partnership: --0 Approved by Partnership: -1- Pending Submission to Partnership: 3

Provider and Site Enrollment and Re-Credentialing/Re-Validation:

Partnership – NEW Provider Enrollments

New Provider Enrollments: ACTIVE - Pending Submission: 5 (1 Touro PA, 1 Nurse Practitioner-LOCUM, 3 Nurse Practitioner-County)
Submitted: 1 Pending Approval: 4
Approved: 0

Partnership – Provider Re-Credentialing

Provider Re-Credentialing: Submitted: 0 Pending Approval: 1 Pending Submission: 0
Approved: 1

Denti-Cal – Provider Revalidations

None During this Reporting Period

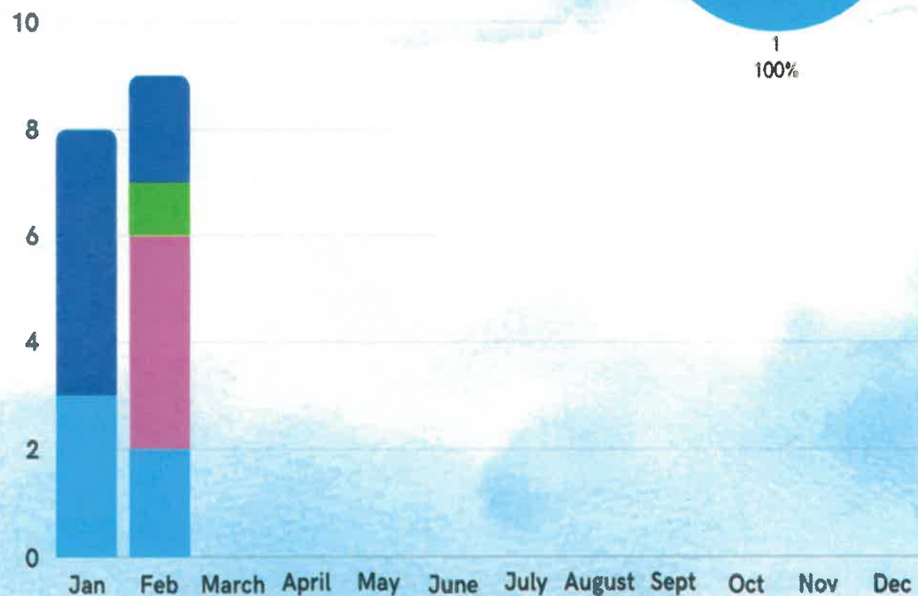
NPI Program/Site Revalidations – CMS (N = +/- 38)

None During this Reporting Period

Technical Assistance – PAVE (Medi-Cal) and PECOS (Medicare) Sites: Upon Request

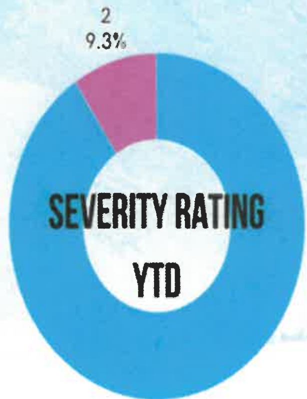
GRIEVANCE REPORT 2024

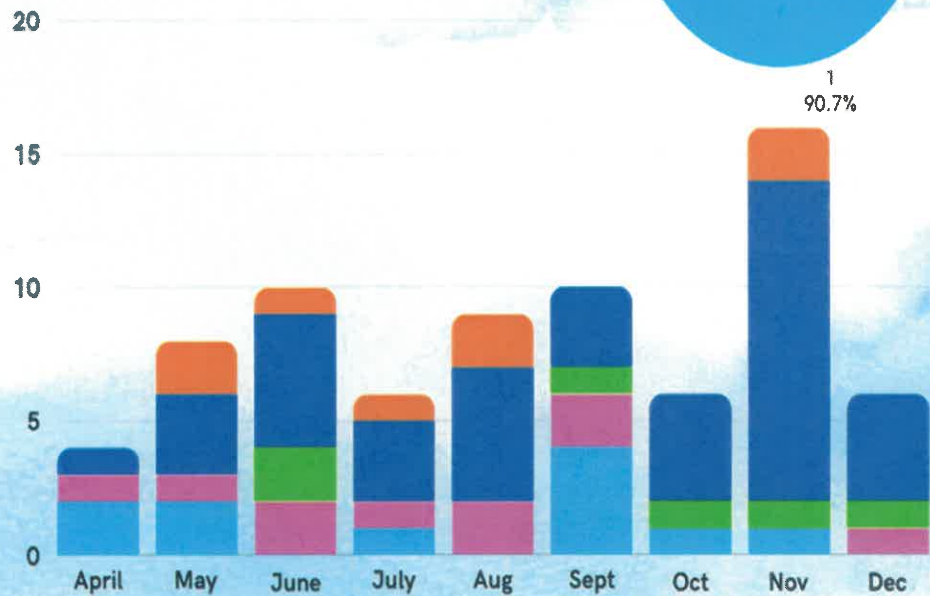
Quality of Care
Referrals
Privacy
Access to Care
Safety
Scheduling
Other



GRIEVANCE REPORT 2023

Quality of Care
Referrals
Privacy
Access to Care
Safety
Scheduling
Other





Family Health Services (FHS) Privacy & Security Incident Report

February 1 to February 29, 2024

Department	Category	Description (Basic Information/Activity)	Total Received
Family Health Services	Security: Lost/Damaged Property	Employee personal vehicle involved in a collision while in County lot	1
			Total = 1

Solano County Family Health Services

OCHIN Epic EHR Implementation 2024

Project Milestones / Highlights

1. January: FHS internally kicked off the OCHIN Epic implementation. Lindsey Fritsch (NetraVine) was hired as the Project Manager. She came onsite to introduce the project to key stakeholders on the implementation workflows and timelines; conducted on-site observations and met with the site managers. The project core team and smaller workgroups are meeting weekly to begin setting up the EHR. Lindsey has been responsive to project leads questions and is doing a great job managing OCHIN on behalf of FHS.

2. Facktor Health serves as a change management strategic partner with the executive and senior management team. A communication plan was developed and approved. FHS leadership team will receive training on the communication plan and tools on March 14th. Natasha will be the primary point of contact for all communication across the sites, utilizing the tools developed by Facktor Health.

3. Facktor Health is developing an MS Teams channel to provide staff with easy access to training materials and schedules. It will also serve as a venue to quickly ask questions about the implementation. A FAQ will be maintained to track these questions and answers to ensure everyone receives consistent information across the sites and departments.

4. February/March: The OCHIN Epic kick off meeting occurred on February 27th. They are scheduled to come onsite in March for three days (March 26-28) to meet with different Solano subject matter experts and stakeholders to learn about the workflows and begin the New Member Set-up.

5. OCHIN Epic Demo: The monthly FHS staff meeting is scheduled for March 28th. A demo of EPIC will be provided to staff who are enthusiastic about getting a preview of the system.

6. Hardware procurement is in progress.

7. The OCHIN Epic training schedule has been confirmed for July for the first round of super users.

Solano County Family Health Services

OCHIN Epic EHR Implementation 2024

OCHIN Epic EHR Implementation Dashboard
March 2024

Project Information

10%

Percent Complete

12/20/23

Start Date

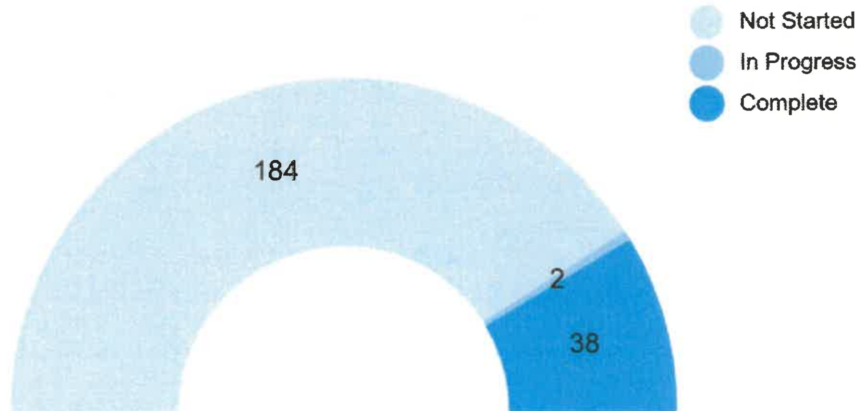
09/24/24

Epic Go Live Date

04/28/25

Project Closure Date

Tasks by Status



Current Status and Project Health

Health & Trend

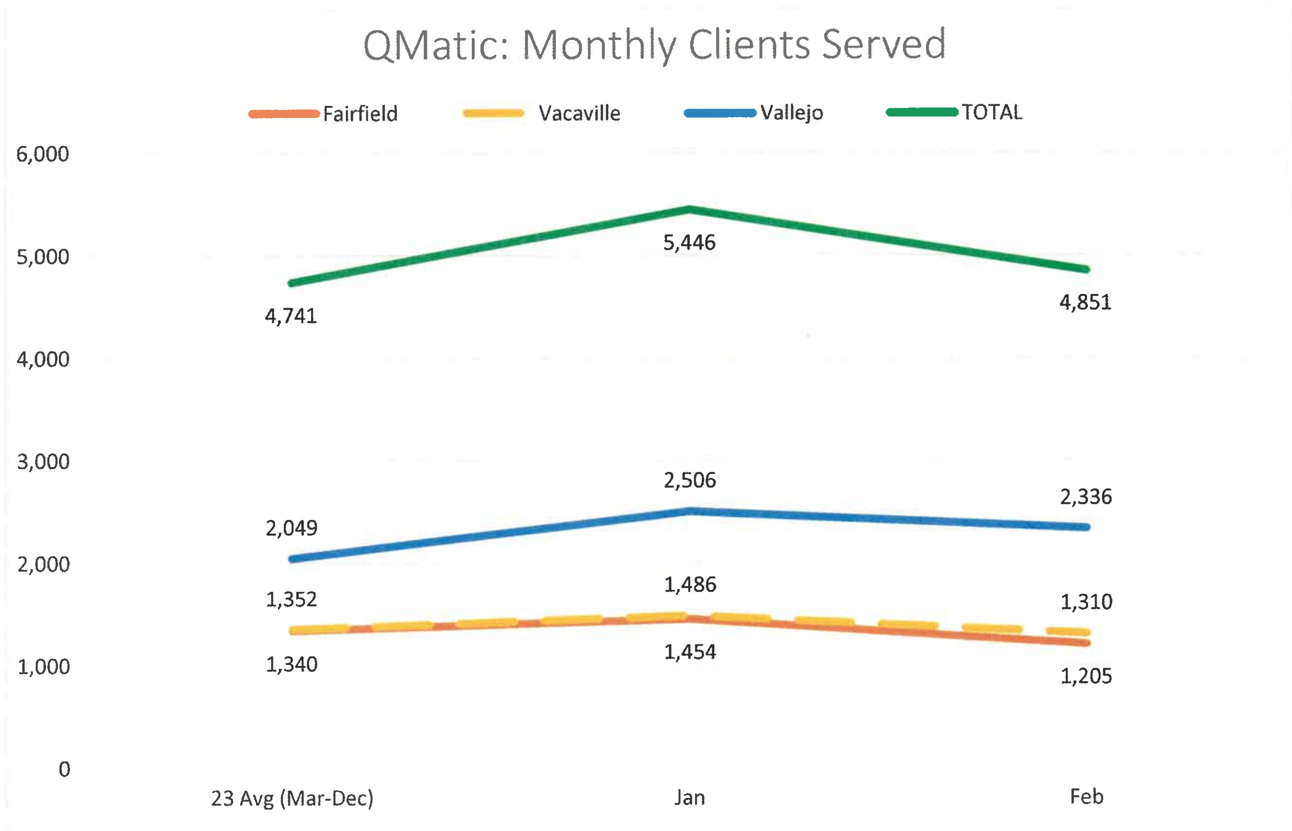
Schedule	Budget	Scope

RED	Issues or risks presenting putting scope, budget, or schedule in jeopardy
YELLOW	Issues or risk presenting putting scope, budget, or schedule on watch list
GREEN	Little to no issues or risk that materially impact scope, budget, or schedule

Clinic Operations Report: Clinic Metrics

Queue Management (Q-Matic) Stats

Clinic Site	Clients Served		
	2023 (Mar to Dec) **Average**	**Jan**	**Feb**
Fairfield			
Lab	93	95	76
Medical (Adult)	1,247	1,359	1,129
Subtotal	*1,340*	*1,454*	*1,205*
Vacaville			
Dental	588	598	535
Medical (Adult & Peds)	764	888	775
Subtotal	*1,352*	*1,486*	*1,310*
Vallejo			
Dental & Medical (Adult & Peds)	1,970	2,413	2,245
Lab	79	93	91
Subtotal	*2,049*	*2,506*	*2,336*
TOTAL	***4,741***	***5,446***	***4,851***



Responsibilities Matrix for Co-Applicants

Task or Function	Co-Applicant Board	Health Center CEO	Public Agency
HRSA GRANT APPLICATION AND BUDGET			
Annual Budget and HRSA Application	Approves plans and priorities, Approves grant application and budget prior to submission, approves any changes to the budget made by public agency	Works with public agency and staff to prepare budget and application. Presents to co-applicant board and public agency	Approves agency budget including health center budget, approves application, refers any recommended changes back to co-applicant board
FINANCIAL POLICIES			
Purchasing	Receives, reviews and approves financial reports	Authorizes purchases per budget, policy and procedural requirements	Establishes and administers purchasing policies.
Accounts Payable	Receives, reviews and approves financial reports	Compares A/P reports to standards and forwards analysis to co-applicant Board	Establishes polices, maintains systems and pays all invoices per policies
Billing and Accounts Receivable (A/R)	Approves credit and collection policies; approves fee schedule	Develops billing and A/R reports and forwards analysis to Board	Bills for all services per agency procedures and Board policies; supports CEO in development of A/R reports for Board.
Annual Audit	Reviews and accepts audit; reviews and approves corrective action, as necessary	Implements any required	Ensures audit is completed in compliance with Single Audit requirements
Partial Payment Schedules	Approves sliding fee discount program policies and procedures; approves nominal fee.	Presents proposed changes to Board for discussion and approval.	Implements sliding fee discount policies
QUALITY IMPROVEMENT AND QUALITY IMPROVEMENT PLAN			
Client Satisfaction	Provides recommendations on content and implementation of survey; reviews results; recommends improvements	Implements survey and summarizes findings	Provides technical support to Board and CEO to develop and implement survey and analyze results
Quality Plan	Approves annual QA plan and receives regular reports on QA activities	Reviews results of quality assessments and regularly reports findings and follow-up actions to Board	Supports CEO in developing goals/measures and implementing plan.
Patient Grievances	Reviews and approves patient grievance policies	Investigates and abates grievances and reports grievance activity and follow-up actions to Board	Supports implementation of grievance process
Credentialing and Privileging	Approves credentialing and privileging policies	Supports credentialing and privileging; implements delegated aspects of policies and procedures	Approves credentialing and privileging policies; implements delegated aspects of policies and procedures

Task or Function	Co-Applicant Board	Health Center CEO	Public Agency
PLANNING AND OPERATIONS			
Scope of Services	Reviews and approves	Develops and recommends to Board	Provides input
Locations and Hours	Reviews and approves	Develops and recommends to Board	Provides input; reviews and approves, refers any recommendations for change to co-applicant Board for consideration
Strategic Planning	Participates in development, approves final	Develops with input from Board	Provides input.
Human Resources			
Personnel Policies and Procedures	Provides input	Communicates HR policies and procedures and impact	Develops and implements
Salary and Benefit Scales	CEO compensation – reviews compensation surveys, etc. and approves final compensation package; all other staff - provides input	Communicate non-CEO salary and benefit policies and procedures and impact	CEO compensation – commissions compensation survey, develops compensation package and presents both to Board for approval; all other staff - develops and implements
Selection of CEO	Provides input on CEO responsibilities and qualifications; participates in interview process; selects from final candidate list	n/a	Solicits candidates, credentials candidates, recommends final candidate list, including preferred candidate if applicable, and employs candidate chosen for the position.
Evaluation of CEO	Evaluates performance related to health center functions and in accordance with public agency policies; shares evaluation with public agency	Self-evaluation	Evaluates performance related to public agency functions and standards; incorporates health center Board evaluation; shares evaluation with health center Board.
Dismissal of CEO	Approves dismissal from health center	n/a	Recommends dismissal and, as applicable, terminates employment.
Selection and Dismissal of Other Staff	Delegates all staff-related issues to the CEO	Supervises staff on all health center related functions; coordinates supervision with public agency as necessary.	Responsible for all the procedural aspects of selection and retention subject to policies
GOVERNANCE			
Monthly Board Meetings	Establishes and maintains monthly Board meeting schedule and calendar	Schedules meetings, prepares and distributes agendas, Board reports and related information; generates and distributes Board minutes	May attend Board and committee meetings as defined in bylaws.

Task or Function	Co-Applicant Board	Health Center CEO	Public Agency
GOVERNANCE			
By-Laws	Develops/amends bylaws; Insures that By-Laws are current, meet all legal and regulatory requirements and provide an effective framework for governance.	Interprets HRSA regulatory requirements for Board	N/A
Board Training	By-laws; develops Board operating policies for the procedural functioning of the Board	N/A	Supports Board training and development priorities established by Board.
Recruits and elects Board members; ensures compliance with Board composition requirements.	Maintains list of Board members and notifies Board when Board composition requires modification.	Recommends potential Board members; as applicable, appoints Board members per bylaws	Supports Board training and development priorities established by Board.
Approves and implements policies	Assists in implementing policies	Provides input into policies	Provides input into policies

SOURCE: 2019 PUBLIC CENTERS MONOGRAPH

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SOLANO COUNTY

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MEMORANDUM

To: Family Health Services Community Healthcare Board

From: Dona Weissenfels, Family Health Services, Chief Executive Officer

Date: March 13, 2024

Subject: QI/QA Evaluation

To: Family Health Services Community Healthcare Board Members:

Introduction

The purpose of this Quality Improvement/Quality Assurance Evaluation is to assess the effectiveness and impact of ongoing quality improvement within Family Health Services (FHS). The evaluation aims to identify areas of success, opportunities for enhancement, and recommendations for continuous improvement. By examining key performance indicators and feedback from stakeholders, we can gauge the overall quality of services and processes.

The Quality Improvement/Quality Assurance Plan is established to ensure that FHS carries out the commitment to patient care and safety while concurrently implementing plan for the improvement of the health of its members and delivery of services. The QI/QA Plan is supervised by the Chief Medical Officer (CMO) and is designed to align with FHS strategic plan. The focus of the FHS QI/QA Plan is to deliver safe, high quality patient care.

Program Overview

FHS' QI/QA Plan applies to all clinical and operational activities. The scope of the QI/QA Plan is over-reaching and meant to serve as a guide to all QA/QI work across the organization. This document focuses on the following:

- Meeting all requirements of the QI/QA Plan required by HRSA for all 330 clinics as a program requirement
- Setting guidelines for the quality structure within the organization
- The quality and utilization of health center services
- Patient satisfaction and patient grievance processes
- Patient safety, including adverse events
- Addressing quality assurance requirements from government agencies
- Reporting on quality data as required by contracts (example: managed care organizations)

- Describing key initiatives
- Addressing findings identified by FHS through audits and assessments

Evaluation Tool

Attached to this Memorandum is a copy of the QI/QA Plan Checklist and Self-Assessment Tool 2024. The tool is used to evaluate the effectiveness of the QI/QA Plan. The Tool is broken down into the following areas for review,

Element 1: The Written QI/QA Plan
Element 2: QI/QA Plan Structure and Participant Responsibilities
Element 3: Data Gathering, Tracking, Trending, Analysis, Monitoring, Protected Reviews
Element 4: QI/QA Activities
Element 5: QI/QA Supporting Documents – Health Center Protocol Document Checklist

Findings:

A copy of the completed Evaluation Tool is attached to this Memorandum for Review. A summary of the findings are as follows:

Element 1: The Written QI/QA Plan

Present: 1.1, 1.2, 1.3, 1.4, 1.5

Element 2: QI/QA Plan Structure and Participant Responsibilities

Present: 2.1, 2.2, 2.3, 2.4, 2.5, 2.6, 2.7, 2.8, 2.9

Element 3: Data Gathering, Tracking, Trending, Analysis, Monitoring, Protected Reviews

Present: 3.1, 3.2, 3.3, 3.4, 3.5, 3.6, 3.7

Element 4: QI/QA Activities

Present: 4.1, 4.2, 4.3, 4.4, 4.5

Element 5: QI/QA Supporting Documents – Health Center Protocol Document Checklist

Present: Policies and Procedures that address Quality, Patient Safety, Grievances, QI Assessments, QI/QA report generation and oversight

Overall Recommendations:

In conclusion, this Quality Improvement/Quality Assurance Evaluation underscores the positive impact of ongoing initiatives while acknowledging areas for improvement. The FHS is committed to utilizing these findings to drive continuous improvement and enhance quality patient care. Of heightened concern moving forward is the staffing levels for Quality. There is an urgent need to hire a Quality Manager and Medical Assistants to ensure compliance with the program and operationally direct the Quality Department.

QI/QA Plan Checklist and Self-Assessment Tool 2024
Family Health Services – Solano County

ELEMENT 1: The Written QI/QA Plan

1.1 The center has a written quality improvement (QI) quality assurance (QA) plan or program and a companion implementation strategy to systematically improve health care delivery and health outcomes for patients serviced by the health center. The scope of the QI/QA plan and strategy is organization wide.

Present ☑ Not Present

Observations/Comments/Recommendations: No Comments

1.2 The QI/QA plan is anchored by a statement of purpose that delineates specific quality improvement aims and priorities for the health center. The statement of purpose also informs the plan's strategy for creating a system to track, trend, and evaluate data and generate reports on clinical and operational quality indicators.

Present ☑ Not Present

Observations/Comments/Recommendations: No Comments

1.3 The QI/QA plan and implementation strategy are reviewed and approved by the board at least every three years as evidenced by the date of the governing board attestation/minutes.

Present ☑ Not Present

Observations/Comments/Recommendations: No Comments

1.4 The QI/QA plan and implementation strategy are reviewed and updated annually by the QA/QI committee. Major revisions to the plan are submitted to the board for approval.

Present ☑ Not Present

Observations/Comments/Recommendations: No Comments

QI/QA Plan Checklist and Self-Assessment Tool 2024
Family Health Services – Solano County

1.5 The QI/QA plan includes definitions of key quality management terms such as the following:

Present ☑

Quality ☑

Quality Assessment ☑

Quality Improvement ☑

Root-Cause Analysis ☑

Process Improvement ☑

PDSA Cycles ☑

Patient Safety ☑

Patient Grievances ☑

Quadruple AIM ☑

Patient Satisfaction ☑

Present ☑ Not Present

Observations/Comments/Recommendations: No Comments

ELEMENT 2: QI/QA Plan Structure and Participant Responsibilities

2.1 The Board of Directors approves the QI/QA plan and implementation strategy and oversees the QI/QA Committee.

Present ☑ Not Present

Observations/Comments/Recommendations: No Comments

2.2 The Board of Directors appoints an individual responsible for leading the implementation of the QI/QA plan for the entire organization. This appointee chairs the QI/QA committee. This role should be filled/supervised by a clinical director whose focus of responsibility is to support the QI/QA plan.

Present ☑ Not Present

Observations/Comments/Recommendations: No Comments

2.3 The Chair of the QI/QA committee reports to the Board of Directors Quarterly

Present ☑ Not Present

Observations/Comments/Recommendations: No Comments

2.4 The Board of Directors reviews the status and outcomes of quality improvement initiatives at least annually.

Present ☑ Not Present

Observations/Comments/Recommendations: No Comments

2.5 The Board of Directors approves the implementation strategy for key quality improvement initiatives identified by the QI/QA Committee.

Key quality improvement initiatives/strategies are identified by the QI/QA and implemented.

The QI/QA Chair in conjunction with the QI/QA committee or quality subgroup identifies additional areas to study and analyze for future quality improvement initiatives/strategies.

Present ☑ Not Present

Observations/Comments/Recommendations: No Comments

2.6 The Chair (appointed by the Board of Directors) selects a QI/QA Committee that is multidisciplinary and represents different divisions within the organization.

Present ☑ Not Present

Observations/Comments/Recommendations: No Comments

QI/QA Plan Checklist and Self-Assessment Tool 2024
Family Health Services – Solano County

2.7 The QI/QA committee reports directly to the Chair.

Present ☑ Not Present

Observations/Comments/Recommendations: No Comments

2.8 The QI/QA Committee oversees the daily QI/QA activities and is empowered by the Board of Directors to assign tasks as needed to health center staff (e.g. data collections, documentation).

Present ☑ Not Present

Observations/Comments/Recommendations

2.9 The QI/QA Committee meets at least six times per year.

Present ☑ Not Present

Observations/Comments/Recommendations: No Comments

ELEMENT 3: Data Gathering, Tracking, Trending, Analysis, Monitoring; Protected Reviews

3.1 Protected periodic assessment of the appropriateness of the utilization of services and the quality of services provided or proposed to be provided to individuals served by FHS is completed.

Present ☑ Not Present

Observations/Comments/Recommendations

3.2 The QI/QA Chair and Committee have the authority to direct health center staff, including providers on gathering data

Present ☑ Not Present

Observations/Comments/Recommendations: No Comments

QI/QA Plan Checklist and Self-Assessment Tool 2024
Family Health Services – Solano County

3.3 The QI/QA Chair and Committee have the authority to ensure that data is appropriately entered into patient records/documentation.

Present ☑ Not Present

Observations/Comments/Recommendations: No Comments

3.4 The QI/QA Chair and Committee develop systems for:

Continuous problem identification and analysis through defined methodologies, PDSA etc.

Comprehensive data collection & analysis.

Corrective action plans.

Tracking, trending, monitoring patient information which may include testing results and or missing or irregular data.

Present ☑ Not Present

Observations/Comments/Recommendations: No Comments

3.5 Collected data is reported to the QI/QA Committee for analysis, discussion and action.

Present ☑ Not Present

Observations/Comments/Recommendations: No Comments

3.6 Data is systematically collected, tracked, trended, displayed and analyzed to identify trends, patterns and performance levels.

Present ☑ Not Present

Observations/Comments/Recommendations: No Comments

QI/QA Plan Checklist and Self-Assessment Tool 2024
Family Health Services – Solano County

3.7 The QI/QA Chair and Committee review and analyze the data collected using national evidence based quality standards and metrics. Includes Joint Commission, UDS, HEDIS, And Patient Centered Health Homes etc.

Present ☑ Not Present

Observations/Comments/Recommendations: No Comments

3.8 The Chair of the QI/QA Committee reports no less than quarterly to the Board of Directors on trends and patterns in the organization, the status of current quality initiatives and recommendations for action steps needed to address pressing concerns that have surfaced during the quarterly reporting period.

Present ☑ Not Present

Observations/Comments/Recommendations: No Comments

ELEMENT 4: QI/QA Activities

4.1 Based on dashboard data and analysis topics for QI/QA may include a range of clinical and operational activities deemed to be in the best interest of the patients at FHS.

Present ☑ Not Present

Observations/Comments/Recommendations: No Comments

QI/QA Plan Checklist and Self-Assessment Tool 2024
Family Health Services – Solano County

4.2 Predetermined evidence-based measures of quality are used to monitor each selected subject area. These may include measures such as:

UDS Data Set ☑

QIP/HEDIS ☑

Joint Commission N/A

Patient Centered Medical Health Home N/A

Local and National Quality Benchmarks N/A

Present ☑ Not Present

Observations/Comments/Recommendations: No Comments

4.3 Short-term projects address issues identified on the QI/QA Dashboards and make initial evaluations.

Present ☑ Not Present

Observations/Comments/Recommendations: No Comments

4.4 Long term projects are undertaken to improve operations, safety, and quality of care and health outcomes for patients.

Present ☑ Not Present

Observations/Comments/Recommendations: No Comments

4.5 The Model for Improvement or similar quality improvement methodologies are used to frame, design and implement short and long-term projects (includes Plan, Do, Study, Act (PDSA cycles) and other quality methodologies).

Present ☑ Not Present

Observations/Comments/Recommendations: No Comments

QI/QA Plan Checklist and Self-Assessment Tool 2024
Family Health Services – Solano County

ELEMENT 5 – QI/QA Supporting Documents – Health Center Protocol Document Checklist

5 Documents that support HRSA QI/QA Program (OSV Audits)

Policies that establish the Quality Improvement/Quality Assurance (QI/QA) program

QI/QA related operating procedures or processes that address:

- Clinical guidelines, standards of care and/or standards of practice
- Patient safety and adverse events, including implementation of follow-up actions
- Patient Satisfaction
- Patient Grievances
- Periodic QI/QA assessments
- QI/QA report generation and oversight

Present ☑ Not Present

Observations/Comments/Recommendations: No Comments

Systems and/or procedures for maintaining and monitoring the confidentiality, privacy, and security of patient records

Present ☑ Not Present

Sample Documentation requested during the OSV
Sample of patient satisfaction results
Sample of two QI/QA assessments from the past year and/or the related reports

QI/QA Plan Checklist and Self-Assessment Tool 2024
Family Health Services – Solano County

ELEMENT 6 - HRSA Chapter 10 Checklist

Section 330(k)(3)(C) of the PHS Act; and 42 CFR 51c.110, 42 CFR 51c.303(b), 42 CFR 51c.303(c), 42 CFR 51c.304(d)(3)(iv-vi), 42 CFR 56.111, 42 CFR 56.303(b), 42 CFR 56.303(c), and 42 CFR 56.304(d)(4)(v-vii)

Requirements

- The health center must have an ongoing quality improvement/assurance (QI/QA) system that includes clinical services and [clinical] management and maintains the confidentiality of patient records.

  - **Present ☑** **Not Present**

- The health center's ongoing QI/QA system must provide for all of the following:
  - Organizational arrangements, including a focus of responsibility, to support the quality assurance program and the provision of high quality patient care; and
  - Periodic assessment of the appropriateness of the utilization of services and the quality of services provided or proposed to be provided to individuals served by the center. Such assessments must:
    - Be conducted by physicians or by other licensed health professionals under the supervision of physicians;
    - Be based on the systematic collection and evaluation of patient records;
    - Assess patient satisfaction, achievement of project objectives, and include a process for hearing and resolving patient grievances; and (needs improvement)
    - Identify and document the necessity for change in the provision of services by the center and result in the institution of such change, where indicated.

  - **Present ☑** **Not Present**

- The health center must maintain the confidentiality of patient records, including all information as to personal facts and circumstances obtained by the health center staff about recipients of services. Specifically, the health center must not divulge such information without the individual's consent except as may be required by law or as may be necessary to provide service to the individual or to provide for medical audits by the Secretary of HHS or his/her designee with appropriate safeguards for confidentiality of patient records.

QI/QA Plan Checklist and Self-Assessment Tool 2024
Family Health Services – Solano County

Demonstrating Compliance

A health center would demonstrate compliance with these requirements by fulfilling all of the following:

- The health center has a board-approved policy/policies that establishes a QI/QA program. This QI/QA program addresses the following:
  - The quality and utilization of health center services;
  - Patient satisfaction and patient grievance processes; and (needs improvement)
  - Patient safety, including adverse events.

- Present ☑ Not Present

- The health center designates an individual(s) to oversee the QI/QA program established by board-approved policies. This individual's responsibilities would include, but would not be limited to, ensuring the implementation of QI/QA operating procedures and related assessments, monitoring QI/QA outcomes, and updating QI/QA operating procedures.
- The health center has operating procedures or processes that address all of the following:
  - Adhering to current evidence-based clinical guidelines, standards of care, and standards of practice in the provision of health center services, as applicable;
  - Identifying, analyzing, and addressing patient safety and adverse events and implementing follow-up actions, as necessary; (needs improvement)
  - Assessing patient satisfaction; (needs improvement)
  - Hearing and resolving patient grievances; (needs improvement)
  - Completing periodic QI/QA assessments on at least a quarterly basis to inform the modification of the provision of health center services, as appropriate; and (needs improvement)
  - Producing and sharing reports on QI/QA to support decision-making and oversight by key management staff and by the governing board regarding the provision of health center services. (needs improvement)

- **Present** ☑ **Not Present**

- The health center's physicians or other licensed health care professionals conduct QI/QA assessments on at least a quarterly basis, using data systematically collected from patient records, to ensure:
  - Provider adherence to current evidence-based clinical guidelines, standards of care, and standards of practice in the provision of health center services, as applicable; and

- The identification of any patient safety and adverse events and the implementation of related follow-up actions, as necessary.

- Present ☑ Not Present

- The health center maintains a retrievable health record (for example, the health center has implemented a certified Electronic Health Record (EHR) for each patient, the format and content of which is consistent with both Federal and state laws and requirements.

- Present ☑ Not Present

- The health center has implemented systems (for example, certified EHRs and corresponding standard operating procedures) for protecting the confidentiality of patient information and safeguarding this information against loss, destruction, or unauthorized use, consistent with Federal and state requirements.

- Present ☑ Not Present

Related Considerations

The following points describe areas where health centers have discretion with respect to decision-making or that may be useful for health centers to consider when implementing these requirements:

- The health center determines whether the position designated with responsibility for the QI/QA program (for example, Clinical Director, QI Director) is full-time, part-time, or combined with another position, and whether it is filled by an employee or via contract.
- Present ☑ Not Present

- The health center determines whether the position designated with responsibility for the QI/QA program is filled by a physician, other licensed health care professional (for example, registered nurse, nurse practitioner), or other qualified individual (for example, an individual with a Master of Public Health or a Master of Healthcare Administration).

- Present ☑ Not Present

- The health center determines which QI/QA methodologies to use.
- Present ☑ Not Present

- The health center determines the type of patient health record system that it will use.
- Present ☑ Not Present

- The health center determines the format, content, and focus of QI/QA reports.
- Present ☑ Not Present

Board Key Management

Policy Number: 900.03

Effective Date	March 20, 2024
Frequency of Review	As Needed
Last Reviewed	March 20, 2024
Last Updated	March 20, 2024
Author	D. Weissenfels
Responsible Department	Family Health Services: Administration

DRAFT

PURPOSE:

The purpose of this policy is to establish the key management staff oversight responsibilities of the Chief Executive Officer (may also be referred to synonymously as "Project Director\CEO" or "Clinic Operations Manager") and ensure demonstration of compliance with the Health Center Program Requirements for Family Health Services (FHS) Key Management Staff as required by the Health Resources and Services Administration (HRSA). Oversight by the CEO of Key Management Staff assigned to FHS is defined in this policy and is consistent with the terms and conditions outlined in the Co-Applicant Agreement between Solano County and the Community Health Board.

DEFINITIONS:

Definition 1: Solano County or "County"– The governmental Agency that has been awarded a grant under the Health Resources and Services Administration's Health Center Program and who is party to a Co-Applicant Agreement together with the Community Health Board.

Definition 2: CHB, Community Health Board (governance board for FQHC) and is the co-applicant entity that is party to a Co-Applicant Agreement with Solano County.

Definition 3: Co-Applicant Agreement – the agreement between Solano County and Community Health Board as required by HRSA.

Definition 4*:* FQHC, Federally Qualified Health Center

Definition 5: CEO, Chief Executive Officer who is the Project Director\CEO for the health center scope of project and synonymous with the titles Project Director\CEO or Clinic Operations Manager

Definition *6:* FHS, Family Health Services which is an in scope FQHC site

Definition *7:* Key Management Staff – Key management staff include the following positions and titles consistent with the County's personnel classification system

Chief Medical Officer
H&SS Finance, (Policy and Financial Analyst, PFA)
IT, DoIT (Various IT staff assigned to Clinic IT Systems)

Board Key Management

Policy Number: 900.03

BACKGROUND
It is the policy of Family Health Services (FHS) to uphold compliance with all Federal, State and local laws and government regulations. Family Health Services follows the mandates contained in the HRSA Compliance Manual, Chapter 11, Key Management Staff, Co-Applicant Agreement and the Community Health Board By-Laws and acknowledges the Solano County personnel policies.

POLICY:
It is recognized that due to the complex nature of the civil service/county staffing structure it is reasonable to utilize agreed upon job duty statements, job classifications and service level agreements to ensure oversight of the health center by the CEO that is otherwise consistent and in compliance with the HRSA Health Center Program Requirements. FHS demonstrates compliance with these requirements by the CEO's oversight of those key management staff positions as defined in this Policy, and the percentage of time dedicated to the Health Center Program project for each position, as necessary to carry out the HRSA approved scope of project. The Co-Applicant Agreement, Bylaws, County personnel policies and this policy establish the responsibility of the CEO for oversight of FHS key management staff and supporting services.

PROCEDURE: N/A

CONSEQUENCES: Non-Compliance with HRSA's Compliance Manual, Chapter 11, Key Management may result in reduction or discontinuation of federal funding and loss of FQHC status.

REFERENCED POLICIES	Solano County Co-Applicant Agreement, Community Health Board By-Laws
REFERENCED FORMS	N/A
REFERENCES	HRSA Compliance Manual

Chair – Community Healthcare Board **Date**

Vice-Chair – Community Healthcare Board **Date**

DRAFT

Board Key Management

Policy Number: 900.03

Effective Date	March 20, 2024
Frequency of Review	As Needed
Last Reviewed	March 20, 2024
Last Updated	March 20, 2024
Author	Dona Weissenfels, Chief Executive Officer
Responsible Department	Family Health Services: Administration

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Board Key Management

Policy Number: 900.03

BACKGROUND

It is the policy of Family Health Services (FHS) to uphold compliance with all Federal, State and local laws and government regulations. Family Health Services follows the mandates contained in the HRSA Compliance Manual, Chapter 11, Key Management Staff, Co-Applicant Agreement and the Community Health Board By-Laws and acknowledges the Solano County personnel policies.

POLICY:

It is recognized that due to the complex nature of the civil service/county staffing structure it is reasonable to utilize agreed upon job duty statements, job classifications and service level agreements to ensure oversight of the health center by the CEO that is otherwise consistent and in compliance with the HRSA Health Center Program Requirements. FHS demonstrates compliance with these requirements by the CEO's oversight of those key management staff positions as defined in this Policy, and the percentage of time dedicated to the Health Center Program project for each position, as necessary to carry out the HRSA approved scope of project. The Co-Applicant Agreement, Bylaws, County personnel policies and this policy establish the responsibility of the CEO for oversight of FHS key management staff and supporting services.

PROCEDURE: N/A

CONSEQUENCES: Non-Compliance with HRSA's Compliance Manual, Chapter 11, Key Management may result in reduction or discontinuation of federal funding and loss of FQHC status.

REFERENCED POLICIES	Solano County Co-Applicant Agreement, Community Health Board By-Laws
REFERENCED FORMS	N/A
REFERENCES	HRSA Compliance Manual

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Chair – Community Healthcare Board **Date**

______________________ ______________________

Vice-Chair – Community Healthcare Board **Date**

DEPARTMENT OF HEALTH & SOCIAL SERVICES

Family Health Services Community Healthcare Board
2024 Annual Calendar

Month	Required Annual Review	Comments/Training
January 17, 2024	• Project Officer/CEO Evaluation Review • Board Members Sign Annual Bylaws Appendix A "Conflict of Interest" and "Confidentiality" forms • Quarterly Financial Report • Quarterly Quality Improvement Report	**Additional Items that can be added to Agenda for Board Approval at any given time:** • Compliance Training • Robert's Rules Review (as needed)
February 21, 2024	• Review UDS Initial Submission Progress • Review and Approve: Sliding Fee Scale Policy	• Review and Update Health Center Policies, Procedures and Services
March 20, 2024	• Review UDS Final Submission Progress • Quarterly Quality Improvement Report • Evaluation of QI/QA Program	• Contracts Review • Compliance Training
April 17, 2024	• Quarterly Financial Report • Quarterly Quality Improvement Report • Board Self-Assessment • FHS Requested Budget Proposal for FY 24/25	• Robert's Rules Review • Brown Act Review
May 15, 2024	• Review Final UDS Submission • Update Community Needs Assessment	
June 19, 2024	• Quarterly Quality Improvement Report • Review Strategic Plan (3-year Cycle)	
July 17, 2024	• Review and Approve Credentialing and Privileging Policy and Procedures • Quarterly Quality Improvement Report	
August 21, 2024	• FY 25/26 Budget Development • Quarterly Financial Report	
September 18, 2024	• FY 24/25 Budget Development (continued) • Quarterly Quality Improvement Report • Evaluation of QI/QA Program (from June) • Review and Approve the QI/QA Plan (from June)	
October 16, 2024	• Review Current HRSA Competing and Non-Competing Continuation Applications/Progress Reports • Quarterly Financial Report • Quarterly Quality Improvement Report	
November 20, 2024	• Review Current HRSA Competing and Non-Competing Continuation Applications/Progress Reports • Board Nominations – Executive Positions • Review Annual Board Calendar	
December 18, 2024	• Review Current HRSA Competing and Non-Competing Continuation Applications/Progress Reports • Quarterly Quality Improvement Report • Board Elections – Executive Positions • Patient Satisfaction Report	

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~~Additional Items that can be added to Agenda for Board Approval at any given time:~~

- ~~Review and Update Health Center Policies, Procedures and Services~~
- ~~Contracts Review~~
- ~~Brown Act Annual Training~~

~~Approved~~ Updated 2024 CHB Calendar ~~as of 12/20/2023~~DRAFT.

DEPARTMENT OF HEALTH & SOCIAL SERVICES

Family Health Services Community Healthcare Board
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2024 CHB Calendar Updated 2-29-2024 – Approved 3-20-2024

Compliance Training Basics

Solano County Medical Services
Community Healthcare Board
(CHB)

Solano County Health & Social Services
Administration: Compliance & QA Unit
Presented by Krista McBride
March 20, 2024

1

Solano County's Commitment to Service

- The County is specifically charged by the State with providing services to those most at risk.
- The County provides a variety of services aimed at improving the lives of children, women, men and the elderly.
- Through countywide planning and coordination, the County's role in health care includes providing clinical services and health care assistance to the impoverished and disabled; providing alcohol, drug and mental health services, and protecting the community from public health threats such as communicable diseases.

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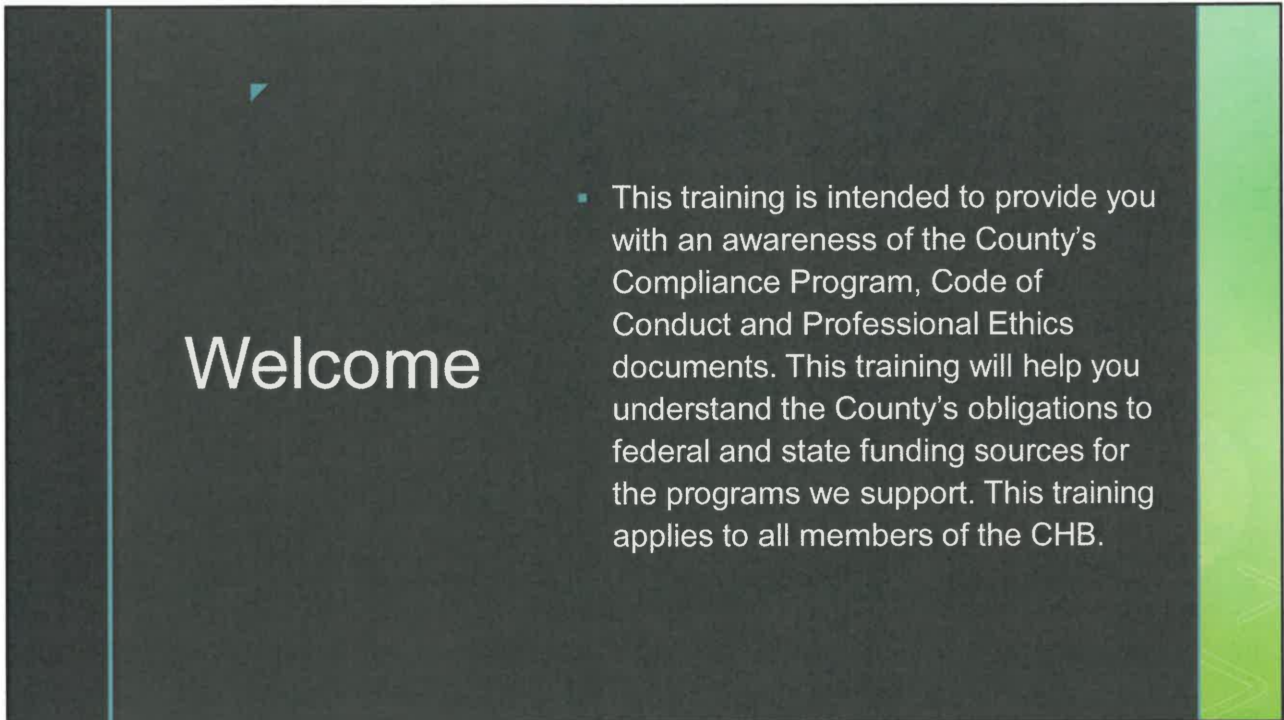

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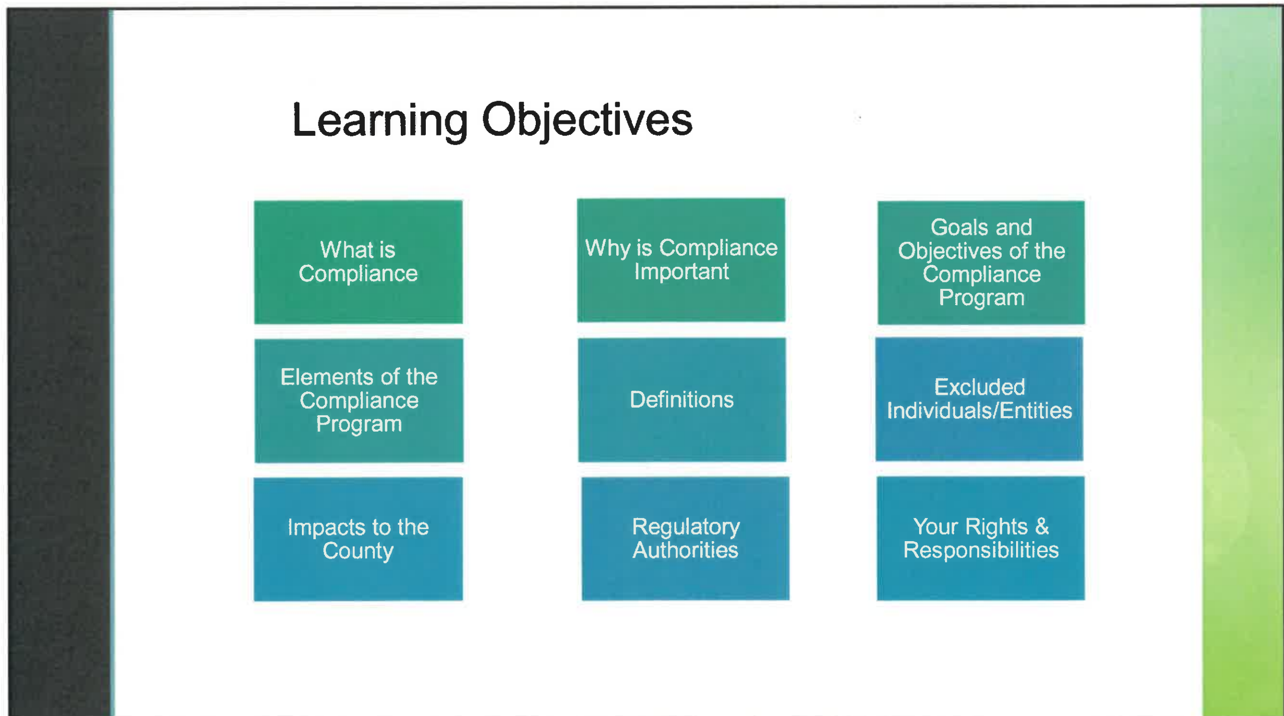

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What is Compliance?

- Ensuring observance of state and federal laws & regulations that ensure individuals with access to health information are trained on privacy and security requirements
- Prevention, detection, and corrective actions for violations of the Code of Conduct, County and Department policies, state or federal laws; including fraud, waste, and abuse of federal or state funds
- Support and reinforcement of the Department's mission, vision, principles and core values

5

Why is Compliance Important? **It's the Law!**

- The Deficit Reduction Act of 2005 (DRA) requires entities, just like the County of Solano, which receive $5 million in Medi-Cal funding annually to:
  - Have a mandatory **Compliance Program**;
  - Develop **Non-Retaliation** policies and procedures;
  - Educate staff on Federal & State **False Claims Act** and **Whistleblower Protection Act** regulations;
- DRA grants the ability to modify each Medicaid program and increases criminal and monetary penalties for each false claim submitted and repayment of triple the amount of damages to the U.S. government for non-compliance.

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Goals and Objectives of the Compliance Program:

Establish	A Compliance Program that encourages employees and volunteers to demonstrate the highest ethical standards
Maintain	An environment promoting ethical behavior, and adherence to all applicable laws
Promote	An understanding of State and Federal laws and regulations
Detect, respond and prevent	Violations of these program requirements

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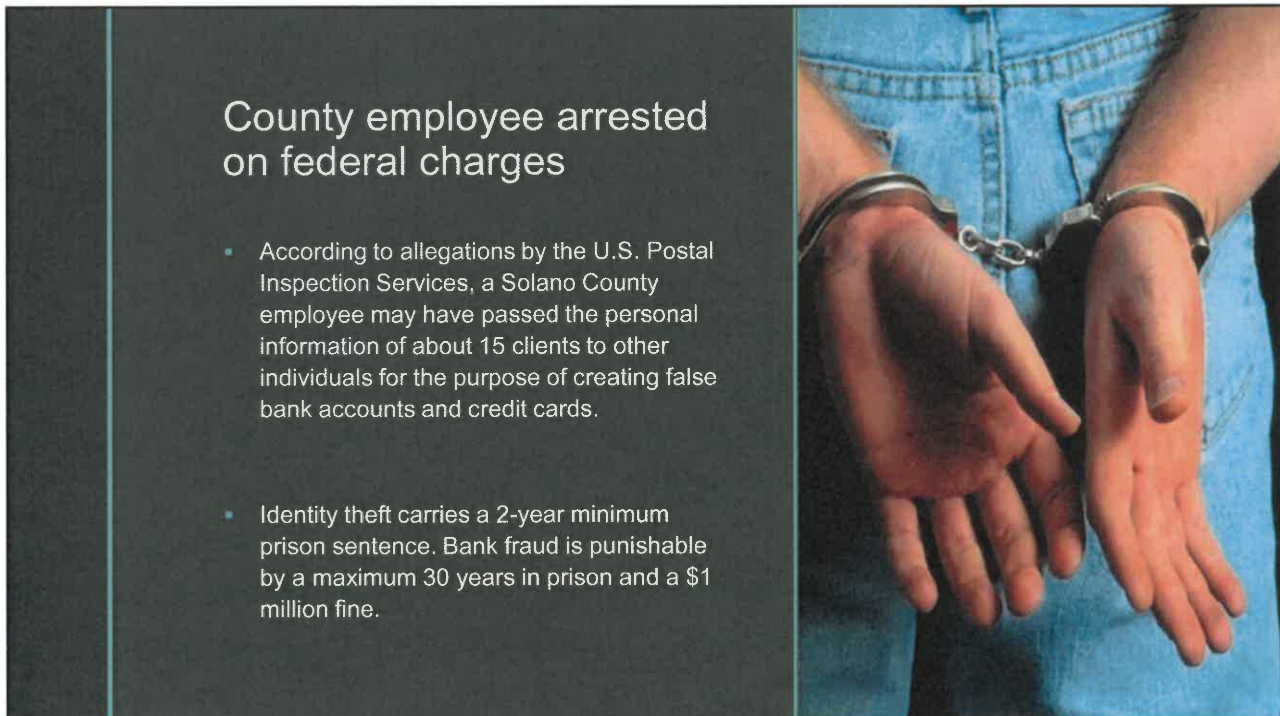

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SEVEN (7) ELEMENTS OF AN EFFECTIVE COMPLIANCE PROGRAM:

1. Written policies, procedures, and Standards of Conduct
2. Designation of a Compliance Officer and a Compliance Committee
3. Effective training and education
4. Effective lines of communication
5. Enforcement of standards
6. Internal monitoring and auditing, and
7. Prompt responses to detected offenses, and the development of corrective action plans

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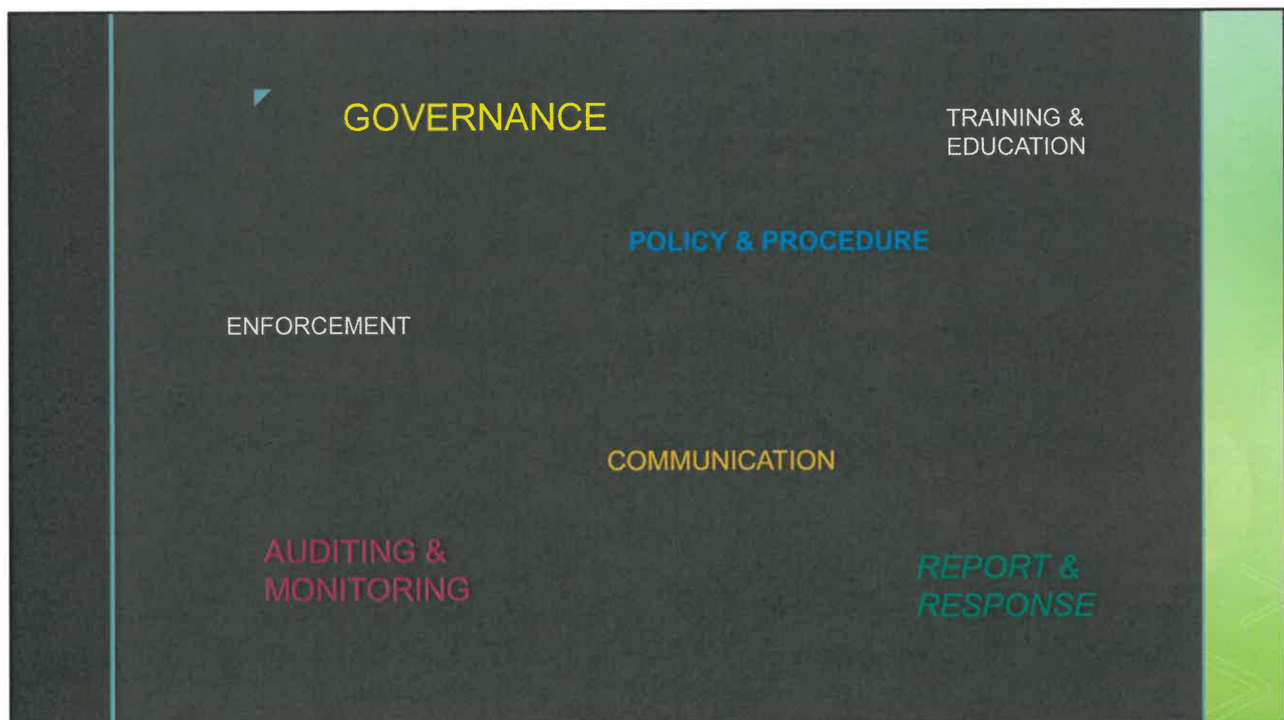

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California Law

- CA False Claims Act applies to the State of CA, Counties, Cities and other local governments
- Private citizen can bring a civil action for a violation known as "Qui Tam Plaintiff" or Whistleblower
- Government Code section starting with 12650

Federal Law

- Federal Civil False Claims (31 U.S.C. section 3729 (a)
- Federal Criminal False Claims (18 U.S.C. Section 1035)
- Federal False Claims Act (31 U.S.C. section 3730)

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Federal False Claims Act: FRAUD

Under the Act, **fraud is .....**

- ***Deliberate ignorance*** of the truth or falsity of the information. Deliberate ignorance can be a crime.
- ***Reckless disregard*** of the truth or falsity of the information. Reckless Disregard can be a crime.
- 3 elements are present in environments where fraud occurs:
  - Pressure
  - Opportunity
  - Rationalization

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Key Definitions: Fraud

- Intentional representation that an individual *knows to be false* or does *not believe to be true* and makes, knowing that the representation could result in some unauthorized benefit to himself/herself or some other person.
- Proof of an intent to defraud is not required.

(42 CFR 455.2)

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Types of Fraud

- bait and switch;
- bankruptcy fraud;
- benefit fraud;
- false insurance claims;
- forgery of documents or signatures;
- Embezzlement;
- false advertising;
- false billing for goods or services;
- securities fraud; and
- tax fraud

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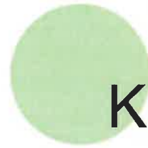

Key Definition: Waste

Waste directly or indirectly results in unnecessary costs to federally funded programs, by activities such as overusing services. Waste is generally considered to be caused by the misuse of resources.

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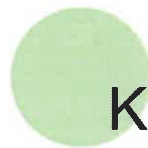

Key Definition: Abuse

- Incidents or practices of individuals that are inconsistent with accepted, sound medical, business, or fiscal practices that may, directly or indirectly, result in unnecessary costs, improper payment, or payment for services that fail to meet professionally recognized standards of care, or that are medically unnecessary.
- Abuse also involves payment for items or services when there is no legal entitlement to that payment and the provider has knowingly or intentionally misrepresented facts to obtain payment. (42 CFR 455.2)

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Examples of Abuse

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- Unentitled/Unauthorized services
- Care for ineligible recipients
- Employment of an excluded individual
- Upcoding billing charges
- Forgery of documents or signatures
- False advertising & misrepresentation
- Conceal or void another's obligation/debt
- Billing for unreceived goods or services

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The Board must act in "Good Faith" when exercising oversight responsibilities. Federal dollars must be spent as intended, used in an efficient manner, and members make fiscally responsible choices to prevent and detect fraud, waste & abuse.

- **Fraud** is a deliberate deception to secure an unfair gain.
- **Waste** is the unnecessary incurrence of costs due to inefficient practices, systems or controls.
- **Abuse** is the intentional misuse of authority, position or resources for personal gain.

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Non-Compliance Could Result In:

- Potential loss of revenue to County
- Recoupment by the government
- Negative publicity
- Interruption of services
- Potential for over payment to contractor
- Negligence in managing contractor activities
- Voluntary disclosure to government
- Integrity Agreement (IA)

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Follow the Money

- Money is received from the federal government…

  and / or
- Money is received from the state government…
- Solano County receives the money…
- Solano County pays the entity, contractor or vendor…

Each hand that the money passes through has compliance obligations!

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Other Regulatory Bodies

- Recovery Audit Contractors (RACs)
- Office of Inspector General (OIG)
- Department of Justice (DOJ)
- Attorney General (AG)
- Federal Bureau of Investigation (FBI)
- Local Law Enforcement
- District Attorney

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Government Areas of Focus

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List of Excluded Individuals/Entities (LEIE)

The Office of Inspector General (OIG) and General Services Administration (GSA), under Congressional mandate, established a list of excluded individuals and entities affected by these various legal authorities.

Presence on this list prohibits participation in government funded programs; including working for entities that accept government funding.

http://oig.hhs.gov/fraud/exclusions/exclusions_list.asp

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Qui Tam Lawsuit or Whistle Blower

- You have the right to file a "whistle blower" or qui tam lawsuit against individuals or entities which make false claims for financial payment or reimbursement from the government.
- Whistle blowers are offered certain protections against retaliation for coming forward and reporting misconduct.

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Your Responsibilities

Respect the rights of those who you work with and serve

Read compliance related materials that are distributed and/or posted

Know what type of conduct is expected, and what is prohibited

Follow all policies and procedures that apply to your position

Understand the compliance risk areas that affect your job responsibilities

Report suspected violations or concerns

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Everyday Compliance Activities Includes:

Proper use computer systems, networks, and software

Data security

Accurate billing and claims submissions

Preserving and protecting the privacy and confidentiality of all records retained by the county

Record retention

Cash handling according to policy

Proper expenditure of county funds and assets

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Code of Conduct

Immediately Disclose Conflicts To Board Leadership

- **Avoiding Conflicts of Interest**
  - Favorable Treatment
  - Personal Benefit or Gain
  - Gifts
- **Protecting and Respecting Information**
  - Release of personal or protected information will only be made with an appropriate written authorization or as required by law
  - Protect and respect the privacy and confidentiality of our clients, constituents, and colleagues.
  - Protect and retain documents as required by regulations and policies.
- **Ethical Decision Making**
  - *Is it Legal?*
  - *Is it Ethical?*
  - *Does it comply with County Policy & Procedure?*

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Obligation to Report

All County staff, contractors, and volunteers have an obligation to report actual, potential or suspected violations of all State, Federal, and County program requirements and all other applicable laws, regulations, policy, procedure, or the Code of Conduct.

If you see something, say something!

Ways to Report

- ComplyTrack Online Reporting Portal https://solanocounty.cqs.symplr.com/Portal
- H&SS Trust Line: 1-707-784-3198
- Email: to hss-compliance@solanocounty.com
- Auditor Whistleblower (Fraud Hotline): 1-866-384-TIPS (8177)

You do not have to identify yourself

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Non-Retaliation

- An individual engaging in protected activities may not be subjected to retaliation through an adverse employment action or subjected to any other form discrimination.
- To be entitled to these protections, actions must not be frivolous, troublesome, vexatious, or filed as a form of harassment.

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Compliance Training Summary

✓ As public servants of Solano County, it is important to avoid Conflicts of Interest and even the "appearance" of a conflict of interest.

✓ You may not use your volunteer status or contractual relationship with the County to obtain favorable treatment or any improper personal benefits.

✓ Report wrongdoings, misconduct, or violations of laws and regulations in good faith. If you see something, say something!

✓ Protected activities may not be subjected to retaliation by adverse employment action or any other form discrimination.

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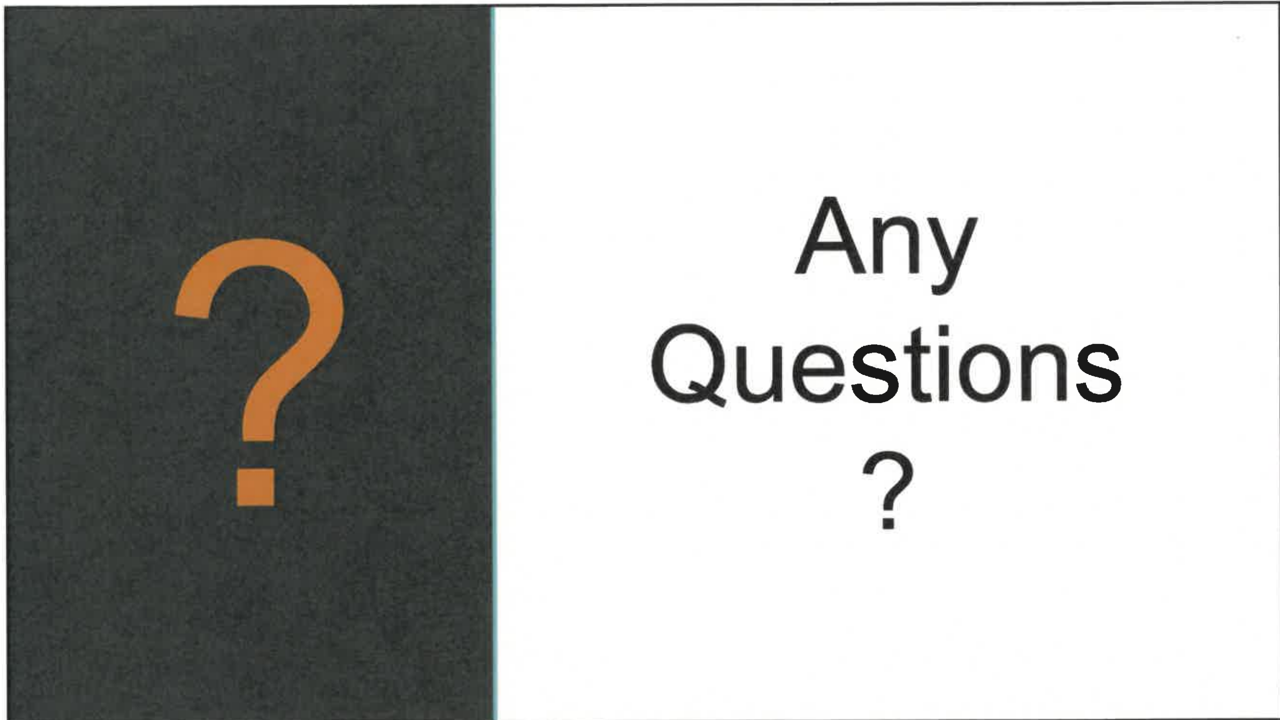

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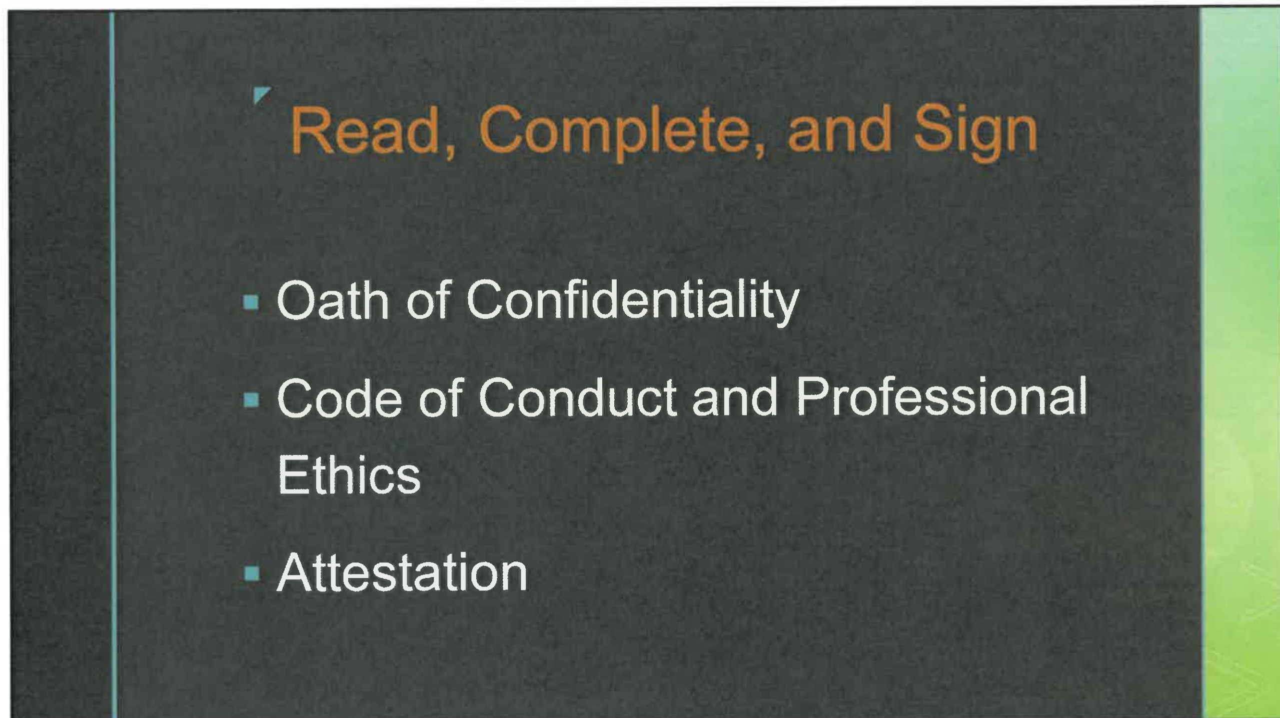

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