

# The County of Santa Cruz

## Integrated Community Health Center Commission

### MEETING AGENDA

March 5, 2020 @ 11:00 am

Meeting Location: 1080 Emeline Ave., 1<sup>st</sup> Floor, Conference Room 109, Santa Cruz, CA 95060  
 1939 Harrison Street, Suite 211, Oakland, CA 94612  
 40 Eileen St., Watsonville CA 95076

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

1. Welcome/Introductions
2. Oral Communications
3. February 6, 2020 Meeting Minutes – Recommend for Approval
4. Quality Management Committee Update
5. 620.03 Risk Management Plan – Action Required
6. 200.03 Credentialing and Privileging – Action Required
7. 130.02 Continuous Quality Improvement Plan – Action Required
8. 130.01 Patient Grievance Process – Action Required
9. County of Santa Cruz Clinic Services Division Emergency Operations Plan (EOP) – Action Required
10. Review and approve Revised draft 100.03 HSA Billing FO Policy Procedures – Action Required
11. Review and approve Revised draft 100.04 HSA Billing Ability to Pay Policy Procedures – Action Required
12. Review data on self-pay patients and total out of pocket cost for FY 18-19 comparing chronic illness and non-chronic illness patients
13. Operational Site Visit and Commission Attendance
14. Financial Update
15. CEO Update

**Action Items from Previous Meetings:**

Action Item	Person(s) Responsible	Date Completed	Comments
Bring updated corrected UDS report.	Raquel		

New Calendar with back up meeting dates.	Mary		
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Next meeting: April 2, 2020 11:00 am- 1:00 pm  
1080 Emeline Ave., Bldg., D (DOC Conference Room, 2<sup>nd</sup> Floor) Santa Cruz, CA 95060

# The County of Santa Cruz Integrated Community Health Center Commission

**Minute Taker: Mary Olivares**

Minutes of the meeting held February 6, 2020

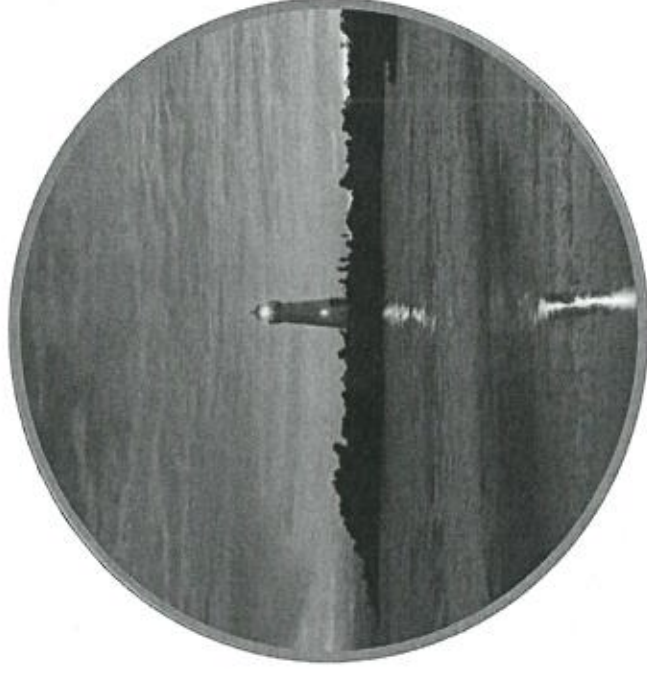
Attendance	
Christina Berberich	Chair
Len Finocch'lo	Vice Chair
Caitlin Brune	Member at Large
Rahn Garcia	Member
Dinah Phillips	Member
Pamela Hammond	Member
Marco Martinez-Galarce	Member
Gustavo Mendoza	Member
James Dyer	Administrative Analyst
Amy Peeier	County of Santa Cruz, Chief of Clinic Services
Raquel Ramirez Ruiz	County of Santa Cruz, Senior Health Services Manager
Julian Wren	Administrative Services Manager
Mary Olivares	Admin Aide
<b>Meeting Commenced at 11:03 am and Concluded at 12:50 pm</b>	
Excused/Absent:	
1. Welcome/Introductions	
2. Oral Communications:	
Caitlin announced that there is an upcoming meeting "Intersections in Immigration" and anyone is welcome to attend. Caitlin will e-mail flyer to Mary and Mary will e-mail out to Commission members.	
3. January 6, 2020 Meeting Minutes - Action item	
Review of January 6, 2020 Meeting Minutes - Recommended for Approval. Caitlin moved to review and accept, Pam second. The rest of the members present were in favour.	
4. Quality Management Committee Update	
Invited guest James Dyer gave a presentation on HIPPA. Raquel stated we must do a risk report quarterly for HRSA. Raquel also reported back from the Peer Review meeting that there were 6 mortalities reported.	
5. Biographies	
Raquel passed out the Current Commission Characteristics Survey for HRSA and Integrated Community Health Center Commission Evaluation Survey for commission to complete. Commissioners took about 10 minutes to complete forms. Mary will e-mail Marco the packet.	
6. Ability to pay survey results	
Julian presented the ability to pay survey to our commissioners for review and any feedback. He stated this is something that must be done per HRSA requirements. Commission stated it was worthwhile to add another section in there so that it is very clear of coverage. Commission member Pam noted that she would like this seen at Sr. Centers and more our reach to the community.	
7. Approval of updated Sliding Fee Discount Scale (Ability to Pay) – Action Required	
Julian stated the only changes that he made per HRSA requirements was to add IBH charges and acupuncture to the sliding fee. Dinah moved to approve, Christina second, the rest of the members present were in favour.	
8. Approval of updated HSA Billing FO Policy Procedures Section 100.3 – Action Required	
Rahn motioned to void previous action, items 8-9 on agenda of February 6, 2020. Items to be brought back to next month's meeting agenda. Len second, the rest of the members present were in favour.	
9. Approval of HSA Billing Ability to Pay Policy Procedures Section 100.4 – Action Required	
Rahn motioned to void previous action, items 8-9 on agenda of February 6, 2020. Items to be brought back to next month's meeting agenda. Len second, the rest of the members present were in favour.	

<b>10. Financial Update</b>
Julian stated that monthly we receive a snapshot of financials what he presented today had data up to November 2019. He stated the budgeted revenues were identified in red and expenditures were identified in black. He stated there was a new column added to add portion of actuals. He stated compared to last year we are 2% ahead. He also stated we took a lot more liability by adding 24 positions. Julian stated he is currently working on next fiscal year's budget.
<b>11. Attendance – Integrated Community Health Center Commission Meetings</b>
Amy stated she received notice from Eddie, and he would like to resign his seat with the Commission at this time. Amy stated did receive a name from HPHP but patient currently is not available at the moment. Amy will continue to reach out to staff for any possible names for our 3 vacancies on the Commission.
<b>12. CEO update</b>
Amy reported that some of the data reported on overdoses of Fentanyl had tested clean making this a possibility of over doses on fentanyl much higher. Amy stated they had their first meeting by phone for the operational site visit that is scheduled in April. Commission members to decide at the next meeting who will be attending the site visit. Christina asked, if there was any work in clinics on the corona virus. Amy stated they have been meeting every morning and the 3 Health Center Managers have developed a workflow and are working with clinic staff. There was also discussion on how the black outs affected the clinics. Amy stated it did affect our HPHP Clinic as they do not have a generator.
<b>Action items:</b> <ul style="list-style-type: none"> <li>• Caitlin will e-mail flyer to Mary and Mary will e-mail out to Commission members for "Intersections in Immigration"</li> <li>• Mary will e-mail Marco the packet Current Commission Characteristics Survey for HRSA and Integrated Community Health Center Commission Evaluation Survey.</li> <li>• Commission members to decide at the next meeting who will be attending the site visit.</li> </ul>

**Next Meeting:** March 5, 2020 11:00 am - 1:00 pm  
1080 Emeline, Santa Cruz, CA

Minutes approved \_\_\_\_\_ (Signature of Board Chair or Co-Chair)      \_\_\_\_/\_\_\_\_/\_\_\_\_ (Date)

# Quality Management Report



## Action Planning Workshop

Santa Cruz County Health Services Agency  
Clinic Services Division

February 2020

# Action Planning Work Shop

- ▶ Santa Cruz County Health Services Agency
  - ▶ Clinic Services Division
    - ▶ February 28, 2020

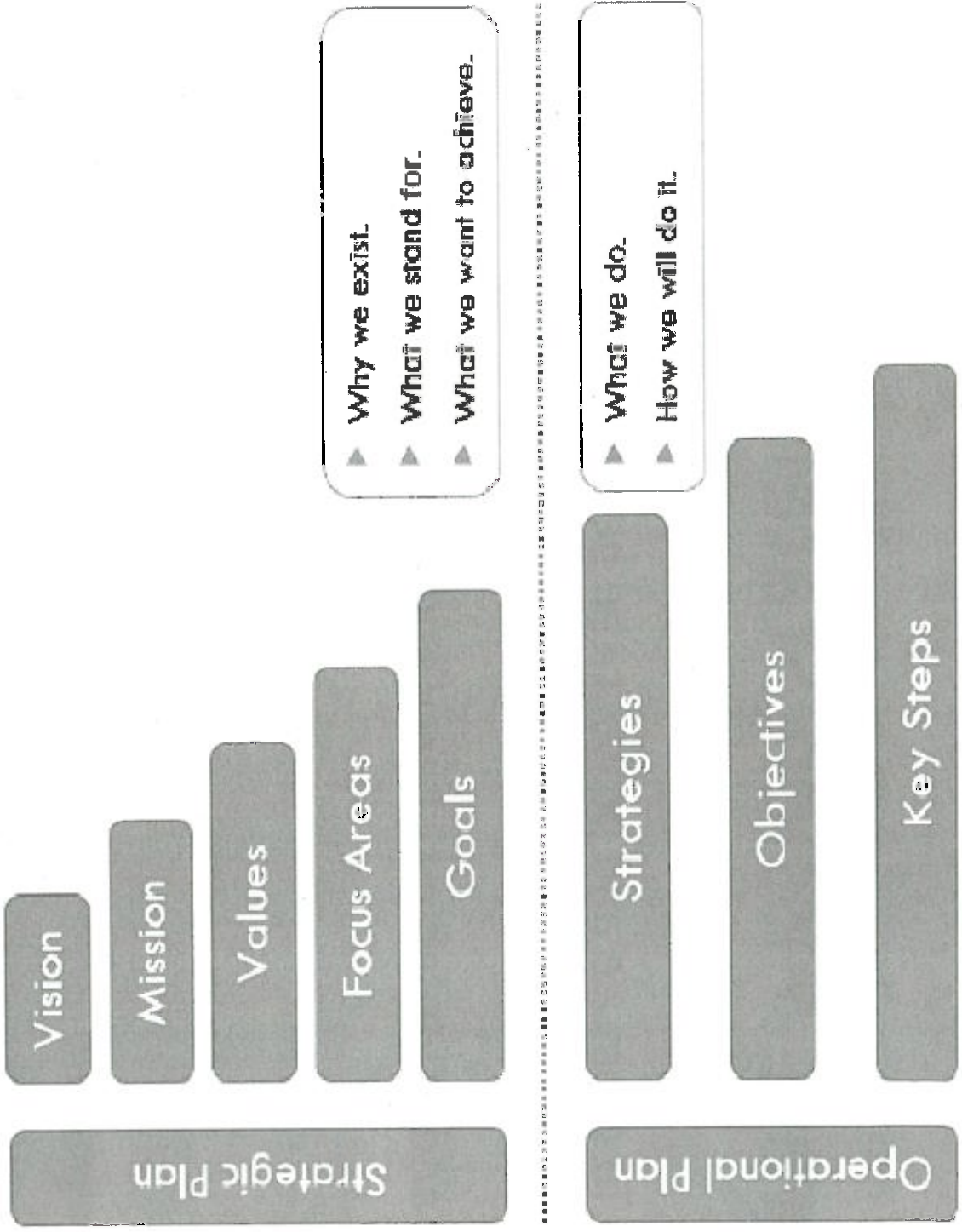


# Draft Mission Statement

- ▶ To promote and protect the health and wellbeing of our community by ensuring access to quality, comprehensive and affordable primary and behavioral health care services.

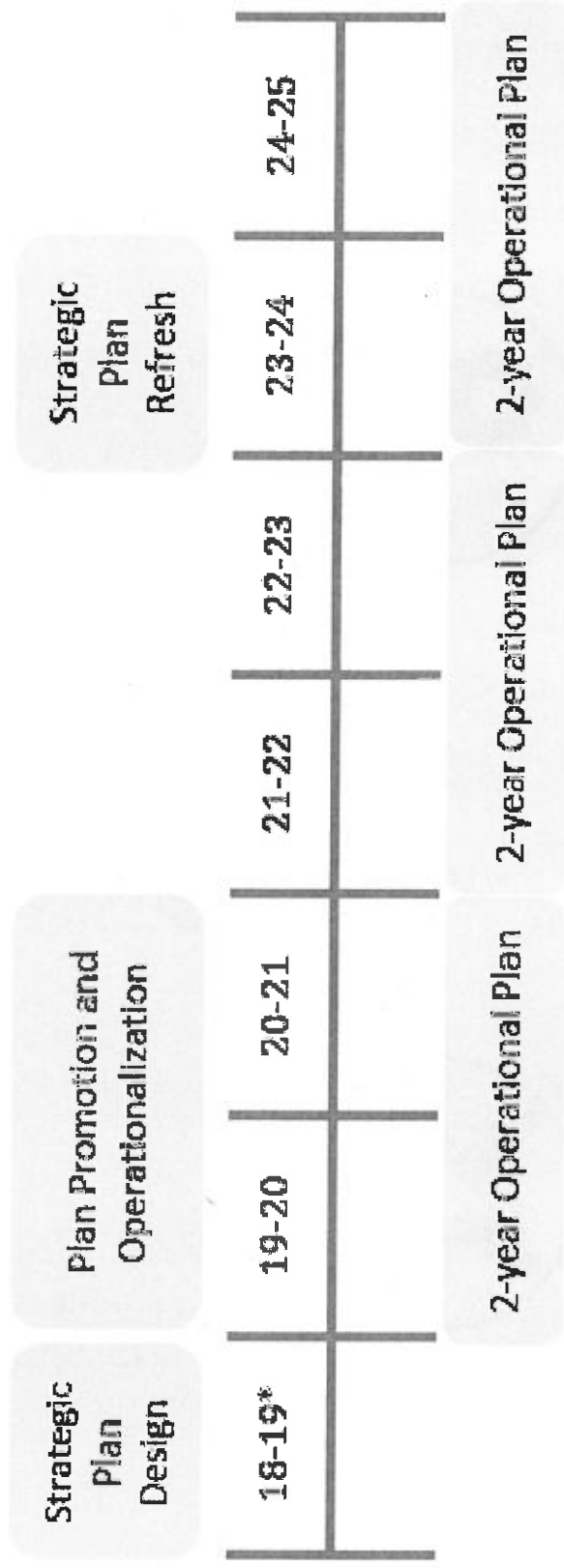


# HSA Strategic Plan Overview





# Strategic Plan Timeline

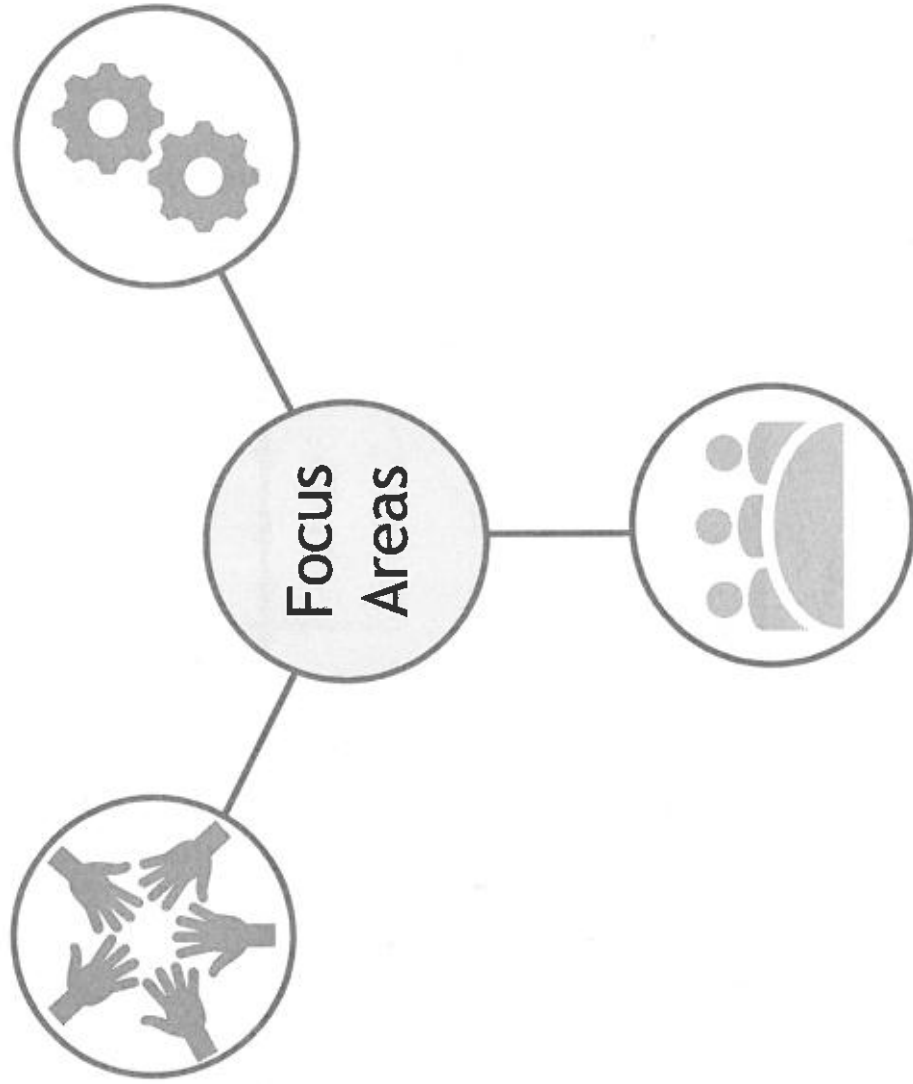


\*Fiscal Years

# HSA Focus Areas

Organizational Culture

Operational Excellence



Community Collaboration



**FOCUS AREA 1: ORGANIZATIONAL CULTURE**

<p><b>Goal 1.1: Workforce Development:</b> Create a workplace environment that fosters an equitable, stable and highly competent workforce.</p>	
<p><b>Strategy 1.1.1:</b> We will develop a comprehensive training and curriculum plan for all employees.</p>	<p><b>Objective 1.1.1.1:</b> Develop policies and procedures for all Clinic Services Division receptions.</p> <p><b>Objective 1.1.1.2:</b> Develop a new employee orientation and training curriculum for Reception, Medical Assistants, Registered Nurses, and Primary Care Providers.</p> <p><b>Objective 1.1.1.3:</b> Provide each EPIC user 2 hours of EPIC training support annually.</p> <p><b>Objective 1.1.1.4:</b> Ensure all staff are trained on new workflows and/or programs within 2-4 weeks prior to launch.</p>
<p><b>Strategy 1.1.2:</b> We will foster a culture of teambuilding.</p>	<p><b>Objective 1.1.2.1:</b> Plan and complete a yearly staff retreat and schedule time for employee mixers.</p> <p><b>Objective 1.1.2.2:</b> Create a Clinic Services Division employee of the month nominated by colleagues (picture and biography included in newsletter or Clinic Services Division intranet).</p>
<p><b>Goal 1.2: Employee Wellbeing:</b> Strengthen organizational resiliency by using trauma-informed approaches to optimize employee well-being, safety, and quality of life.</p>	
<p><b>1.2.1:</b> We will ensure the safety, well-being, and quality of life for all employees.</p>	<p><b>Objective 1.2.1.1:</b> Increase security presence at vulnerable times of the workday.</p> <p><b>Objective 1.2.2.2:</b> More ergonomically friendly equipment for all staff regardless of physical injury.</p>
<p><b>1.2.2:</b> We will create a work culture which values all employee input.</p>	<p><b>Objective 1.2.2.1:</b> Create an anonymous employee suggestion and response system.</p> <p><b>Objective 1.2.2.2:</b> Offer time when staff can express feelings.</p>

# Draft

<b>Goal 1.3: Diverse Workforce:</b> Create a workforce that reflects the community at all levels.	
<b>Strategy 1.3.1:</b> We will ensure the diversity of our workforce is representative of our community.	<p><b>Objective 1.3.1.1:</b> By June 2021, we will collaborate with community institutions to develop employment opportunities that reflect the cultural diversity of our community.</p> <p><b>Objective 1.3.1.2:</b> By June 2021, we will conduct a workforce diversity assessment to determine community representation and identify diversity needs.</p>
<b>Strategy 1.3.2:</b> We will celebrate the diversity of our workforce.	<p><b>Objective 1.3.2.1:</b> By June 2021, we will create a diversity committee that will foster cultural representation across the division.</p> <p><b>Objective 1.3.2.2:</b> By June 2021, we will implement trainings that will increase the cultural competence of our workforce.</p>



## FOCUS AREA 2: OPERATIONAL EXCELLENCE

**Goal 2.1: Continuous Process Improvement:** Strengthen systems through continuous process improvements.

**Strategy 2.1.1: We will improve** standardization of clinical practices.

**Objective 2.1.1.1:** By December 31, 2020 we will create and revise workflows and policies and train staff on these policies.

**Objective 2.1.1.2:** By December 31, 2020 we will use EHR to continuously improve and monitor clinical care.

**Strategy 2.1.2: We will involve all** primary care teams in clinical improvement project including panel management approaches to improve patient care and staff satisfaction.

**Objective 2.1.2.1:** By October 31, 2020 we will provide time in staff schedules to be involved in patient improvement projects.

**Objective 2.1.2.2:** By October 31, 2020, we will build staff capacity to implement quality improvement projects at all clinic locations.

**Goal 2.2: Goal 2.2 Fiscal Sustainability:** Create fiscally sustainable systems that support operational services and growth.

**2.2.1: We will use key financial** metrics and staff input to inform operational decisions.

**Objective 2.2.1.1:** By December 31, 2020 create web form on intranet to seek input from staff on improving operations.

**Objective 2.2.1.2:** By June 30, 2021 Clinic Services Division will develop a financial and operational metric dashboard accessible to all clinic staff.

**2.2.2: We will develop policy and** systems changes to increase revenue.

**Objective 2.2.2.1:** Objective 2.2.2.1: By June 30, 2021 develop a plan to implement electronic payment feature utilizing My Chart.

**Objective 2.2.2.2:** By June 30, 2021 conduct three-month pilot to test telehealth technology between clinic sites.

Draft

# Draft

<b>Goal 2.3: Equitable Resources:</b> Maximize equity in program resources, support and technology.	
<b>Strategy 2.3.1:</b> We will improve communication and utilization of existing resources across all clinic locations.	<b>Objective 2.3.1.1:</b> By September 30, 2020 create clinic-wide user friendly, and shared schedule to proactively solve staffing gaps. <b>Objective 2.3.1.2:</b> By December 31, 2020 create a resource guide for all staff that identifies the service providers by services.
<b>Strategy 2.3.2:</b> We will ensure our facilities are equitably staffed and equipped to meet the needs of our community.	<b>Objective 2.3.2.1:</b> By June 30 complete needs assessment of all clinic facilities to meet the community demands. <b>Objective 2.3.2.2:</b> By December 31, 2020 the Homeless Persons Health Project (HPPH) will finish an interim expansion plan and evaluate options to expand and get approval.



**FOCUS AREA 3: COMMUNITY COLLABORATION**

**Goal 3.1: Public Awareness:** Increase public awareness to empower our community to address key health and environmental issues.

**Strategy 3.1.1:** We will identify areas to engage the community and partners in order to provide education and outreach.

**Objective 3.1.1.1:** Prioritize needs and gaps in community engagement efforts.

**Objective 3.1.1.2:** Develop an action plan.

**Strategy 3.1.2:** We will inform community members of the clinic services available to them.

**Objective 3.1.2.1:** Develop educational materials to inform community members of the resources available to them.

**Objective 3.1.2.2:** Provide educational materials to community members through presentations and outreach.

**Goal 3.2: Improve Health and Wellbeing:** Maximize access to services to improve health and wellbeing.

**3.2.1:** We will increase staff capacity for programs to improve patient access and wellbeing.

**Objective 3.2.1.1:** We will invest in staff to provide culturally appropriate care services for all patients.

**Objective 3.2.1.2:** We will invest in staff to improve access to quality and affordable care services for all patients.

**3.2.2:** We will provide patient-centered care.

**Objective 3.2.2.1:** We will increase quality improvement services through patient and staff engagement.

# Draft

<b>Goal 3.3: Health Equity:</b> Normalize/integrate health equity, resiliency, and environmental stewardship for current and all future residents.	
<b>Strategy 3.3.1:</b> We will ensure an atmosphere of patient safety and equitable care in our programs and services.	<b>Objective 3.3.1.1:</b> Provide staff trainings in cultural humility and empathy. <b>Objective 3.3.1.2:</b> Provide focused outreach to individuals who might be fearful of utilizing our services for immigration or stigma-related reasons.
<b>Strategy 3.3.2:</b> We will collaborate with community members and local partners to address and ensure inclusivity in program planning.	<b>Objective 3.3.2.1:</b> We will work with Watsonville Law Center and other immigration organizations to provide education and resources related to immigration for our patients. <b>Objective 3.3.2.2:</b> Design methods to gather input for patients and community stakeholders to measure inclusivity.





SANTA CRUZ COUNTY CLINIC SERVICES DIVISION  
ACTION PLANNING

Two-Year Action Plan (2019-2021)



FOCUS AREA 1: ORGANIZATIONAL CULTURE

GOAL 1.1 WORKFORCE DEVELOPMENT: Create a workplace environment that fosters an equitable, stable and highly competent workforce.

Strategy 1.1.1: We will...

Key Steps (i.e., Activities/Tasks)	Responsible Parties	Target	Timeline
<b>Objective 1.1.1.1</b>			
<b>Key Step 1:</b>	(List key staff who will assist in implementing this objective)	(Evaluation measure/intended outcome)	(Estimated completion date)
<b>Key Step 2:</b>			
<b>Key Step 3:</b>			
<b>Key Step 4:</b>			
<b>Objective 1.1.1.2</b>			
<b>Key Step 1:</b>			

# Project Plans

Benchmarks	Timeline
Mission Statement workshop	December 13
Broader staff input into Mission Statement Options (i.e., surveys and polls)	December 18
SCC HSA Finalizes the agency-wide Strategic Plan (including the Vision, Mission, Values, Focus Areas and Goals)	March-April
Action Planning workshop (identify divisional Strategies and broad Objectives)	February 28
Divisional Work Groups develop Action Plans	March-April
Finalize Divisional Operational Plan	May-June



# Quality Council

## FOLLOW-UP FOR PATIENTS WITH POORLY-CONTROLLED DIABETES (HGBA1C > 9%)

The attached list is an Epic Workbench report and includes your patients with diabetes who meet one of the following criteria regardless of age:

1. No HgbA1c value ("Overdue")
2. Last HbA1c value >12 months ago ("Overdue")
3. Last HbA1c value >9%

### UDS description for Diabetes: Hemoglobin A1c Poor Control

Percentage of patients 18-75 years of age with diabetes who had hemoglobin A1c greater than 9.0% during the measurement period. (Please note, your report includes patients outside this age range and those that have not had a HgbA1c test in over a year.)

### Additional non-pharmacological treatment options to consider

- Refer patient to shared medical appointment classes
- Refer patient to counseling
- Refer patient to Diabetes Health Center
- Schedule monthly visits until good control is achieved
- Add the last HgbA1c value collected to the schedule and call for new appointment if the patient no-shows.

### Performance

Performance metrics were pulled from EPIC Workbench and is current as of the date of this report.

HP2020 Goal	Current Enclave performance	Individual PCP baseline	Individual PCP current performance
16.2%	28.3% (143/505)	25.8% (8/31) 9/2018	29.2% (7/24)

# Diabetes Management Pilot with Alliance Pharmacy Team

Impact of Medication Management  
Therapy (MTM) on patient outcomes.

Pharmacists will provide their  
assessment in a format of Medication  
Therapy Management to our physicians.

We determine which patients should be  
targeted.

Meeting next week to brainstorm  
different processes that works the best  
for your needs.

# Peer Review and Risk Management Committee

- ▶ Reviewed two deaths, no issues to report
- ▶ May 2020-next Chart Review Party





**County of Santa Cruz  
Health Services Agency  
HSA Clinic Services Division**

**Emergency Operations Plan - DRAFT**

Approved by Board XX/XX/XXXX

# Signature Page

## County of Santa Cruz Health Services Agency HSA Clinic Services Division Emergency Operations Plan

The following signatories have agreed to the terms and conditions of this Emergency Operations Plan, which is subject to revision as needed. This Plan supersedes all previous plans.

_____	_____
Amy Peeler MPH, Chief of Clinic Services	Date
_____	_____
Raquel Ramirez Ruiz, Operations Director	Date
_____	_____
Michele Violich, MD, Medical Director	Date
_____	_____
Rahn Garcia, Chair of the Board	Date



# Clinic Services Emergency Operations Plan

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**A. Incident Command System**

# **1 INTRODUCTION**

## **1.1 Purpose**

The purpose of the Health Services Agency Clinic Services Division Emergency Operations Plan (EOP) is to establish a basic emergency program to provide timely, integrated, and coordinated response to the wide range of natural and man-made events that may disrupt normal operations and require preplanned response to internal and external disasters.

The objectives of the EOP include:

- To provide maximum safety and protection from injury for patients, visitors, and staff.
- To attend promptly and efficiently to all individuals requiring medical attention in an emergency.
- To provide a logical and flexible chain of command to enable maximum use of resources.
- To maintain and restore essential services as quickly as possible following an emergency incident or disaster.
- To protect health property, facilities, and equipment.
- To satisfy all applicable regulatory and accreditation requirements.
- To safeguard post-emergency solvency through proper planning and systems that optimize reimbursement, minimize liability, and ensure eligibility for disaster assistance.

## **1.2 Policy**

- Clinic Services Division Staff will be prepared to respond to a natural or man-made disaster, suspected case of bioterrorism or other emergency in a manner that protects the health and safety of its patients, visitors, and staff, and that is coordinated with a community-wide response to a large-scale disaster.
- All employees will know and be prepared to fulfill their duties and responsibilities as part of a team effort to provide the best possible emergency care in any situation. Each supervisor at each level of the organization will ensure that employees are aware of their responsibilities.
- During an emergency, the designated Clinic Services Division Staff Incident Commander and/or Public Information Officer will work in close coordination with the County Health Officer, County and City emergency management departments and other local emergency officials, agencies and health care providers to ensure a community-wide coordinated response to disasters.

## **1.3 Scope**

- This plan describes the policies and procedures Clinic Services Division Staff will follow to mitigate, prepare for, respond to, and recover from the effects of emergencies.

- Within the context of this plan, an emergency is any event that overwhelms or threatens to overwhelm the routine capabilities of one or more of the health centers.
- The HSA Clinic Services Division Emergency Operations Plan is an “all-hazards” plan that will guide Clinic Services Division Staff response to any type of a disaster or emergency, including natural and man-made disasters or incidents.

#### **1.4 Legal Considerations**

This EOP is in compliance with the following regulations, statutes and accepted emergency management standards:

- California Code of Regulations (Title 22) Division 5, Section 78423 Disaster Plan
- US Department of Health and Human Services Health Resources and Services Administration Bureau of Primary Health Care Health Center Emergency Management Program Expectations Policy Information Notice 2007-15 (HRSA PIN 2007-15)
- National Incident Management System (NIMS)
- Standardized Emergency Management System (SEMS)

#### **1.5 Key Terms**

The following terms are used frequently throughout this document.

##### **Clinics Command Center**

The location for where emergency response staff, working under Incident Command System (ICS) coordinate all response activities at the Clinic Services Division level. The Clinics Incident Commander may establish a Clinic Command Center in the clinic facility or at an alternate site.

##### **Continuity of Operations (COOP)**

Plans and actions necessary to continue essential business functions and services and ensure continuation of decision-making even though primary facilities are unavailable due to emergencies.

##### **Departmental Operations Center (DOC)**

The location where emergency response staff, working under Incident Command System (ICS) coordinate all response activities at the HSA level. The Incident Commander may establish a DOC at the agency or alternate site to coordinate response efforts among the different divisions and ensure one point of contact to the Emergency Operations Center (EOC). This typically occurs when the emergency response needed is larger than the Clinic Services Division’s capacity to respond.

##### **Emergency Operations Center (EOC)**

The location where emergency response staff, working under Incident Command System (ICS) coordinate all response activities at the County level. All DOCs will report to the

EOC, which then acts as the single point of contact to the Regional, State, and/or Federal response efforts.

### **Mission Essential Functions**

Mission essential functions and services are those that implement the Clinic Services Division's core mission and goals. These are a limited set of functions that must be continued throughout, or resumed rapidly, after disruption of normal operations. The extended loss of these functions, following an emergency, would create a threat to life/safety, or irreversible damage to the clinics, staff or stakeholders.

### **Hazard Mitigation**

Measures taken by a facility to lessen the severity or impact a potential disaster or emergency may have on its operation. Hazard mitigation can be divided into two categories.

- **Structural Mitigation.** Reinforcing, bracing, anchoring, bolting, strengthening or replacing any portion of a building that may become damaged and cause injury, including exterior walls, exterior doors, exterior windows, foundation, and roof.
- **Nonstructural Mitigation:** Reducing the threat to safety posed by the effects of earthquakes on nonstructural elements. Examples of nonstructural elements include light fixtures, gas cylinders, HazMat containers, desktop equipment, unsecured bookcases, and other furniture.

### **Hazard Vulnerability Analysis (HVA)**

Hazard Vulnerability Analysis (HVA) identifies ways to minimize losses in a disaster considering emergencies that may occur within the facility as well as external to the facility in the surrounding community.

### **Incident Command System (ICS)**

A temporary management system used to manage and coordinate health center activities during an emergency. ICS is designed to facilitate efficient decision-making in an emergency environment and to be adaptable to any incident.

### **Medical Health Operational Area Coordinator (MHOAC)**

The position in the County's Standardized Emergency Management System (SEMS) responsible for all disaster medical and health operations in an operational area. During emergency response the MHOAC can be stationed in the County EOC and is frequently, but not always, the County Health Officer or designee. During the response to disasters, the MHOAC is the Operational Area contact point for requests pertaining to medical and health resources including personnel, supplies and equipment, pharmaceuticals, and medical transport.

### **Multi-hazard Approach**

A multi-hazard approach to disaster planning evaluates all threats including the impacts from all natural and man-made disasters, including technological threats, hazardous materials, violence, terrorism, and a state of war.

## **Operational Area (OA)**

An intermediate level of the State emergency organization, consisting of a county and all political subdivisions within the county area. Clinics and other health facilities will coordinate their disaster response through the Medical Health Operational Area Coordinator.

## **Phases of Emergency Management**

**Mitigation** - Pre-event planning and actions that aim to lessen the effects of potential disaster.

**Preparedness** – Actions taken in advance of an emergency to prepare the organization for response.

**Response** - Activities to address the immediate and short-term effects of an emergency or disaster. Response includes immediate actions to save lives, protect property and meet basic human needs.

**Recovery** - Activities that occur following a response to a disaster that are designed to help an organization and community return to a pre-disaster level of function.

## **Standardized Emergency Management System (SEMS)**

SEMS is the mandatory system established by Government Code Section 8607(a) for managing the response of government agencies to multi-agency and multi-jurisdiction emergencies in California. SEMS incorporates the use of the Incident Command System. SEMS operates at the following levels: national, state, regional, operational area (Santa Cruz County), local, field responders.

## **Types of Emergencies**

**External Disaster** – An event that occurs in the community. Examples include earthquakes, floods, fires, hazardous materials releases or terrorist events. An external disaster may directly impact a clinic facility and its ability to operate.

**Widespread Emergency** – An event with widespread impact. Nearby medical resources are likely to be strained and therefore less likely to be able to offer assistance to clinics. Hospitals may have priority over clinics for resupply and other response assistance. Clinics can free hospitals to care for the most critically injured or ill by treating all lesser injuries or illness at the clinic.

**Local Emergency** – A disaster with effects limited to a relatively small area. In local emergencies, other health facilities and resources will be relatively unaffected and remain viable options for sending assistance or receiving patients from the disaster area.

**Internal Emergency** – An event that causes or threatens to cause physical damage and injury to the clinic facility, patients, visitors, or staff. Examples are fire, explosion, hazardous materials releases, violence or bomb threat. External disasters may also create internal emergencies.

## **2 MITIGATION**

### **2.1 Introduction**

Clinic Services Division will undertake risk assessment and hazard mitigation activities to lessen the severity and impact of a potential emergency. Mitigation begins by identifying potential emergencies (hazards) that may affect the organization's operations or the demand for its services. Staff then develop and implement a strategy to strengthen the perceived areas of vulnerability within the organization.

During the mitigation phase, the Clinic Services Division Leadership Staff will identify internal and external hazards and take steps to reduce the level of threat they pose by mitigating those hazards or reducing their potential impact on the clinics. The areas of vulnerability that cannot be strengthened sufficiently are then addressed in emergency plans. Mitigation activities may occur both before and following a disaster.

### **2.2 Hazard Vulnerability Analysis (HVA)**

Clinic Services Division Leadership Staff will conduct an HVA to identify hazards and the direct and indirect effect these hazards may have on the health centers. This assessment occurs on an annual basis through participation in the County of Santa Cruz Health Care Coalition (HCC).

### **2.3 Hazard Mitigation**

Designated HSA Staff will undertake hazard mitigation or retrofitting measures to lessen the severity or impact a potential disaster may have on its operation. These measures are taken prior to disasters to minimize the damage to the facility.

### **2.4 Risk Assessment**

Clinic Services Division Leadership Staff will assess the risks identified in its HVA that could not be eliminated or satisfactorily mitigated through its hazard mitigation program and determine their likelihood of occurrence and the severity of their consequences. This assessment of remaining risks will help to define the emergency response role the Clinic Services Division adopts for itself and the preparation required to meet that role.

### **2.5 Insurance Coverage and Financial Reserves**

- 2.5.1 The Director of Administrative Services or designee will assess all insurance policies and the facility's coverage for relocation to another site, loss of supplies and equipment, and structural and nonstructural damage to the facility. If coverage for floods or earthquakes is absent or inadequate, the Director of Administrative Services and/or Chief of Fiscal will recommend if it is financially sound to acquire it. Clinics located in special flood hazard areas must have flood insurance to be eligible for disaster assistance.
- 2.5.2 The Chief of Fiscal will recommend a goal for cash reserves and a line of credit sufficient to recover from a disaster and reopen the health centers while waiting for disaster assistance.

## **2.6 Clinic Emergency Response Roles**

2.6.1 Clinic Services Division Staff may play a variety of roles in responding to disasters, including providing urgent or emergency medical care, providing temporary shelter and expanding primary care services to meet increased community needs created by damage to other health facilities. Clinic Services Division Staff may also provide behavioral health services to disaster victims and serve as a conduit for information dissemination to affected communities. However, clinics are not equipped to respond definitively to all disasters. Clinic roles may be constrained by limited resources and technical capability and by the impact of the disaster on the clinic facility.

2.6.2 As a part of its mitigation program, Clinic Services Division Staff will take the following steps to define the disaster response roles for which it should prepare:

- Assess the pre-disaster medical care environment and the role the health centers perform in providing health services.
- Assess resources including availability of staff to respond and ability of the health centers to survive intact.
- Discuss potential response roles and findings of risk assessment with County Health Officer and appropriate City and County emergency response officials.
- Participate in the County of Santa Cruz HCC monthly meetings, which includes health care preparedness planning activities, drills, and other community preparedness activities.
- Include relevant input from organization management, staff, the community, and Operational Area partners.
- Present recommendations to its Board for ratification.



## **3 PREPAREDNESS**

### **3.1 Introduction**

Preparedness activities build organization capacity to manage the effects of emergencies should one occur. During this phase, Clinic Services Division Leadership Staff will develop plans and operational capabilities to improve the effectiveness of response to emergencies. Specifically, Clinic Services Division will:

- Develop and update emergency plans and procedures, including the Emergency Operations Plan.
- Develop and update agreements with other community health care providers and with civil authorities.
- Train internal emergency response personnel.
- Maintain emergency supplies and equipment.
- Participate in and conduct drills and exercises.

### **3.2 Standardized Emergency Management System (SEMS)**

According to California Government Code Section 8607, SEMS shall be used by all State Agencies responding to emergencies. Clinic Services Division has incorporated the principles of SEMS into its Emergency Operations Plan to ensure maximum compatibility with local and state government response plans and procedures. Clinic Services Division interfaces with SEMS through the Santa Cruz County Medical Health Operational Area Coordinator (MHOAC). Clinic Services Division utilizes the Incident Command System (ICS) as outlined by SEMS. See Appendix A for details of ICS organization.

### **3.3 Integration with Community-wide Response**

Clinic Services Division Chief of Clinic Services, or designee, will notify the County MHOAC of any emergency impacting clinic operations and will coordinate its response to community-wide disasters with the overall medical and health response of the Operational Area.

#### **3.3.1 Coordination with Government Response Agencies**

To the extent possible, the Chief of Clinic Services Division, or designee, will ensure that its response is coordinated with the decisions and actions of the County MHOAC and other health care agencies involved in the response. To ensure coordination with Operational Area response, the Chief of Clinic Services Division, or designee, will:

- a. In coordination with the Santa Cruz County HCC, meet with the County MHOAC to define the Clinic Services Division Staff's role in the emergency response system.
- b. Participate in planning, training, and exercises sponsored by medical and health agencies.

- c. Use procedures developed by the County for communication, reporting, requesting and obtaining medical resources, and evacuating / transporting patients.

### 3.3.2 Coordination with Emergency Responders

Clinic Services Division staff will cooperate fully with Emergency Medical Services (EMS) and law enforcement personnel when they respond to emergencies at the health centers. This may include providing information about the location of hazardous materials or following instructions to evacuate and close the clinic.

### 3.3.3 Coordination with other Medical Facilities

Clinic Services Division will maintain informal arrangements with other facilities to cover disaster response conditions. Clinic Services Division recognizes that it may need to rely on other facilities, especially those nearby, to augment its capacity to meet patient care needs in a disaster, and/or to provide support to other facilities if conditions allow.

- a. Examples of potential disaster related arrangements with nearby facilities include:

- Referral / diversion of patients to nearby hospitals, especially patients that require a higher level of care than Clinic Services Division can provide.
- Acceptance of patients diverted from hospitals to increase their capacity to care for seriously ill and injured.

- b. Limitations

During an area-wide disaster in which the Operational Area has opened its EOC, patient transfers and access to ambulances may need to be coordinated through the County MHOAC, overriding other agreements.

### 3.3.4 Acquiring Resources

Chief of Clinic Services Division, or designee, will augment supplies, equipment and personnel from a variety of sources. Assistance may be coordinated through the following channels:

- Stockpiles of medical supplies and pharmaceuticals anticipated to be required in an emergency response.
- Prior agreements with vendors for emergency re-supply.
- Santa Cruz County assistance to clinics.
- From other clinics, hospitals or health care providers.
- MHOAC

## 3.4 Roles / Responsibilities

The Chief of Clinic Services Division is responsible, directly or through delegation, for the development and implementation of the Emergency Operations Plan and for directing

the response to emergencies. The Chief of Clinic Services Division has delegated primary responsibility for emergency planning and response to the Operations Director and/or Emergency Preparedness Coordinator. Under the Operations Director, the Emergency Preparedness Coordinator is responsible for ongoing assessment, mitigation and preparedness. The Emergency Preparedness Coordinator acts as the Clinic Services Division liaison at the HSA Safety Committee with staff representatives from across the agency. The HSA Safety Committee is chaired by HSA's Safety & Facilities Manager.

### **3.5 Emergency Supplies**

The Safety and Facilities Manager will provide emergency supplies and equipment at each Clinic Services Division location. These supplies will be maintained and kept by the Health Services Managers at each location.

### **3.6 Hazardous Materials Management**

Clinic Services Division Health Center Managers will maintain a list of all hazardous materials and their Safety Data Sheets (SDS), locations, and procedures for safe handling, containing and neutralizing them. This list should be kept accessible to all employees and with offsite backup. All materials will have their contents clearly marked on the outside of their containers.

### **3.7 Communication Methods**

#### **3.7.1 Clinic Services Division Staff Call List**

Chief of Clinic Services Division will maintain an internal staff call list that will include the following information for all staff: name, position title, home phone, cell phone, language capabilities, and other information that may affect their ability to respond during a disaster. The Staff call list contains sensitive contact information and will be treated confidentially.

The Emergency Preparedness Coordinator will ensure that the current staff call list is kept onsite by key employees, available at key locations, stored in offsite backup, and updated at least annually.

Chief of Clinic Services Division will maintain an emergency phone tree for employees to facilitate rapid staff contact by phone or text.

#### **3.7.2 External Notification**

All necessary contacts are in the Santa Cruz County Emergency Operations Guide (EOG), maintained by County of Santa Cruz HCC. Clinic Services Division Health Center Managers will also maintain a contact list of key vendors and resources.

#### **3.7.3 Communications Methods**

The primary means of emergency communication is the telephone system, which is internet-based and would not operate during a power outage or server failure. Each building also has analog phone lines that are during normal operations will be used as the fax line that can be converted for phone usage in an emergency: Emeline: 831-454-4508, 831-454-5001, 831-454-4296, Watsonville 831-XXX-XXXX, and HPHP 831-454-3424, 831-454-3079.

Alternate communications tools include staff cell phones, fax, Internet/email, and public pay phones. If telephone and Internet are unavailable, runners will take messages to and from clinic sites and appropriate agencies rendering assistance, such as nearby police and fire departments. Clinic Services Division Leadership Staff will investigate other technologies as they emerge as best practices for clinic emergency preparedness.

a. Using phones during a power outage or broad band failure

Clinic Services Division will maintain at least one analog phone at each business site. The location of dedicated analog phones (that bypass the internet-based phone system) will be shown on the evacuation map for each site.

b. Public pay phones

The Clinic Services Division Health Center Managers will keep change for pay phones in its disaster supplies. The nearest pay phones for each site are:

- 1080 Emeline: In front of the clinic front doors
- 1430 Freedom Blvd: In front of the clinic front doors
- 136 River Street - Outdoor World

c. CAHAN Redundant Communication Systems

As part of the County of Santa Cruz HCC, the Clinic Services Division Leadership Staff participates in the California Health Alert Network (CAHAN) redundant communication system.

### **3.8 Alert Systems**

Clinic Services Division Leadership Staff are registered with local, state and national alert systems to receive notice of potential emergencies as well as health care notifications:

- County of Santa Cruz HCC Emergency Operations Guide
- California Health Network (CAHAN)
- Nixle law enforcement alert system
- ReddiNet

### **3.9 Continuity of Operations**

#### **3.9.1 Policy**

It is the policy of the Clinic Services Division to maintain service delivery or restore services as rapidly as possible following an emergency that disrupts those services. As soon as the safety of patients, visitors, and staff has been assured, Clinic Services Division Staff will give priority to providing or ensuring access to health care for current patients.

### 3.9.2 Continuity of Operations Goals and Planning Elements

In an emergency or widespread disaster, Clinic Services Division Staff will work to maintain or rapidly restore essential services, which include patient care, facility operations, safety, infection control and surveillance, security, legal/regulatory obligations, supplies, and communications. Clinic Services Division Staff will take the following actions to increase its ability to maintain continuity of operations during an emergency.

a. Patient, visitor and staff safety

Clinic Services Division Leadership Staff will train and drill staff on responding to internal emergencies and evacuating patients, visitors, and staff when the facility is threatened.

b. Continuous performance or rapid restoration of essential services

Clinic Services Division Leadership Staff will work with the HSA's Public Health to obtain needed medical supplies, equipment and personnel; identify a backup site to provide services; and/or make provisions to transfer services to a nearby provider.

c. Protection of medical records

To the extent possible, Clinic Services Division Staff will protect medical records from fire, damage, theft and public exposure. Clinic Services Division Leadership Staff will have systems to ensure privacy and safety of electronic medical records in the event of a clinic site evacuation.

d. Protection of vital records, data and sensitive information

- Ensure offsite backup of financial and other data.
- Store copies of critical legal and financial documents in an offsite location.
- Protect financial records, passwords, credit cards, provider numbers and other sensitive financial information.
- Update plans for addressing interruption of computer processing capability. Protect information technology assets from theft, virus attacks and unauthorized intrusion.

e. Protect medical and business equipment

- HSA's Administrative Services Division maintains a complete list of equipment serial numbers, dates of purchase and costs with offsite electronic backup.
- Maintain a contact list of vendors who can supply replacement equipment.
- Protect computer equipment against theft through use of security devices.
- Use surge protectors to protect equipment against electrical spikes.

- Secure equipment to floors and walls to prevent movement during earthquakes.
- Place fire extinguishers near critical equipment, train staff in their use, and inspect fire extinguishers at intervals according to manufacturer's recommendations. The locations are to be listed on the evacuation plan map.

f. Relocation of services

In a disaster that makes a clinic facility unusable, the Chief of Clinic Services Division will work with the County MHOAC to identify health facilities able to accept referrals of clinic patients and may deploy clinic personnel to other facilities as directed.

g. Restoration of utilities

The Chief of Clinic Services will request priority status for maintenance and restoration of service from local utility providers.

h. Emergency power supply

HSA's Administrative Services maintains a backup generator or UPS at each health center to power vital areas such as the medication refrigerators during a power outage.

### 3.10 Emergency and Surge Levels

Surge Level	Description	Clinic Services Division Leadership Staff Roles
Level 1: Facility only	<p>An internal situation or emergency exists within a clinic facility that has impacted services. Could include, but not limited to:</p> <ul style="list-style-type: none"> <li>• Severe staff shortage</li> <li>• Utility or water disruption</li> <li>• Computer/communications outage.</li> <li>• Fire, structural damage, or other safety hazard limited to one building.</li> </ul>	<ul style="list-style-type: none"> <li>• Assess facility, services, patients, staff, and supplies limitations.</li> <li>• Communicate with other agencies as needed.</li> <li>• Resume normal patient care as soon as possible.</li> </ul>
Level 2: Operational Area (County)	<p>A community/regional situation exists that has or will soon impact the safety of patients in the facility. Could include, but not limited to:</p> <ul style="list-style-type: none"> <li>• Extensive utility or communication disruption.</li> </ul>	<p>As above, plus:</p> <ul style="list-style-type: none"> <li>• Communicate with other agencies.</li> <li>• Attend to CAHAN communications and MHOAC directions.</li> <li>• Assess communications devices.</li> </ul>

	<ul style="list-style-type: none"> <li>• Natural or man-made disaster with severe impacts to the community</li> <li>• Communicable disease outbreak.</li> <li>• Contamination with chemical, biological, or radiobiological agent.</li> </ul>	<ul style="list-style-type: none"> <li>• Assess transportation supplies, power.</li> <li>• Consider Alternate Care Site (ACS)</li> <li>• Provide triage, first aid and urgent care. Cancel routine care.</li> <li>• Ration/conserves supplies.</li> <li>• Maintain security, crowd control.</li> <li>• Shelter in place or evacuate as instructed.</li> </ul>
Level 3: Region/State and/or Federal	<p>A widespread disaster or attack threatens the region, state or country. Could include, but not limited to:</p> <ul style="list-style-type: none"> <li>• Extensive utility or communication disruption</li> <li>• Natural or man-made disaster with severe and widespread impacts</li> <li>• Terrorist attack</li> <li>• Pandemic</li> </ul>	As above and as directed by government emergency operations centers.

### 3.11 Clinic Patient Surge Preparedness

3.11.1 Surge capacity encompasses health center resources required to deliver health care under situations which exceed normal capacity, including potential available space in which patients may be triaged, managed, vaccinated, decontaminated, or simply located; available personnel of all types; necessary medications, supplies and equipment; and even the legal capacity to exceed authorized care capacity.

3.11.2 Normal clinic capacity could be exceeded during any type of emergency for reasons that include one or more of the following:

- Random, seasonal, or epidemic spikes in numbers of presenting patients.
- Convergence of ill or injured resulting from disasters.
- Convergence of patients with behavioral health needs that results from emergencies.

Events that create patient surge may also reduce clinic resources through exhaustion of supplies and pharmaceuticals and reduced staff availability. Staff may be impacted directly by the emergency, the inability to reach Clinic Services Division Staff, and/or by the requirement to meet commitments at other health facilities.

### 3.11.3 Medical and behavioral health provider capacity

Clinic Services Division Administration maintains a group of credentialed providers to assist with both normal and emergency fluctuations in provider availability and patient demand.

### 3.11.4 Patient flow and site planning

- a. Clinic Services Division Clinical Staff at each site will periodically review patient flow and identify areas on clinic grounds that can be converted for triage, patient holding, medical treatment, behavioral health treatment, and isolation.
- b. The Clinic Services Division Facilities have very limited rooms with adequate ventilation and controlled access to properly isolate victims contaminated with chemical or biological agents. When isolation is necessary, staff will use the nearest or best available room with a closing door and place a sign on the door to restrict access until the patient can be transported to an appropriate facility.
- c. The ICS team will ensure triage and isolation areas are accessible to emergency vehicles and to patients.

3.11.5 Clinic Services Division Staff may also be able to refer/divert patients to nearby clinics if a clinic site is damaged, overwhelmed, or obtain space and support from other providers.

## 3.12 Behavioral Health Surge Preparedness

3.12.1 Clinic Services Division must be prepared for a surge in behavioral health caseload in the event of an emergency, disaster, or terrorist/violent incident. All such incidents have a behavioral health impact, even for those not injured or directly involved. Research suggests that there may be many more people needing behavioral health care than physical care. Those in need would include patients, family members of the ill and injured, the bereaved, witnesses, clinic staff, and emergency workers. Even incidents that do not result in a medical surge may cause trauma, anxiety, and other behavioral health needs.

3.12.2 The Integrated Behavior Health (IBH) Director will establish an Emergency Behavioral Health Team to be activated as needed. The team will include IBH staff and other clinical/non-clinical staff who have been trained for crisis intervention and de-briefing.

3.12.3 IBH Director will maintain a contact list and communication chain or phone tree to efficiently activate the Emergency Behavioral Health Team.

3.12.4 The Emergency Behavioral Health Team has an important role in the dissemination of credible information and reassurance during and after an emergency. When appropriate, the Chief of Clinic Services Division may open an Emergency Drop-In Center for support, de-briefing, and information needs of patients, families, and staff.



### **3.13 Disaster Medical Resources**

#### **3.13.1 Personnel**

3.13.1.1 Clinic Services Division Health Center Managers will rely primarily on its existing staff for response to emergencies and will, therefore, take the following measures to estimate staff availability for emergency response:

- Identify clinical staff with conflicting practice commitments.
- Identify staff with distance and other barriers that limit their ability to report to Clinic Services Division Health Center Managers.
- Identify key staff who are likely to be able to respond rapidly to the clinic site.
- Identify staff with Spanish language capabilities.

3.13.1.2 To facilitate response to clinic emergencies by its staff when their homes and families may be impacted, Clinic Services Division Leadership Staff will promote staff home emergency preparedness.

3.13.1.3 Personal Protective Equipment (PPE):

- a. Chief of Clinic Services Division will take measures to protect its staff from exposure to infectious agents and hazardous materials. Clinic health care workers will have access to and be trained on the use of personal protective equipment.
- b. Front or back office staff will access protective equipment when a patient with a suspected infectious disease presents.

### **3.14 Training, Exercises and Plan Maintenance**

#### **3.14.1 Employee Orientation and Annual Training**

All employees will learn the following information from their new employee orientation or subsequent safety training. This checklist will also be used to design facility-wide drills to test the Clinic Services Division's emergency response capabilities. Employee essential knowledge and skills include:

- The location and operation of fire extinguishers.
- The location of fire alarm stations and how to shut off fire alarms.
- When to dial 911.
- How to assist patients and staff in the evacuation of the premises.
- Location of Emergency Kit of first aid supplies, and other supplies such as spill kit, HAZMAT suits, patient forms, staff timecards, analogue phone, etc.
- Location and use of medical emergency equipment including AED and oxygen (medical staff and staff trained on AED).
- Location and use of personal protective equipment (PPE).
- Actions to be taken during fire and other emergency drills.

All employees must also attend annual training and updates on emergency preparedness, including elements of this plan.

### 3.14.2 Drills and Exercises

3.14.2.1 Clinic Services Division Staff will rehearse the emergency plan annually with table-top drills and functional exercises. All drills shall include an after-action debriefing evaluating the drill or exercise. Exercises should include one or more of the following response issues in the scenarios:

- Clinic evacuation
- Coordination with government emergency responders
- Continuity of operations
- Expanding clinic surge capacity

3.14.2.2 Clinic Services Division Staff will participate in community drills that assess communication, coordination, and the effectiveness of the community's command structures.

### 3.14.3 Evaluation

3.14.3.1 After each activation of the emergency plan for a drill or an actual emergency, the Emergency Preparedness Coordinator and Clinic Services Division Leadership will evaluate effectiveness and identify gaps in planning, resources, and staff skills. Gaps will be identified in an after-action evaluation or hot wash.

3.14.3.2 Based on the after-action evaluation, Clinic Services Division Leadership will develop and implement a corrective action plan that includes recommendations for one or more of the following:

- Additional training and exercises.
- Changes in disaster policies and procedures.
- Plan updates and revisions.
- Acquisition of additional resources.
- Enhanced coordination with response agencies.

### 3.14.4 Plan Development and Maintenance

3.14.4.1 The Emergency Preparedness Coordinator is responsible for coordinating the development and implementation of a comprehensive emergency preparedness program and this plan.

The Emergency Preparedness Coordinator will review and update this plan at least annually. The plan will also be reviewed following its activation in response to any emergency, following exercises and other tests, as new threats arise, or as policies and procedures require.

3.14.4.2 The clinic environment undergoes frequent change including remodeling, construction, installation of new equipment, and changes in

key staff. When these events occur, the Emergency Preparedness Coordinator will review and update the Emergency Operations Plan to ensure:

- Evacuation routes are reviewed and updated.
- Emergency response duties are assigned to new staff, if needed.
- The locations of key supplies, hazardous materials, etc. are updated.
- Vendors, repair services and other key information for newly installed equipment are incorporated into the plan.

## **4 RESPONSE**

### **4.1 Introduction**

During this phase, Clinic Services Division Leadership Staff will mobilize the resources and take actions required to manage its response to emergencies. This plan may be activated in response to events occurring within the clinic or external to it. The Chief of Clinic Services, or designee, may also activate the plan at the request of the County MHOAC.

### **4.2 Response Priorities**

Clinic Services Division Leadership Staff have established the following emergency response priorities:

- Ensure life safety – protect life and provide care for injured patients, visitors, and staff present in clinic facilities at the time of disaster.
- Contain hazards to protect life, prevent injury, and safeguard the environment.
- Protect critical infrastructure, facilities, vital records and other data.
- Resume the delivery of patient care, prioritizing current patients and staff.
- Support the overall community response.
- Restore essential services/utilities.
- Provide crisis public information.

### **4.3 Alert, Warning and Notification**

Disasters can occur both with and without warning. Upon receipt of an alert from the County MHOAC or other credible sources, the Chief of Clinic Services will notify leaders and managers, order the updating of phone lists, and the inspection of protective equipment and supply and pharmaceutical caches. The Chief of Clinic Services, in consultation with the Clinic Leadership Staff and Safety and Facilities Manager will determine if health center sites remain open or close.

Depending upon the nature of the warning and the potential impact of the emergency on Clinic Services Division Staff, the Chief of Clinic Services Division may activate the Incident Command System (see Appendix A) and decide to evacuate the facility; suspend or curtail clinic operations; take actions to protect equipment, supplies and records; move equipment and supplies to secondary sites; backup and secure computer files; or other measures appropriate to reduce patient and staff risk. If clinics are to close, leaders will encourage patients and staff to return home or shelter-in-place as appropriate.

Chief of Clinic Services Division will communicate clinic situation status to County MHOAC.

### **4.4 Response Activation and Initial Actions**

Any employee or staff member who observes an incident or condition that could result in a hazard or emergency should report it immediately to his/her supervisor or a member of the management team. For fires, serious injuries, threats of violence and other serious emergencies, staff should immediately call 911.

If the emergency significantly impacts patient care capacity or the community served by Clinic Services Division Staff, the Chief of Clinic Services Division will notify the County MHOAC.

#### **4.5 Emergency Management Organization**

Clinic Services Division Leadership Staff will organize its emergency response structure to clearly define roles and responsibilities and quickly mobilize response resources. The Clinic Services Division Leadership Staff will use the Standardized Emergency Management System (SEMS) Incident Command System (ICS) model to manage its response to disasters. ICS is a standardized management system used by government agencies and hospitals in emergency response. ICS staffing builds from the top down and allows for rapid expansion and contraction of deployed staff as an incident unfolds or concludes. See Appendix A for details on ICS structure, roles, and responsibilities.

#### **4.6 Clinics Command Center Operations**

- 4.6.1 The Incident Commander activated the Clinics Command Center in consultation with the Chief of Clinic Services and/or Medical Director during an emergency which creates one or more of the following circumstances:
- One or more clinic site will be inoperable for more than 24 hours during its normal work week.
  - Coordination is required with the County MHOAC or local medical responders over an extended period of time.
  - Clinic Services Division requires augmentations of medical supplies, pharmaceuticals or personnel.
  - Clinic Services Division Leadership Staff needs to coordinate movement of patients to other facilities through the Operational Area EOC.
  - Damage to a clinic facility or operations is sufficient to require management to set priorities for restoring clinic services and manage the full restoration of services over an extended period of time.
  - A public alert system warns of need for immediate or potential evacuation.
  - There is a locally declared disaster with potential for illness or injury in the Clinic Services Division service area.
- 4.6.2 The Clinics Command Center will be located in the administrative offices at 1080 Emeline Avenue, Santa Cruz. Medical Operations will be located in the Clinic Services Division Provider Rooms at 1080 Emeline Avenue, Santa Cruz, 115 Coral Street, Santa Cruz, and 1430 Freedom Blvd, Watsonville. In the event that either or all sites are obstructed or inoperable, the Incident Commander will choose a new location based on environmental conditions.
- 4.6.3 Required supplies include copies of this disaster plan, copies of the ICS chart for assigning role, forms for recording and managing information, paper patient forms, frequently used telephone numbers, pens, floor plans, and alternative communications equipment.

- 4.6.4 The Incident Commander will deactivate the Clinics Command Center when the threat subsides, the response phase ends, and recovery activities can be performed at normal workstations.

#### **4.7 Decision on Clinic Operational Status**

Following the occurrence of an internal or external disaster or the receipt of a credible warning, the Chief of Clinic Services, in consultation with the Clinic Services Division Leadership Staff, will decide the operating status for Clinic Services Division. The decision will be based the nature and severity of the disaster and whether the health centers can operate safely and effectively.

- 4.7.1 The decision to evacuate a Clinic Services Division site, return to the facility and/or re-open the facility for partial or full operation depends on an assessment of the following:

- Extent of facility damage/operational status
- Status of utilities (e.g. water, sewer lines, gas and electricity)
- Presence and status of hazardous materials
- Condition of equipment and other resources
- Environmental hazards near the facility
- Sanitary conditions in the facility
- Security conditions

- 4.7.2 If it is safe to do so, Clinic Services Division will stay open and provide medical care. First priority will be first aid and urgent care for current patients and staff. The Medical Director and/or other qualified staff will assess when and if the health center has the resources to help other patients or see existing patients for full scope services.

#### **4.7.3 Staff Responsibility to Report**

In the event of an emergency or disaster, all staff must call in to their supervisor to learn whether their facility will be open and to report their ability to work. Unless it is unsafe at the facility or vicinity or unsafe to travel, staff are strongly encouraged to report for their regularly scheduled shifts and asked to make themselves available for additional hours if requested. Staff should talk to their supervisor about any concerns for safety. Staff who are injured, ill, or need to care for family members must still call in to report that they cannot come to work and why.

#### **4.7.4 Operating without electrical power**

Clinic Services Division maintains a backup generator or uninterruptible power supply (UPS) to power vital areas such as the medication refrigerators during a power outage. In the event that the generator or UPS fails or runs out of fuel before power is restored, the clinics will continue to see patients as able.

Staff will use flashlights to see patients for urgent care and maintain paper medical records in lieu of the electronic medical record (EMR).

## **4.8 Medical Care**

### **4.8.1 Medical Management**

To the extent possible, people injured and/or traumatized on-site during an internal or external disaster will be given first aid and/or psychological first aid by the clinic staff. Patients, visitors, or staff who requires medical evaluation or minor treatment will be treated and referred to their physician, or an appropriate medical or behavioral health facility.

To avoid overloading the hospital emergency room during a community-wide emergency, patients with minor injuries will be treated on site or referred to the nearest operating urgent care site.

If the circumstances do not permit treating patients at Clinic Services Division sites, they will be referred to the nearest open urgent or emergency care facility, depending on the nature of the injuries.

If immediate medical attention is required and it is not safe or appropriate to refer the patient to the emergency room, 911 will be called and the patient will be sent by ambulance to the nearest emergency room. If 911 services are not available, the Incident Commander will make a request for medical transport to the Santa Cruz County Medical Health Operational Area Coordinator (MHOAC).

#### **4.8.1.1 Triage/First Aid Procedures**

##### **a. Triage site**

For each clinic site, the Medical Director or Clinic Manager will establish a site with controlled access for triage and first aid under the direction of a designated licensed medical provider, nurse, or other professional trained in triage.

##### **b. Assessment**

The triage provider will assess victims' needs for medical and behavioral health treatment. Triage decisions will be based on the patient condition, clinic status, availability of staff and supplies and the availability of community resources. Triage staff will:

- Register all patients entering the triage area and tag with patient name.
- Categorize patients for immediate or delayed treatment, medical or behavioral health care.
- Arrange for transport of patients requiring higher levels of care as rapidly as possible through 911 or the County MHOAC.
- Direct uninjured yet anxious patients to the area designated for behavioral health treatment and information. Recognize that some

chemical and biological agents create symptoms that manifest themselves behaviorally.

c. Treatment

The clinical staff will provide medical and behavioral health services within Clinic Services Division's capabilities and resources. Additional resources may be requested through procedures outlined in Section 4.10.

d. Suspected bioterrorism attack or other chemical/ biological hazard

If a hazardous or contagious agent is suspected, staff in the triage area will wear Hazmat Suits and will isolate infected patients from other patients until they can be transported to the emergency room. Staff will use standard infection control standards at all times and implement decontamination procedures as appropriate.

4.8.2 Surge capacity

4.8.2.1 Clinic Services Division Staff follows surge guidelines established by the Santa Cruz County HCC.

4.8.2.2 The Chief of Clinic Services Division, Medical Director, or Incident Commander will activate Clinic Services Division procedures for increasing surge capacity when  
1) civil authorities declare a bioterrorist emergency or other disaster that affects the community, or  
2) clinic utilization or anticipated utilization substantially exceeds clinic day-to-day capacity with or without the occurrence of a disaster.

Clinic Services Division Leadership Staff will take the following actions to increase clinic surge capacity:

- Establish a communication link with County MHOAC at the County DOC or EOC.
- Periodically report clinic status, numbers of ill/injured, types of presenting conditions and resource needs and other information requested by the County MHOAC in a format defined by the Operational Area (OA).
- Reduce patient demand by canceling or rescheduling non-essential visits.
- Refer patients to open urgent or emergency care facilities as appropriate.
- Clinic Services Division Leadership Staff will prioritize current patients and staff and will accept new patients as resources permit.

4.8.3 Confidentiality and liability

a. Security of medical records and the confidentiality of patient information remain important even during emergency conditions. Clinic Services



Division Staff will take feasible and appropriate steps to ensure confidential information is protected.

- b. Clinic Services Division Staff will collect new patient information and consent and document visits in the medical record per normal procedure or on paper forms if the electronic system is inoperable.
- c. Due to legal liabilities, staff will never transport patients in private vehicles under any circumstance. In a widespread emergency, the County MHOAC will determine how and where to transport victims through already established channels selected by the County.
- d. Children will be allowed to leave only with parents, family members or other adults who accompanied them to the clinic and who provide confirming identification (e.g., driver's license or other government identification). If no appropriate adult is available, staff will:
  - Provide a safe supervised site for children away from adults.
  - Attempt to contact each child's family.
  - If contact is not possible, contact Child Protective Services to provide temporary custodial supervision until a parent or family member is located.

#### **4.9 Behavioral Health Care**

##### **4.9.1 Designated Assessment and Treatment Area**

The Integrated Behavioral Health (IBH) Director, in consultation with Incident Commander and Medical Director, will establish a separate site for behavioral health assessment, triage, and care in an emergency.

##### **4.9.2 Activation of Emergency Behavioral Health Team**

Depending on the type of emergency and the anticipated surge level, the Incident Commander will alert the IBH Director to activate the designated Emergency Behavioral Health Team.

##### **4.9.3 Emergency Drop-In Center**

As determined by the Incident Commander, an Emergency Drop-In Center may be established and manned to provide immediate support and de-briefing for those in need. Those served may include patients, patients' family members, emergency personnel, staff, and members of the community.

##### **4.9.4 Communications**

The IBH Director or other IBH staff should be included in ICS communication planning. The Emergency Behavioral Health Team help disseminate accurate information and reassurance to those seeking information and care.

##### **4.9.5 Additional Staffing**

During an emergency, when ICS is activated, all requests for additional personnel go through the Incident Commander as described in section 4.10.

The local Red Cross Disaster Mental Health Team, Medical Reserves Corps and local pastoral care professionals may be available for additional support.

#### **4.10 Acquiring Response Resources**

The ICS team should carefully monitor medical and pharmaceutical supplies and staffing availability. The Incident Commander will request augmentation of resources from County MHOAC at the earliest sign that stocks may become depleted or staffing will be insufficient. See the Santa Cruz County Healthcare Emergency Operations Guide (EOG) for current procedures for Situation Status Reporting and Resource Requesting.

Clinic Services Division Staff will maximize use of supplies available from vendors and other clinics and facilities as feasible.

#### **4.11 Emergency Procedure for Offsite Staff**

Staff may be offsite during an emergency or disaster. Offsite work may include training sessions, meetings, outreach events, or travel to and from designated work events. It is critical that staff know what to do if an emergency or disaster occurs, whether the incident impacts their offsite work location, travel, or their worksite.

When a disaster occurs while working offsite, staff should take the following actions:

- Stay calm.
- Take emergency actions to ensure safety of self and others.
- If driving, pull over when safe to do so. Remain in vehicle until safe to seek shelter at a nearby building, if available.
- Follow Clinic Services Division emergency contact procedures to check in.
- Do not attempt to return to Clinic Services Division sites until have verified that road conditions are safe and been instructed if and where to return.

#### **4.12 Communications**

##### **4.12.1 Communication with staff**

Communication with staff is one of the first priorities in an emergency. The Incident Commander and Team will:

- Designate a point person for staff communications.
- Develop and deliver a concise message for all staff onsite.
- Use the emergency phone tree to deliver the message to all staff off duty or offsite.
- Record the message on the staff emergency call-in line and have a point person take questions and concerns from staff. As noted previously, staff are required to call in during an emergency and report for scheduled or additional shifts if safe to do so and if the Clinic Services Division are operating in emergency or regular mode.

##### **4.12.2 Communication with Patients**

All staff are responsible to help patients remain calm and behave safely during an emergency. Incident Commander and Team will:

- Develop and deliver a concise message to all patients on premises.
- Post a sign on the clinic door with current status of clinic and when normal operations are expected to resume, if known.
- If conditions allow, update the outgoing bilingual voicemail with current status of clinic operations and when normal operations are expected to resume, if known.
- Develop an announcement to local newspapers and radio stations, to be conveyed by Public Information Officer.
- If conditions and resources allow, update website and all social media interfaces with appropriate announcement.
- If conditions and resources allow, assign staff to call scheduled patients to cancel or reschedule patients for that day and foreseeable future days of interrupted operations.

#### 4.12.3 Communication with outside agencies and the media

The Chief of Clinic Services or Incident Commander will inform and consult with the HSA's Public Information Officer (PIO) and/or the County of Santa Cruz's PIO, as needed, to use communications resources to communicate with:

- The Santa Cruz County Medical Health Operational Area Coordinator
- Emergency response agencies
- Outside relief agencies
- Other clinics
- Media news outlets

4.12.3.1 All external communications will go through the Public Information Officer and be authorized by the Incident Commander unless emergency conditions require immediate communications. Incoming messages will be shared with relevant ICS team members.

#### 4.12.4 Communication with HRSA

The Health Resource and Services Agency (HRSA) Bureau of Primary Health Care (BPHC) has oversight for Federally Qualified Health Center (FQHC) status. HRSA BPHC Policy Information Notice 2007-15 requires that clinics submit data to BPHC Project Officer before, during or after emergency events as requested. HRSA may request the status of health center operations, patient capacity, and/or staffing/resource/infrastructure needs.

### 4.13 Response to Internal Emergencies

An *internal emergency* is an event that causes or threatens to cause physical damage to the clinic facility or injury to patients, visitors, or staff. Examples are fire,

explosion, hazardous materials releases, violence or bomb threat. External disasters may also create internal emergencies.

Any employee or staff member who observes an incident or condition that could result in an internal emergency should report it immediately to his/her supervisor or a member of the management team. For fires, serious injuries, threats of violence and other serious emergencies, staff should immediately call 911.

#### 4.13.1 Clinic evacuation

Clinic Services Division sites may be evacuated due to a fire, hazardous material spill, or other occurrence, threat, or by order of the Chief of Clinic Services, Incident Commander, or designee. The Clinic Services Division Leadership Staff will ensure that all employees are oriented to evacuation procedures and conduct an evacuation drill at least annually.

#### 4.13.2 Damage assessment

Clinic Services Division Leadership Staff will conduct an assessment of damage caused by the disaster to determine if an area, room, or building can continue to be used safely or is safe to re-enter following an evacuation. Systematic damage assessments are indicated following an earthquake, flood, explosion, hazardous material spill, fire or utility failure. The facility may require three levels of evaluation:

- Level 1: A rapid evaluation to determine if the building is safe to occupy
- Level 2: A detailed evaluation to address structural damage and utilities
- Level 3: A structural/geological assessment

Depending on the event and the level of damage, fire or police personnel may conduct a Level 1 or 2 assessment. If damage is major, a consulting engineering evaluation, assessment by a county engineer, and/or an inspection by the licensing agency may be required before the health center can reopen for operations.

Following each level of evaluation, inspectors will classify and post each building as: 1) Apparently OK for Occupancy; 2) Questionable: Limited Entry; 3) Unsafe for any Occupancy. In some cases, immediate repairs or interim measures may be implemented to upgrade the level of safety and allow occupancy.

#### 4.14 Extended Clinic Closure

If the Clinic Services Division sites experiences major damage, loss of staffing, a dangerous response environment or other problems that severely limit its ability to meet patient needs, the Incident Commander, in consultation with the Chief of Clinic Services, may suspend clinic operations until conditions change. If that decision is made, the Clinic Services Division Leadership Staff will:

- If possible, ensure clinic site is secure.

- Notify staff of clinic closure and require that they remain available for return to work unless an exception is granted.
- Notify the Santa Cruz County Medical Health Operational Area Coordinator (MHOAC) of its change in status. Request location of nearest source of medical services.
- Notify the California Department of Health Services Licensing and Certification Division, local field office or other appropriate licensing agency.
- Notify the nearest hospital(s) and clinic(s) of the change in Clinic Services Division operating status and intent to refer patients to alternate sources of care.
- Place a sign on the health center(s) in appropriate languages that explains the circumstances, indicates when the health center intends to reopen (if known), and location of nearest source of medical services.
- If the environment is safe, station staff at health center entrance to answer patient questions and make referrals.
- Implement business recovery operations.

#### **4.15 Bioterrorism Response**

Per California Code of Regulations Title 17, Section 2500 the Clinic Services Division Staff will immediately report diseases suspected of resulting from bioterrorist agents to the Santa Cruz County Health Services Agency Epidemiologist and the County MHOAC. See Appendix D for details on Bioterrorism Response including infection control, collection of evidence, and mass prophylaxis.

## **5 RECOVERY**

Recovery actions begin immediately following the emergency to restore essential services and resume normal operations as quickly as possible. Depending on the emergency's impact on the organization, this phase may require a large amount of resources and time to complete. In a community-wide event, it may be necessary to expedite resumption of health care services to address unmet community medical needs.

This phase includes activities taken to assess, manage and coordinate the recovery from an event as the situation returns to normal. These activities include:

### **5.1 Deactivation of Emergency Response**

The Incident Commander, in consultation with the Chief of Clinic Services Division or designee, will call for deactivation of the emergency when the health center(s) can return to normal or near normal services, procedures, and staffing.

### **5.2 Recovery Support for Staff and Patients**

- 5.2.1 Behavioral health needs of patients and staff are likely to continue during the recovery phase. The Integrated Behavioral Health Director will continue to monitor for and respond to the behavioral health needs of patients and staff.
- 5.2.2 The Personnel Department and the Integrated Behavioral Health Director will collaborate to establish an employee support system. Human Resources will coordinate referrals to employee assistance programs as needed.
- 5.2.3 Local pastoral care professionals may be another source of support for staff, patients, and families.
- 5.2.4 Clinic Services Division Leadership Staff recognizes that staff and their families are impacted by community-wide disasters. Clinic Services Division Leadership Staff will assist staff in their recovery efforts to the extent possible.

### **5.3 Documentation of Damages and Disaster-Related Losses**

- 5.3.1 The ICS Commander will immediately begin gathering complete documentation, including photographs, of damages to facilities, grounds and equipment. They will annotate the pre-emergency clinic equipment inventory list with serial numbers and costs to provide a list of damaged equipment to Operations Director, Chief of Fiscal, and Director of Administrative Services.
- 5.3.2 The Chief of Fiscal or delegate will work with the ICS Team to document all expenses incurred from the disaster. Documentation will include direct operating cost, revenue lost through disruption of services, costs from increased use and unreimbursed urgent care, all damaged or destroyed equipment, replacement of capital equipment, and construction related expenses.
- 5.3.3 The Chief of Fiscal will oversee an audit trail to assist with qualifying for any Federal reimbursement or assistance available for costs and losses incurred by the Clinic Services Division as a result of the disaster.

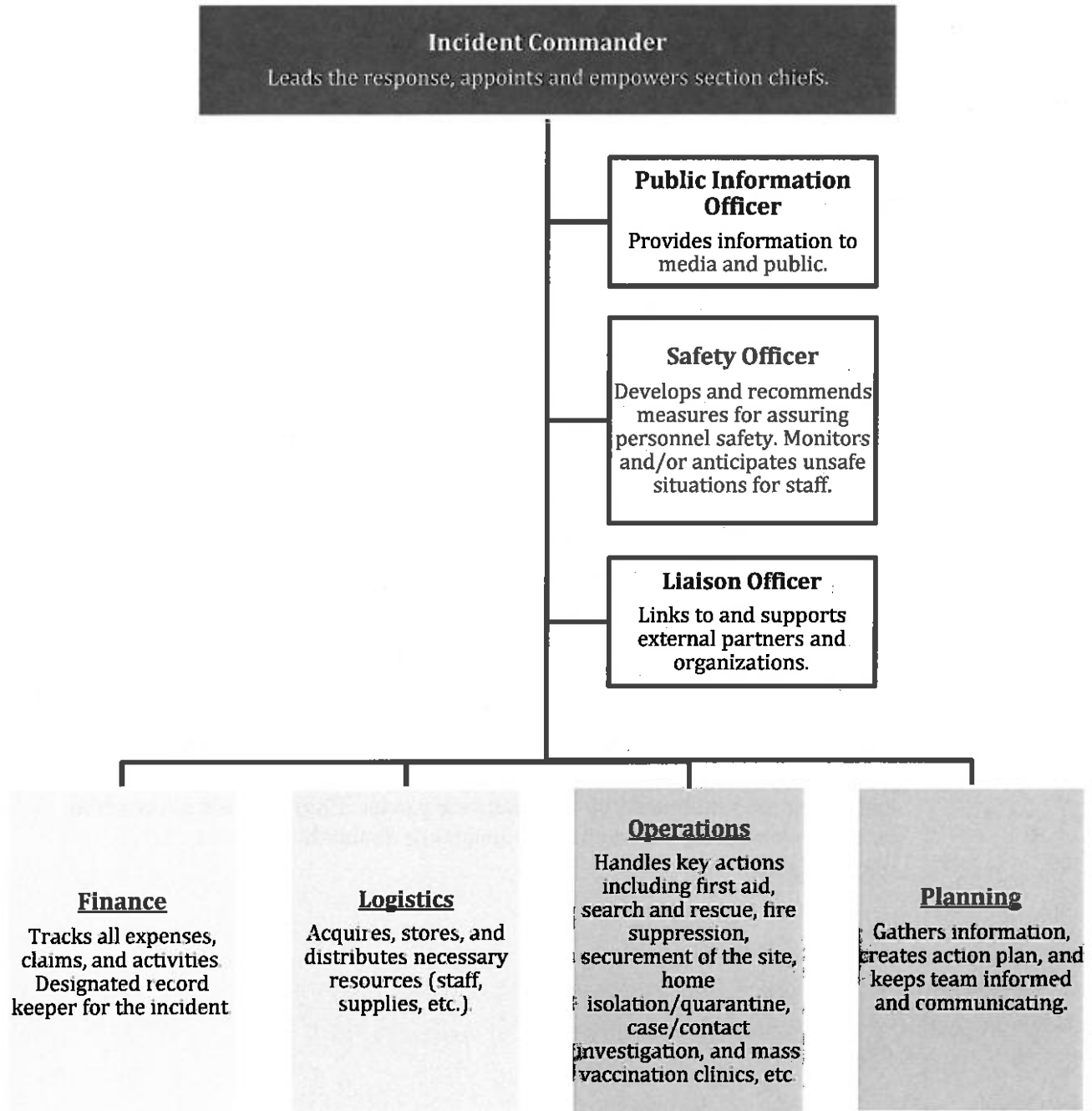
## **5.4 Cost and Loss Recovery**

Depending on the conditions and the scale of the incident, the Chief of Fiscal will seek financial recovery resources as available.

- 5.4.1 The eligibility of clinics for federal reimbursement for response costs and losses remains ambiguous. It may be possible to gain reimbursement through County channels under some circumstances.
- 5.4.2 FEMA/OES - After a disaster occurs and the President has issued a Federal Disaster Declaration, assistance is available to applicants through FEMA and the OES. The Small Business Administration (SBA) provides physical disaster loans to businesses for repairing or replacing disaster damages to property owned by the business. Businesses and non-profit organizations of any size are eligible.
- 5.4.3 Federal Grant - Following a presidential disaster declaration, the Hazard Mitigation Grant Program (HMGP) is activated. A private non-profit facility is eligible for emergency protective measures (i.e., emergency access such as provision of shelters or emergency care or provision of food, water, medicine, and other essential needs), and may be eligible for permanent repair work to restore the damaged facility's pre-disaster design, function and capacity.
- 5.4.4 Cal EMA – The California Emergency Management Agency may reimburse clinics for disaster assistance activities if:
  - The Governor of California declared the emergency.
  - All of the activities were performed within 6 months of the proclamation (unless Cal EMA provided prior written authorization).
  - The clinic acted as part of a larger emergency response network and was asked by local or state government to provide services or had a prior written agreement in place specifying the circumstance under which the clinic would provide services.
- 5.4.5 Insurance Carriers – The Clinic Services Division will file claims with its insurance companies for damage to any Clinic Services Division facilities. Clinic Services Division will not receive federal reimbursement for costs or losses that are reimbursed by the insurance carrier. Eligible costs not covered by the insurance carrier, such as the insurance deductible, may be reimbursable.

## APPENDIX A: Incident Command Systems

The Incident Command System (ICS) is an organization structure used for the command, control, and coordination of emergency response. Hospital Command Centers, Departmental Operations Centers, and Emergency Operations Centers utilize ICS.





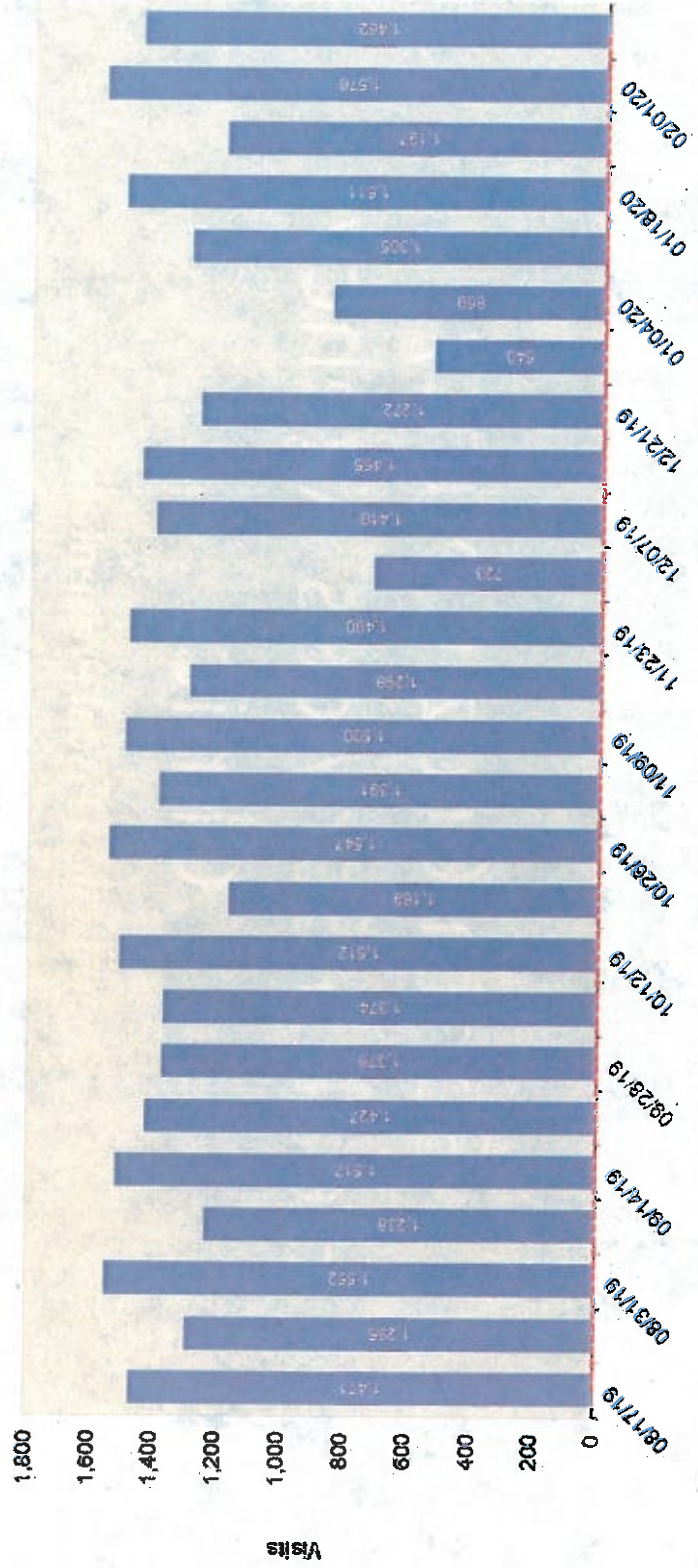
# Santa Cruz County Health Services Agency Clinics

Commission Fiscal Presentation

03/05/20

Dr. Julian N. Wren MSW, Ed.D.

# Visits



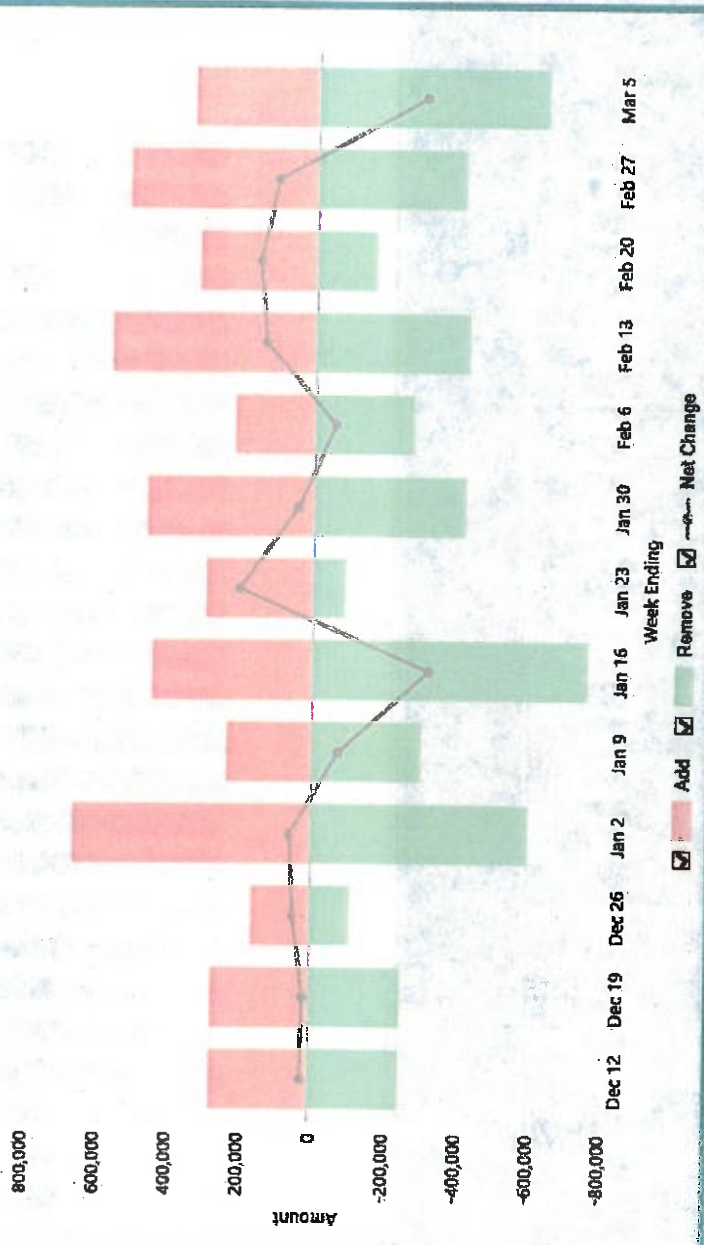
# Total Aging % of Total



# Visits

## PB Workqueue Activity - All Owning Areas by Amount

© Data collected: Thu 3/5 02:26 AEST



# Financials Report


County of Santa Cruz (HSA)  
 FY 19/20 (All) CLINIC(All)  
 0

GLKey	(All)
Division	CLINIC
Object	(All)

Row Labels	Sum of Budget	Sum of Actual	Percent Remaining
REVENUE	(44,827,400)	(18,287,016)	39.21%
CLINIC ADMINISTRATION	(2,526,301)	(1,525,638)	39.61%
CORAL STREET CLINIC (HPHP)	(5,059,664)	(1,507,094)	70.21%
EMELINE CLINIC	(12,561,394)	(4,577,409)	63.56%
MENTAL HEALTH FQHC	(9,530,841)	(3,546,700)	62.79%
WATSONVILLE CLINIC	(12,400,200)	(5,696,411)	54.06%
WATSONVILLE DENTAL	(2,750,000)	(1,433,765)	47.86%
EXPENDITURE	44,951,812	21,037,732	53.20%
CLINIC ADMINISTRATION	7,297,439	3,847,465	47.28%
CORAL STREET CLINIC (HPHP)	6,033,429	2,192,926	63.65%
EMELINE CLINIC	9,999,064	6,008,563	39.91%
FORENSIC SERVICES	21,580	38,178	-76.91%
MENTAL HEALTH FQHC	9,530,841	3,579,510	62.44%
WATSONVILLE CLINIC	10,468,959	5,052,082	51.74%
WATSONVILLE DENTAL	1,600,500	319,057	80.07%
Grand Total	124,412	2,750,716	-2110.98%

# Financials Forecast

Row Labels	Forecasted as of 1/31/20	Actual	Difference	% Difference Forecast vs. Actual	Notes
REVENUE	(26,149,317)	(18,287,016)	(7,862,301)	70%	Revenue Down
15-INTERGOVERNMENTAL REVENUES	(2,885,514)	(1,870,684)	(1,014,830)	65%	
19-CHARGES FOR SERVICES	(22,029,505)	(15,973,501)	(6,956,003)	70%	
23-MISC. REVENUES	(334,298)	(442,830)	108,532	132%	
EXPENDITURE	26,221,890	21,037,732	5,184,158	80%	Expense Correlation to Revenue Down
50-SALARIES AND EMPLOYEE BENEF	15,158,018	13,681,389	1,476,629	90%	
60-SERVICES AND SUPPLIES	3,530,173	1,959,843	1,570,329	51%	
70-OTHER CHARGES	1,599,162	1,767,128	(167,966)	111%	
80-FIXED ASSETS	188,612	129,356	59,256	69%	
90-OTHER FINANCING USES	58,333	0	58,333	0%	
95-INTRAFUND TRANSFERS	5,387,593	3,500,016	1,887,576	65%	
Grand Total	72,574	2,750,716			

<p><b>SUBJECT:</b> Billing Department Ability to Pay (Sliding Fee Scale Program) Policies and Procedures</p> <p><b>SERIES: 100</b> Administration</p> <p><b>APPROVED BY:</b> Amy Peeler, Chief of Clinic Services</p>	<p><b>POLICY NO.:</b>  <b>100.04</b></p> <p><b>PAGE: 1 OF 4</b></p> <p><b>EFFECTIVE DATE:</b> March 2020</p> <p><b>REVISED:</b> January 2020</p>	 <p>COUNTY OF SANTA CRUZ HEALTH SERVICES AGENCY</p> <hr/> <p><b>Clinics and Ancillary Services</b></p>
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**PURPOSE:**

The purpose of this policy is to reduce and/or eliminate financial barriers to patients who qualify for the Ability to Pay (ATP) (Sliding Fee Discount Program) to ensure access to services regardless of the patient’s ability to pay. At no time will a patient be denied services because of an inability to pay.

The ATP applies to the full scope services provided by Health Services Agency’s (HSA) Clinic Services Division, which includes Primary Care, Integrated Behavioral Health, Acupuncture, and Dental Services.

**POLICY STATEMENT:**

The Health Services Agency (HSA) Clinic Services Division operates county-run community health centers. The purpose of this policy is to describe all billing policies and procedures currently in use for ensuring assets are safeguarded, guidelines of grantors are complied with, and finances are managed with accuracy, efficiency, and transparency.


It is the policy of County of Santa Cruz Health Services Agency (HSA) to comply with government regulations. HSA is a Federally Qualified Health Center (FQHC) and received federal funding under the Health Center Program authorized by Section 330 of the Public Health Services (PHS) Act (42 U.S.C. 254b) (“section 330”), as amended (including sections 330C and (h)). The program is administered by the federal Health Resources and Services Administration (HRSA)

HSA staff with a role in the management of billing operations are expected to comply with the policies and procedures in this manual.

These policies will be reviewed annually and revised as needed by the staff and approved by the Integrated Community Health Center Commission, the Chief of Clinic Services, and HSA Director.

**PROCEDURE:**

- A. Billing Overview: Clinic Services Division will provide methods for appropriate and sensitive evaluation of each patient's ability to pay for services rendered.
  - 1. Financial screening of each patient shall not impact health care delivery.


<b>SUBJECT:</b> Billing Department and Front Office Operations Policies and Procedures	<b>POLICY NO.:</b>  <b>100.04</b>  <b>PAGE: 2 OF 4</b>	
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2. The screening will include exploration of the patient's possible qualification for specialized payer programs. Staff will encourage patients to apply for appropriate funding programs and facilitate an application when appropriate.
  - a. The Business Office Manager and Health Center Managers are authorized to waive patient fees due to expressed financial hardship or disputes, as described in the HSA Billing FO Policy and Procedures 100.3 (Section A, #4).
3. The Health Services Agency (HSA) will ensure access to health care services by families and individuals regardless of the patient's ability to pay. At no time will a patient be denied services because of an inability to pay, as described in the Sliding Fee Scale Discount Program policy #100.04.

**B. Ability to Pay Program (Sliding Fee Discount Program)**


1. Ability to Pay (ATP) is a sliding fee program available to all patients who qualify according to family size and income (individuals/families living at or below 200% of the Federal Poverty Level (FPL). Partial discounts are provided for individuals and families with incomes above 100% of the current FPL and at or below 200% of the current FPG.
2. Patients will self-report income and family size on the ATP self-declaration/provisional application if the individual or family does not have the proof of income at the time of the visit. Patients applying for the ATP program are re-assessed if income or family size changes, as self-reported or the ATP eligibility period expires, and a new application is received.
3. Patients must first be screened for other public insurance eligibility. Nominal fee charges apply to individuals and families with annual incomes at or below 100% of the Federal Poverty Guidelines. Nominal fees shall be waived for patients who are experiencing homelessness. No discounts are provided to individuals and families with annual incomes above 200% of the current FPL. Ability to Pay (Sliding Fee Discount Scale Program) levels are described in Attachment 1 for Clinic, Integrated Behavioral Health, and Acupuncture services. Ability to Pay scale levels are described in Attachment 2 for Dental Services.
4. Patients interested in applying for this program are required to complete an application and provide proof of household income and identification. Registration staff collects preliminary income and family size documentation for each applicant then enters the information into the appropriate EPIC module for payment range determination in




<b>SUBJECT:</b> Billing Department and Front Office Operations Policies and Procedures	<b>POLICY NO.:</b>  <b>100.04</b>  <b>PAGE: 3 OF 4</b>	
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accordance with FPL. **Self-declaration of income and household information will be accepted.**

5. For full program qualification, patients must provide photo identification and income verification documents to support their application, such as:
  - a. Most recent Federal tax return
  - b. IRS form W-2 or 1099
  - c. **Two (2) most recent consecutive paystubs**
  - d. Social Security, disability or pension benefit statements
  - e. Documentation of other governmental assistance
  - f. Verification of Student status and FAFSA form
  - g. Unemployment Benefits / Workman's Compensation
  - h. **Self-declaration form may be accepted if formal documentation is not available.**
  
6. The ATP shall apply to all required and additional health services within the HRSA-Approved scope of project for which there are distinct fees.
  
7. All documentation received from the patient related to the ATP application are filed and kept on site until the HSA Fiscal retention date has expired.
  
8. HSA will annually assess the ATP activity and present findings to the Community Health Commission that ensure the ATP does not create a barrier for patient access to care. HSA will:
  - a. Collect utilization data that allows it to assess the rate at which patients within each of discount pay classes, as well as those at or below 100% of the FPG, are accessing health center services:

<b>SUBJECT:</b> Billing Department and Front Office Operations Policies and Procedures	<b>POLICY NO.:</b> <b>100.04</b> <b>PAGE: 4 OF 4</b>	
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- b. Utilize this and, if applicable, other data (for example, results of patient satisfaction surveys or focus groups, surveys patients at various income levels to evaluate the effectiveness of its sliding fee scale discount program in reducing financial barriers to care; and
  
- c. Identify and implement changes as needed.

<p><b>SUBJECT:</b> Billing Department and Front Office Operations Policies and Procedures</p> <p><b>SERIES: 100</b> Administration</p> <p><b>APPROVED BY:</b> Amy Peeler, Chief of Clinic Services</p>	<p><b>POLICY NO.:</b>  <b>100.03</b></p> <p><b>PAGE: 1 OF 12</b></p> <p><b>EFFECTIVE DATE:</b> March 2020</p> <p><b>REVISED:</b> January 2020</p>	 <p>COUNTY OF SANTA CRUZ HEALTH SERVICES AGENCY</p> <hr/> <p><b>Clinics and Ancillary Services</b></p>
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**POLICY STATEMENT:**

The Health Services Agency (HSA) Clinic Services Division operates Santa Cruz County-run community health centers. The purpose of this policy is to describe all billing policies and procedures currently in use for ensuring assets are safeguarded, guidelines of grantors are complied with, and finances are managed with accuracy, efficiency, and transparency.


The Health Services Agency (HSA) will ensure access to health care services by families and individuals regardless of the patient's ability to pay. At no time will a patient be denied services because of an inability to pay, as described in the Sliding Fee Scale Discount Program policy #100.04.

HSA staff with a role in the management of billing operations are expected to comply with the policies and procedures in this manual.

These policies will be reviewed annually and revised as needed by the staff and approved by the Chief of Clinic Services.

**PROCEDURE:**

- A. Billing Overview: Clinic Services Division will provide methods for appropriate and sensitive evaluation of each patient's ability to pay for services rendered.
  - 1. Financial screening of each patient shall not impact health care delivery.
  - 2. The ability to pay (Sliding Fee Discount Program) is available for all patients to apply.
  - 3. The screening will include exploration of the patient's possible qualification for specialized payer programs. Staff will encourage patients to apply for appropriate funding programs and facilitate an application when appropriate.
  - 4. The Business Office Manager and Health Center Managers are authorized to waive patient fees due to expressed financial hardship or disputes. The Business Office staff, or the registration desk staff will request the waiver from the Health Center Manager or the Business Office Manager prior to waiving of any fees either through email, in person, or by telephone.


<b>SUBJECT:</b> <b>Billing Department and  Front Office Operations  Policies and Procedures</b>	<b>POLICY NO.:</b>  <b>100.03</b>  <b>PAGE: 2 OF 12</b>	
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**B. General Payers**

1. **Medi-Cal:** Most Medi-Cal patients are insured through Santa Cruz County’s local managed care provider, Central California Alliance for Health (CCAH). CCAH members must be:
  - a. Assigned to HSA for their primary care; or
  - b. Within their first 30 days of CCAH membership and therefore not yet formally assigned to a care provider (administrative member); or
  - c. Pre-authorized to be seen by an HSA provider.
2. Patients who have State Medi-Cal are generally patients with restricted benefits or transitioning to the managed care program.
3. **Medicare:** (non-managed care type) Recipients may qualify due to age and/or disability or may be dependent of an aged and/or disabled person.
4. **Private Insurance:** Contracted with Blue Shield PPO. Courtesy billing for other PPO insurance is available, however, the patient is responsible for any costs not covered by non-contracted insurance providers.

**C. Specialized Payers**

1. The following payer types are government-funded program and require application screening to determine eligibility:
  - a. **Family Planning, Access, Care and Treatment (Family PACT) program:** State program for family planning services. Covers annual exams, sexually transmitted infection (STI) checks, birth control methods and emergency contraception.
  - b. **Every Woman Counts (EWC):** Breast and cervical cancer screening and diagnostic services. Covers clinical breast exam, screening and diagnostic mammogram, pelvic exam and pap.

<b>SUBJECT:</b> <b>Billing Department and  Front Office Operations  Policies and Procedures</b>	<b>POLICY NO.:</b>  <b>100.03</b>  <b>PAGE: 3 OF 12</b>	
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- c. Child Health and Disability Prevention (CHDP) Program: Well care visits, including immunizations, for children. The age limit is 18 years and 11 months. Grants 60 days of full Medi-Cal benefits while the family formally applies for on-going insurance.
- d. MediCruz: Locally funded program that provides specialty care to patients who fall at or below 100% of the Federal Poverty Level and are not eligible for Medi-Cal. Patients fill out an application and provide verification documents.

**D. Self-Pay Payers**

- 1. The Ability to Pay (Sliding Fee Discount Program) is available for all patients to apply. Patients with non-contracted insurance types, are responsible to pay for visit costs, including ancillary services. Patients are encouraged to apply for the Ability to Pay (Sliding Fee Discount Program), if eligible. Refer to the Ability to Pay (Sliding Fee Scale Discount Program) policy and procedure, #100.04.


**E. Verification of Eligibility and Benefits Determination by Payer**

**1. Medi-Cal**

- a. Eligibility Verification: Verification of coverage, restrictions, and cost-share must be obtained through the Medi-Cal website. Patients who may be eligible for Medi-Cal, but are not enrolled, will be encouraged to apply
- b. Benefits Determination: Once the eligibility is verified, the benefit type must be reviewed. There are several types of Medi-Cal benefits, ranging from full scope to restricted services. For additional information, the Medi-Cal provider manual can be referenced for benefit rulings. If coverage indicates that the patient is a member of CCAH, then eligibility and assignment must be verified via the CCAH website.

**2. Central California Alliance for Health (CAAH)**

- a. Eligibility Verification: Information regarding the eligibility of coverage must be obtained through the CCAH provider web portal.
- b. Benefits Determination: All Medi-Cal benefit rulings apply to CCAH patients assigned to HSA; however, CCAH may offer more benefits than State Medi-Cal (see CCAH provider manual). If the patient is assigned to another provider, they

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may only be seen by our office for a sensitive service or under the authorization from their assigned primary care provider. A list of sensitive services can be found on the CCAH website.

### 3. Medicare

- a. **Eligibility Verification:** Medicare eligibility may be verified on-line through the Trizetto Gateway EDI website or by phone. Some Medicare patients have supplemental insurance coverage that may include commercial insurance or Medi-Cal coverage.
- b. **Benefits Determination:** Co-insurances are due on the date of service. Normally Medicare requires an annual deductible that must be met prior to accessing benefits, however, HSA's Federally Qualified Health Center status allows waiver of the deductible.

### 4. Other Government Funded Programs

- a. **Eligibility Verification:** Government Funded Programs have eligibility period limitations, ranging from one day to one year. Eligibility periods for Family PACT, EWC, and CHDP Medi-Cal can be obtained through the Medi-Cal eligibility portal. MediCruz eligibility may be determined via the County's MediCruz Office.
- b. **Benefits Determination**
  - i. **Family PACT:** covers all birth control methods offered at the HSA clinics, STI screenings, and treatments as part of the primary benefits. For secondary benefits, review the Family PACT Benefits Grid located on the Medi-Cal website.
  - ii. **EWC:** covers annual cervical and breast cancer screenings as part of the primary benefits. For secondary benefits, review the covered procedure list located on the Medi-Cal website.
  - iii. **CHDP:** grants full-scope Medi-Cal benefits on a temporary basis to allow application processing for Medi-Cal.
  - iv. **MediCruz** covers specialty care on a temporary and episodic basis.

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5. Commercial Insurance


- a. **Eligibility Verification:** Eligibility will be verified with contracted insurances using the insurance company's website or via the telephone number provided on the patient's insurance card.
- b. **Benefits Determination:** As insurance plan benefits vary significantly, it is the patient's responsibility to understand their insurance benefits prior to obtaining services. Since understanding health insurance benefits can be challenging, as a courtesy, HSA staff may assist patients with obtaining coverage information.

F. Enrollment: Other State Funded Programs

HSA is a Qualified Provider allowed to screen, verify, and enroll patients in State Funded Programs using the guidelines set forth by each of the following programs:

1. CHDP

- a. The CHDP program provides complete health assessments for the early detection and prevention of disease and disabilities for low-income children and youth. A health assessment consists of health history, physical examination, developmental assessment, nutritional assessment, dental assessment, vision and hearing tests, a tuberculin test, laboratory tests, immunizations, health education/anticipatory guidance, and referral for any needed diagnosis and treatment.
- b. In accordance with current CHDP guidelines, HSA staff will pre-screen patients for program eligibility and provide a program application to eligible patients. Staff enters the completed application via the CHDP Gateway and prints two paper cards, with one card signed by the participant's parent and retained at HSA. The other card is provided to the participant's parent, along with a verbal explanation from HSA staff that the child is fully covered by Medi-Cal until the expiration date printed on the card. It is the parent's responsibility to follow-up with County Human Services regarding further application requirements for ongoing Medi-Cal eligibility.

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2. Family PACT

- a. Family PACT clients are residents of California that demonstrate a need for family planning services, but have no other source of family planning coverage, and qualify for the program based on family income. Medi-Cal clients with an unmet cost-share may also be eligible. In accordance with Family PACT guidelines, eligibility determination and enrollment are conducted by HSA staff (patient completes an application) with the point of service activation, granting the applicant up to one year of benefits for family planning and reproductive health services. Qualified applicants are given a membership card and informed about program benefits, state-wide access, as well as the renewal process.


3. Every Woman Counts (EWC)

- a. EWC provides free clinical breast exams, mammograms, pelvic exams, and Pap tests to California's underserved women. The mission of the EWC is to save lives by preventing and reducing the devastating effects of cancer for Californians through education, early detection, diagnosis and treatment, and integrated preventive services, with special emphasis on the underserved. Income qualification and age-related service information are available at the EWC website.
- b. HSA Clinics staff will screen patients for eligibility in accordance with program guidelines. The EWC application packet is completed by the patient, and the completed application is processed by HSA staff via the online portal. Patients are issued a paper membership card granting up to one year of benefits for breast and/or cervical services and given information regarding program benefits and the program renewal process. They are also instructed to present their membership card when obtaining services outside of HSA, such as a mammogram.

4. Ryan White HIV/AIDS Program (RWHAP)

- a. For patients receiving Ryan White HIV/AIDS Program funded services the following process on charges related to HIV care will be followed: Patients receiving Ryan White HIV/AIDS Program funded services will not be charged fees related to care. The office visit fees will be waived (see section A, #4).



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## G. Patient Information Policy

### 1. Exchange of Information

- a. Registration forms are maintained by Registration staff. Patients are either offered forms or questions are asked verbally, depending on patient preference. Information is collected on all new patients and updated at least every 12 months. All information on the registration form must be collected. The patient address/phone number must be confirmed at each visit. The registration form is also used to collect demographic information necessary for program and agency-wide reporting purposes.

### 2. Patient Scheduling

- a. Appointment requests may be made in person or over the phone. At the time of an appointment request, staff will confirm the patient's name, date of birth, and phone number. The patient's reason for the appointment should be requested to determine appointment type and duration.

### 3. No Show and Late Cancels Defined


- a. No Show Appointment: The patient does not arrive for a scheduled appointment.
- b. Late Cancel Appointment: The patient cancels appointment less than 24 hours prior.

### 4. Follow-up


- a. If deemed necessary by the medical provider, HSA staff will follow up with patients unable to attend a previously scheduled appointment in order to schedule another appointment or determine if the health issue has been resolved.

## H. Financial Policies

### 1. Accepted Forms of Payment

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- a. **Cash:** Cash is counted in front of the patient, payments are posted on the patient account (via Epic), and a receipt is printed for the patient.
  - b. **Credit/Debit Card:** Charge information is submitted via the credit card merchant services portal. Payment is then posted on the patient account (via Epic), and a receipt is printed for the patient.
  - c. **Personal Checks:** Checks are verified with the patient's name; the back of the check is stamped with the Santa Cruz County Bank account information for deposit. Payments are posted on the patient account (via Epic), and a receipt is printed for the patient.
  - d. **Money Orders:** Money order backside is stamped with HSA Bank account information for deposit. Payments are posted on the patient account (via Epic), and a receipt is printed for the patient.
2. **Payment Agreements:** Payment agreements may be negotiated between the patient and BO staff, providing up to three payment installments for past due charges (over 30 days).
  3. **Refunds:** Patient refunds are requested by BO staff using the appropriate County form and require BO Manager approval. Once approved, the request for a refund check is submitted to HSA Finance. Once prepared, the check is forwarded to the BO for delivery coordination with the patient. BO staff documents the refund in the patient account.
  4. **Non-sufficient Funds (NSF) Returned Checks:** NSF Returned Checks are received by mail, email, or identified via bank account review by HSA Finance. The payment is reversed on the patient's account; a new billing claim is created and the County's NSF fee charge of \$40 is posted and billed to the patient.
  5. **Insurance Payments:** HSA receives insurance payments in two forms: electronic funds transfer and paper checks. All payments are reconciled to the Explanation of Benefits (EOB), Remittance Advice (RA), or Electronic Remittance Advice (ERA). EOB, RA, and ERA all provide detailed information about the payment.
  6. **Payments Received by Mail:** BO staff are responsible for opening and sorting business office mail. Insurance checks received by mail will be distributed to appropriate BO staff members for processing and deposit preparation, following established County procedures. Payment detail may be posted manually using the correlated EOB via upload to the practice management system through an ERA. The final daily deposit should be completed by a different BO staff member.

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7. **Direct Deposits:** Most direct deposits from third party insurances are accompanied by an ERA uploaded to the practice management system. The biller will reconcile the bank account direct deposits with the ERAs received.

**I. Billing Procedures**

1. **Encounter Development and Management**


- a. **ICD, CPT, and HCPCS Code Upgrades:** ICD and CPT codes are updated as needed by HSA's practice management system vendor. Periodic manual updates are made by BO staff as necessary, and at the request of the medical team. Fees are updated at the beginning of each fiscal year, as applicable, following the Board of Supervisors approval of the Unified Fee Schedule.

2. **Encounter to Claim Process**


- a. **HSA Medical Providers** consists of physicians, nurse practitioners, physician assistants, and registered nurses. Providers select CPT and ICD codes for every outpatient face-to-face encounter. CPT codes include but are not limited to: evaluation and management (E&M) codes, preventative care codes, and/or procedure codes depending on the type of service provided. Additional information regarding coding, including program/payer specifications, can be found in HSA's BO Operations Manual. Once providers complete documentation of an encounter, a claim is generated.
- b. **Claims that do not automatically transmit** are retained in a billing work queue for review by the BO. Following review, the claim is either corrected by a biller or coder as appropriate or returned to the provider for consideration of chart level correction. Following these reviews and possible changes, the claim is then submitted for processing.
- c. **Claims are submitted through the payment clearinghouse** in batches grouped by payer type. The clearinghouse then forwards claims to the prospective payers. Claim batches are tracked weekly for transmission and payer acceptance.

3. **Collections:** HSA makes every reasonable effort to collect reimbursement for services provided to patients. This includes collection at time of service, as well as follow-up collection methods including statement dispatch and account notes.


4. **Denial Management Procedure**

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- a. Information regarding denied claims are uploaded into the practice management system electronically or entered manually. BO staff are responsible for researching, correcting, and resubmitting (or appealing) clean claims within a 30-day period upon receipt of denial information. Researching may involve contact with the payer, patient, or clearinghouse. A review of the payer-provider manual may also serve as a resource for denied claims.
  - b. Discoveries may include: patient responsibility for all or part of the charges; incorrect or incomplete information originally submitted to the payer; claim and EOB information must be forwarded to another insurance through a crossover claim process. Correcting the claim may require provider review, CPT or ICD code update within the practice management system, and/or submission to a secondary or tertiary insurance. As soon as the claim is corrected it may be resubmitted with the next batch of claims. If a crossover claim, then required documentation is submitted to the secondary payer.
5. Patient Account Balances: Patient's with account balances of \$15 or more are sent a monthly statement. Patients with unpaid balances are flagged during the appointment registration process and directed to the Business Office.
6. Uncollectable and Bad Debt Adjustments
- a. Under the direction of the Business Office Manager, staff will adhere to the following write-off guidelines. The Business Office Manager has the authority to approve write-offs. Write-offs will be measured by HSA Fiscal Department after the month-end close and accounts will be audited as part of standard fiscal year-end practice.
7. Write-off Adjustments by Payer
- a. Medicare - Use uncollectible adjustment code
    - Write off balances over 12 months from Date of Post (DOP) when Medicare is primary.
    - Write off balances over 12 months from DOP when Medicare is secondary.
  - b. Commercial Insurance - Use uncollectible adjustment code

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- Write off balances over 12 months from the DOP when insurance is primary.
- Write off balances over 12 months from the DOP when insurance is secondary.
- c. EWC - Use uncollectible adjustment code
  - Write off any balance 12 months from DOP.
- d. Family PACT - Use uncollectible adjustment code
  - Write off any balance 12 months from DOP.
  - Write off any unpaid lab work balance over 12 months from DOP.
- e. CHDP - Use uncollectible adjustment code
  - Write off any balance over 12 months from DOP.
  - Write off any unpaid lab work balance over 12 months from DOP.
- f. Medi-Cal - Use uncollectible adjustment code
  - Write off any balance 12 months from DOP.
- g. CCAH - Use uncollectible adjustment code
  - Write off any unpaid lab work balance over 12 months from DOP.
  - Write off any balance over 12 months from DOP.
  - Write off any balance over 12 months from the DOP when Alliance is secondary.
- h. Self-Pay - Use bad debt adjustment code

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- Write off any balance over 12 months from DOP.
- Write off any balance for patients not assigned to HSA following Referral Authorization Form (RAF) denial or denial for out of county managed care.

i. Beacon – Use uncollectible adjustment code


Write off any balance 12 months from DOP.

8. Other Adjustments

- a. Billing Error (BE) – For duplicate claims, when a non-payable charge is billed to an insurance, or a split claim is erroneously created.
- b. Professional Courtesy (PC) – For charges disputed by patients or hardship waiver (see section A, #4).

9. Month End Closing Procedure: The month-end closing is performed at the end of each month and involves the reconciliation of payments and charges for that period.

- a. Reconciliation: For every insurance payment received, BO staff will log the payment on a spreadsheet titled Record of Receipt (ROR) and E-remit tracking prior to posting the payment in the practice management system. At the end of the month, assigned staff will reconcile the payments deposited into HSA's bank account with the ROR entered onto the spreadsheet, and the payments posted in the practice management system. Discrepancies will be reported to HSA Fiscal staff assigned to HSA.
- b. All patient payments will be collected by BO staff and reconciled on a daily basis in the practice management prior to deposit. Any discrepancies will be reported to the Business Office Manager and HSA Fiscal.
- c. Claim dates will be reconciled by date of service. All charges to third party insurances must be submitted prior to the month-end closing.

<p><b>SUBJECT:</b> Patient Complaint / Grievance Process</p> <p><b>SERIES: 100</b> Administration</p> <p><b>APPROVED BY:</b> Amy Peeler, Chief of Clinic Services</p>	<p><b>POLICY NO.:</b> <b>130.01</b></p> <p><b>PAGE: 1 OF 2</b></p> <p><b>EFFECTIVE DATE:</b> July 2001</p> <p><b>REVISED:</b> <del>June 2016</del> March 2020</p>	 <p>COUNTY OF SANTA CRUZ HEALTH SERVICES AGENCY</p> <hr/> <p><b>Clinics and Ancillary Services</b></p>
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**GENERAL STATEMENT:**

This policy establishes a uniform process which allows patient and/or patient's authorized representative grievances/concerns and complaints from all sources to be evaluated and resolved in a manner that assures quality care and service throughout Health Services Agency- Clinics Services Division.


**POLICY STATEMENT:**

It is the policy of the ~~County of Santa Cruz Health Services Agency~~ Clinic Services Division to provide and adhere to a procedure for receiving, resolving and responding to the grievances/complaints and concerns of a patient and/or patient's representative. ~~Health Service Agency Clinics~~ The Clinic Services Division Chief has designated the Health Center Managers to:

1. Inform patient and or patient's authorized representative of the right to file a grievance/complaint and the mechanism for doing so;
2. Investigate the grievance/complaint or concern;
3. Ensure resolution occurs; and
4. Respond to patient and/or patient's authorized representatives' grievances/concerns and complaints as required under applicable state and federal law.

**PROCEDURE:**

- I. Procedure for informing a patient and/or patient's authorized representative of the right to file grievances/complaints.
  - A. Staff are required to inform each patient, or when appropriate, the patient's representative, of the patient's rights in advance of furnishing or discontinuing patient care.
    1. The following written materials are available to staff to provide to patients with notice regarding ~~Health Services Agency Clinics~~ Clinic Services Division grievance/complaint process. They include:
      - a. Patients' Rights and Responsibilities located throughout reception area and patient copies at reception desk.
      - b. Patient Complaint Forms are available for patients at the reception areas.
  - B. Staff should promptly inform patients who want to file a grievance and or complaint to contact the Health Center Manager.
  - C. Complaint letters sent to or received from governmental offices or Regulatory Agencies should be immediately forwarded to the Chief of Clinic Services Division.
- II. Patients/Patients' authorized representatives may register a grievance or complaint with Health Center Manager as follows:


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- A. By phone or in person.
  - 1. Please call the main clinic line (831)454-4100 and ask to be transferred to Health Center Manager.
  - 2. The Health Center Manager, upon verbal receipt of the grievance or complaint, will immediately record and include information sufficient to identify the complainant, date and nature of the problem, any steps taken to resolve the grievance/complaint. If an individual or an individual other than the patient expresses a complaint on behalf of an adult patient, the patient's authorization will be obtained before discussing any Protected Health Information.
- B. In writing.
  - 1. Complete a Patient Complaint Form available in the reception area. If patient and/or patient's friend or relative is unable to complete a written complaint, someone from reception, not involved in the case/complaint, will be glad to help.
  - 2. A letter to Health Center Manager.
  - 3. Suggestion Box- Suggestion Box is located in the lobby area.

III. Response to Patients and/or Patient's Representative

- A. Responses to informal investigations or inquiries.  
The response to a complaint or grievance that does not require a formal investigation should be made using one of the following:
  - 1. Phone call when appropriate and when the problem can be resolved without a formal investigation; and
  - 2. Letter of explanation, apology and/or description of actions taken to any concerns that cannot be resolved quickly and that require a formal investigation.
- B. Final Response for formal investigations.
  - 1. Health Center Manager should provide the patient/family with a written response to a complaint or grievance within 30 days or advise the patient that the investigation is continuing and provide the patient with a specific anticipated date of completion.
  - 2. The letter should include a written notice of the health center's decision regarding the complaint/grievance, an explanation of the steps taken to investigate the grievance, date of completion of the review, name of the Health Center Manager (contact person). Copies of the response are sent to those named on the grievant/complainant's letter and to other appropriate individuals/agencies subject to HIPAA authorization requirements.



<p><b>SUBJECT:</b> Continuous Quality Improvement</p> <p><b>SERIES: 100</b> Administration</p> <p><b>APPROVED BY:</b> Amy Peeler, Chief of Clinic Services</p>	<p><b>POLICY NO.:</b> <b>130.02</b></p> <p><del>PAGE: 1 OF 2</del></p> <p><b>EFFECTIVE DATE:</b> February 2014</p> <p><b>REVISED:</b> <del>October 2015</del> <del>June 2016</del> March 2020</p>	 <p>COUNTY OF SANTA CRUZ HEALTH SERVICES AGENCY</p> <hr/> <p><b>Clinics and Ancillary Services</b></p>
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**POLICY STATEMENT:**

It is the policy of the County of Santa Cruz Health Services Agency Clinics Services Division (HSA) to use an ongoing quality improvement (QI) process to identify opportunities for improvement.

**REFERENCE:**

~~None.~~ Quality Management Plan

**FORMS:**


None.

**PROCEDURE:**

The HSA Clinic Services Division maintains a clear, continuous QI process that includes the regular review of performance data and evaluation of performance against goals or benchmarks. It is recognized that the QI process enables the HSA Clinic Services Division to identify and prioritize areas for improvement, analyze potential barriers to meeting goals, and plan methods for addressing the barriers.

The HSA Clinic Services Division establishes goals and takes action to improve performance based on clinical quality and resource data gathered from preventive care measures, chronic care measures, acute care measures, and utilization measures affecting healthcare costs and vulnerable populations, to assess the disparities of care.

The HSA Clinic Services Division establishes goals and takes action to improve performance based on patient experience data gathered from quantitative and qualitative patient feedback. The Quality Management Committee, in concert with the Administration, decides on the data, a specific time period, and persons responsible.


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To execute its QI process, the Clinic Services Division HSA uses the PDSA (Plan-Do-Study-Act) cycle. The PDSA cycle allows the HSA-Clinic Services Division to test a change by developing a plan to test the change (Plan), carrying out the test (Do), observing and learning from the consequences (Study), and determining what modifications should be made to the test (Act). This four-step process, as described below, is a useful QI tool because it permits the HSA-Clinic Services Division to test the change before implementing it.

1. PLAN: Determine a change or test of how something works; define the objective, questions, and predictions; strategize to answer the questions.
2. DO: Carry out the plan; collect the data; analyze the data.
3. STUDY: Look at the results; compare data to predictions; summarize what was learned.
4. ACT: Decide whether the change can be implemented; determine what actions should be taken to improve.

The HSA-Clinic Services Division monitors the policy and procedure in the following manner:

1. ~~Annual~~ Continuous monitoring of the goals and achievements of each QI process. For both ~~failures~~ challenges and successes, lessons that can be extracted to improve the next QI process are determined.

<p><b>SUBJECT:</b> Credentialing and Privileging</p> <p><b>SERIES: 200</b> Personnel</p> <p><b>APPROVED BY:</b> Amy Peeler, Chief of Clinic Services</p>	<p><b>POLICY NO.:</b> <b>200.03</b></p> <p><b>PAGE: 1 OF 9</b></p> <p><b>EFFECTIVE DATE:</b> July 2001</p> <p><b>REVISED:</b> February 2017 August 2018 September 2018 March 2020</p>	 <p>COUNTY OF SANTA CRUZ HEALTH SERVICES AGENCY</p> <p><b>Clinics and Ancillary Services</b></p>
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**GENERAL STATEMENT:**

Credentialing and privileging are processes of formal recognition and attestation that an independent licensed practitioner or other licensed or certified practitioner is both qualified and competent.

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

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

**POLICY STATEMENT:**

Health Services Agency Clinic Services Division (HSA) shall credential and privilege all employed, contracted, locum tenen, or volunteer licensed and certified practitioners in accordance with the Bureau of Primary Health Care (BPHC) guidelines and standards.

Credentialing and privileging shall be conducted without regard to race, ethnicity, national origin, color, gender, age, creed, sexual orientation, or religious preference.


**Reference:**

HRSA Health Center Compliance Manual

**KEY DEFINITIONS:**

**Credentialing:** The process of assessing and confirming the qualifications for a licensed or certified health care practitioner.

**Credentials Verification Organization (CVO):** A contracted organization that performs verification of a variety of primary and secondary sources.

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**Privileging:** The process of authorizing a licensed or certified health care practitioner's specific scope and content of patient care services. This is performed in conjunction with an evaluation of an individual's clinical qualification and/or performance.

**Licensed, Independent Practitioner (LIP):** Physician, dentist, physician assistant, nurse practitioner, psychiatrist, licensed clinical social workers (LCSW), or psychologist permitted by law to provide care and services without direction or supervision, within the scope of the individual's license and consistent with individually granted clinical privileges. This includes contracted practitioners providing care at any HSA Clinic Services Division-Health Center.


**Other Licensed or Certified Practitioner (OLCP):** An individual who is licensed, registered or certified but is not permitted by law to provide patient care services without direction or supervision; this includes laboratory technicians, medical assistants (MA), licensed practical nurses (LPN), registered nurses (RN), public health nurses (PHN), registered dietitians (RD), and registered dental assistants (RDA). This includes contracted OLCPs providing care at any HSA Clinic Services Division Health Center.

**Primary Source Verification (PSV):** Verification by the original source of a specific credential to determine the accuracy of a qualification reported by an individual health care practitioner. PSV methods include direct correspondence, telephone verification, internet verification or reports from credential verification organizations (e.g. American Medical Association (AMA) Masterfile or American Osteopathic Association (AOA) Physician Database).

**Secondary Source Verification (SSV):** Verification of a specific credential by a source other than the original source; SSV is used to verify credentials when PSV is not required. SSV methods include the original credential, a notarized copy of the credential or a copy of the credential (when made from an original by Health Services Agency/Clinic Services Division staff).

**Peer Review and Risk Management Committee:** The goal of the medical peer review is to improve quality and patient safety by learning from past performance, errors and near misses. Educational peer review, for both the provider and the health center, is a tool for identifying, tracking, and resolving suboptimal inappropriate clinical performance and medical errors in their early stages. Plan, Do, Study Act cycles are used for providing feedback and developing strategies for improvement. Both the medical and educational peer reviews will be conducted annually by the Peer Review and Risk Management Committee made up of the Medical Director and Provider Members of the Quality Management Committee. Aggregated data and summaries of the PDSA cycles will be presented to the Co-Applicant Board.

**Forms:**  
 Credentialing/ Re-Credentialing Checklist  
 Health Services Agency Privilege/Procedure List for Licensed, Independent Practitioners

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Health Services Agency Privilege/Procedure List for Other Licensed or Certified Practitioners

**PROCEDURES:**


Verification of credentials will occur for all LIPs and OLCPs by obtaining Primary Source or Secondary Source Verification using accepted national verification sites. Credentialing documents requiring verification and the verification sites for licensed, registered and certified staff are included in the Credentialing/Re-credentialing Checklist (ATTACHMENT 1). The candidate must submit applicable documentation for review.

Through a formal contract between Health Services Agency and Dignity Health patients can be admitted by the Emergency Department physician and will be followed by a hospitalist.

**RESPONSIBILITIES:**

The completed Credentialing Checklist and additional materials will be reviewed by the hiring manager for completeness and forwarded to the Credentials Verification Organization (CVO) for verification. Any missing information will be requested from the applicant. The additional requested materials must be returned within two weeks to hiring manager or designee.

1. CVO verifies credentials and forwards information to the hiring manager or designee. The hiring manager maintains the credentialing spreadsheet to accurately track all practitioners' credentials.
2. County Personnel Department will complete query of Department of Justice (DOJ) and Federal Bureau of Investigation (FBI) criminal index systems pursuant to standard process. LIPs and OLCP additionally have a query of the National Practitioner Data Bank (NPDB) and Medi-Cal Suspended and Ineligible Provider List completed by the CVO. Clearance of query is filed in the LIP or OLCP credentialing file. The LIP or OLCP bears the burden of establishing and resolving any reasonable doubts about his/her qualifications. A copy of government issued photo identification will be requested at Personnel during the onboard processing and additionally, will be kept in the Employee Documents Database. Failure to meet this burden may result in denial of the application. Verification of Basic Life Support Training for LIPs and OLCPs.
3. All adverse information found on the background check is evaluated by the Medical Director and Peer Review and Risk Management Committee.
4. A pre-employment physical is completed in accordance with County Personnel Procedures. Fitness for duty is evaluated at time of hire with a physical exam reviewing immunizations

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and PPD status. Annually, thereafter fitness for duty will be documented in the annual evaluation for LIPs and OLCPs.

5. The Supervising Practitioner completes proctoring of twenty patient encounters for LIPs ~~and LCSWs~~ during initial evaluation of competency. Peer chart audits are completed at least twice a year thereafter at designated Provider meetings. Each Practitioner will review up to ten charts to assess current competencies. If issues arise it will be elevated to a supervisory review to determine if corrective action is needed. All other licensed, registered and certified practitioners will have clinical competencies evaluated during orientation and annually thereafter. The evaluation data shall be provided to the HSA Clinic Services designated Division designated staff for placement into ~~practitioner's~~ credentialing ~~file~~ database.
6. Practitioner shall complete a Clinical Privileges/Procedure Application (ATTACHMENT 2) prior to providing clinical services. Practitioners, employed and contracted, shall have the burden of producing all necessary information in a timely manner for an adequate evaluation of their qualifications and suitability for clinical privileges. The applicant's failure to sustain this burden may be grounds for denial or termination of privileges.
7. At any time based on an incident and competency issues, ~~the Chief Medical Officer~~, Medical Director or Supervising Practitioner may revise or revoke privileges of the LIP or OLCP. A corrective action will be issued and LIP or OLCP will have the right to appeal to the ~~Chief Medical Officer of Clinic Services~~. The Chief Medical Officer of Clinic Services will have five business days to respond to the LIP or OLCP. If revocation is reversed the LIP/OLCP must complete a renewal of privileges document and competencies will be reviewed by the Medical Director at six months and then again at twelve months.

#### APPROVAL PROCESS

Health Services Agency Co-Applicant Board authorizes the Medical Director, in combination with the appropriate Supervising Practitioner, to approve credentialing and privileging of health care practitioners who meet the standards for verification. The Supervising Practitioner and Medical Director will assess the credentials of each health care practitioner as outlined in the Credentialing/ Re-credentialing Checklist.

Upon the final decision by the Medical Director, ~~HSA Clinic Services Division~~ staff will notify the physician in a timely manner of the approval and the next re-credentialing period. If the Medical Director denies the practitioner's application the Medical Director will work with the Personnel Department on next steps.

<b>SUBJECT:</b> Credentialing and Privileging	<b>POLICY NO.:</b>  <b>200.03</b>  <b>PAGE: 5 OF 9</b>	
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#### RE-CREDENTIALING AND RE-PRIVILEGING:

Credentialing and privileging of current LIPs and other Licensed or Certified Practitioners shall be reviewed at a minimum of every two years. Application for reappointment will be sent to practitioner ~~sixty months~~ sixty days prior to their appointment expiration day. The Practitioner shall complete attestation for completion of continuing education and attestation questionnaire. Primary source verification of expiring or expired credentials shall be completed by HSAClinic Services Division staff on an on-going basis. A performance evaluation shall be completed annually by the Supervising Practitioner. All reappointment information will be forwarded to the Medical Director for review. ~~The Peer Review Committee meets annually to review credentials, privileges, chart audit results, and any relevant clinical information of current LIPs and Other Licensed or Certified Practitioners.~~

#### TEMPORARY PRIVILEGING:

Temporary privileges may be granted to a LIP by the Medical Director to fulfill a patient care need. This includes providing temporary privileges to a locum tenens LIP or extra help LIP who is covering for an employed or contracted LIP who is ill or taken a leave of absence. Privileges may be granted to a LIP who has the necessary skills to provide care to a patient that a LIP currently privileged does not possess. Temporary privileges may be granted provided current licensure and current competence has been verified.

#### EXPIRED LICENSURE:

Each month, ~~HSAClinic Services~~ staff ~~Division~~ staff, will audit the database to determine which providers have a California Professional License, DEA Certificate, or current Board certification that will be expiring in sixty (60) and thirty (30) days. An e-mail notice is sent to the provider 60 days prior to expiration and a final notice is sent 30 days prior to expiration. E-mail notifications are copied to their Health Center Managers and the Medical Director. ~~The copies of the e-mails are printed and placed in the file.~~

If provider fails to respond and the license expires the Medical Director will have the provider perform limited duties, if possible, until the next steps are coordinated with the Personnel Department.

**ATTACHMENT 1: Credentialing/ Re-Credentialing Checklist**

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Initial Credentialing

Provider Name: \_\_\_\_\_

Provider Type: \_\_\_\_\_

**Licensed Independent Provider (LIP)**

- Physician
- Physician Assistant
- Nurse Practitioner
- Psychiatrist
- Licensed Marriage and Family Therapy
- Licensed Clinical Social Worker
- Clinical Psychologist

**Other Licensed or Certified Practitioner**

- Registered Nurse (RN, PHN, LPN)
- Medical Assistants
- Public Health Microbiologist
- Clinical Lab Scientist
- Laboratory Assistant (Phlebotomist)
- Radiologic Technologist
- Pharmacist

Credentialing Requirement	Practitioner Type	Verification Type	Verification Source	Date Verified or Reviewed	Initials of Person Whom Verified or Reviewed
<b>Licensure, Registration, or Certification</b>	All Practitioner Types	Primary Source	Perform internet verification with licensing board or telephone verification. <ul style="list-style-type: none"> <li>• MD/DO: Medical Board of California</li> <li>• NP/PHN/RN: Board of Registered Nursing</li> <li>• PA: Physician Assistant Committee</li> <li>• LCSW: Board of Behavioral Sciences</li> <li>• Lab Scientist: CA Department of Public Health Laboratory Personnel License Verification</li> <li>• MA: Telephone Verification</li> </ul>		
<b>Curriculum Vitae</b> (For re-credentialing obtain attestation by practitioner that CV has not changed since initial credentialing)	Licensed Independent Practitioners	Not applicable	Copy of Curriculum Vitae		



<b>Education/Training</b> 1. Graduation from Medical School 2. Residency 3. Board Cert, if applicable	Licensed Independent Practitioners	Primary Source	<ul style="list-style-type: none"> <li>• Education Commission for Foreign Medical Graduates</li> <li>• American Board of Medical Specialists</li> <li>• American Osteopathic Association Physician Database</li> <li>• American Medical Association Masterfile</li> </ul> <p>Alternatively, perform direct correspondence or telephone verification</p>		
	Other Licensed or Certified Health Care Practitioners	Secondary Source	Copy of Credential (made from the original)		
<b>Board Certification, if applicable</b>	MD and DO	Primary Source	Perform internet verification by specialty at the Board site (e.g. American Board of Internal Medicine or American Board of Family Medicine)		
<b>Current Competence to Practice</b>	Licensed Independent Practitioners	Primary Source	Complete through proctoring of first 20 patient encounters by Supervising Practitioner for new County Employees and Contracted LIPs. Established LIPs have peer chart reviews completed biannually.		
	Other Licensed or Certified Health Care Practitioners	Primary Source	Completed through a review of clinical competency and performance by the Supervisor during orientation for new employees. Established employees have clinical competency reviewed biannually by the Supervisor.		
<b>Government Issued Picture ID</b>	All Practitioner Types	Secondary Source	Copy of ID (made from the original and kept in Employee Documents)		

			Database		
<b>DEA</b>	Licensed Independent Practitioners, as applicable	Secondary	Notarized copy or copy of credential (made from the original)		
<b>NPDB Query</b>	LIP and OLCP	Required every two years	NPDB copy will be kept in Employee Document Database		
<b>Background Check</b>	All Practitioners Types	Primary Source	Completed by Personnel Department: <ul style="list-style-type: none"> <li>Processing of fingerprints through the Department of Justice (DOJ) and Federal Bureau of Investigation (FBI) criminal index systems</li> </ul>		
	Licensed Independent Practitioners	Primary Source	Completed by HSA Clinic Services - Staff Division Staff/CVO: <ul style="list-style-type: none"> <li>National Practitioner Data Bank (NPDB) query completed</li> <li>Medi-Cal Suspended and Ineligible Provider List query completed</li> </ul>		
<b>Immunization/PPD Status Current</b>	All Practitioners Types	Secondary Source	Copy of immunization record (made from the original) or statement from Occupational Health Program of immunization and PPD status in accordance with CAL OSHA Aerosolized Transmissible Diseases (ATD) vaccine requirements submitted at the time of the pre-employment physical. Record of completion and expiration is kept in Employee Document Database.		
<b>Health/Fitness</b>	Licensed Independent Practitioners	Primary Source	Pre-employment physical signed by the Occupational Health Provider. Must have ability to perform requested privileges.		
<b>Basic Life Support Training</b>	LIP and OLCP	Secondary Source	Copy of certificate made from original		

**Medical Director Review**

Supervisor Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Medical Director Signature and Credentials: \_\_\_\_\_  
Date: \_\_\_\_\_

**Medical Director Recommendation**

- Recommend approval of credentialing
- Do not recommend approval of credentialing

Provider Name: \_\_\_\_\_

**ATTACHMENT 2: HEALTH SERVICES AGENCY CLINIC SERVICE DIVISION PRIVILEGE/PROCEDURE LIST FOR LICENSED, INDIVIDUAL PRACTITIONER**

**Section A: Ambulatory Practice**

These privileges include routine diagnostic and therapeutic procedures associated with outpatient care such as but not limited to:

- Obtain a history, perform a physical examination, order and interpret clinical laboratory tests, provide routine primary care procedures, prescribe medications, request consultation and make referrals.
- Care of neonates and infants, including both well-baby and ill newborns.
- Illnesses, disorders and injuries of childhood, such as pneumonia, asthma, gastrointestinal infections, dehydration and urinary tract infections.
- Illnesses, disorders and injuries of adolescence.
- Illnesses, disorders and injuries of the adult, including but not limited to conditions of the heart, kidney, lung, musculoskeletal system, skin, eye and nervous system, and including multi-system diseases such as diabetes mellitus, HIV/AIDS and cancer.
- Women's health, including illnesses, disorders and injuries of the female reproductive and genitourinary systems.
- Pre-and post-operative evaluation and care.
- Acute and chronic diseases of the elderly, including dementias, as well as functional assessment, physiologic and psychologic aspects of senescence and end-of-life care.
- Psychiatric disorders in children and adults, emotional aspects of non-psychiatric disorders, psychopharmacology, alcoholism and other substance abuse.
- Community issues, such as child abuse and neglect, domestic violence, elder abuse and neglect, disease prevention and disaster preparedness.

**Exclusions:** Though considered core privileges for Family Medicine, the following privileges will be excluded for this applicant at their request.

Privileges in Ambulatory Practice	Please Check Requested Privileges	Approved by Medical Director
Primary Care Infants: 0-2 years	<input type="checkbox"/> yes <input type="checkbox"/> no	<input type="checkbox"/> yes <input type="checkbox"/> no
Primary Care Children: 2-12 years	<input type="checkbox"/> yes <input type="checkbox"/> no	<input type="checkbox"/> yes <input type="checkbox"/> no
Primary Care Adolescents: 12-18 years	<input type="checkbox"/> yes <input type="checkbox"/> no	<input type="checkbox"/> yes <input type="checkbox"/> no
Primary Care Adults: 18-65 Years	<input type="checkbox"/> yes <input type="checkbox"/> no	<input type="checkbox"/> yes <input type="checkbox"/> no
Primary Care Seniors: 65 + Years	<input type="checkbox"/> yes <input type="checkbox"/> no	<input type="checkbox"/> yes <input type="checkbox"/> no

**Section B: Special Procedures**

Procedures	Please Check Requested	Approved by Medical
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	Privileges	Director
Anoscopy, Proctoscopy	<input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> n/a	<input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> n/a
Bursal & Joint Aspirations & Injections	<input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> n/a	<input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> n/a
Cervical Polypectomy	<input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> n/a	<input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> n/a
Colposcopy	<input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> n/a	<input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> n/a
Cryotherapy	<input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> n/a	<input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> n/a
Debridement of Minor Burns	<input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> n/a	<input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> n/a
Dx & Rx of Most Common Dermatological Disease	<input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> n/a	<input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> n/a
EKG Interpretation	<input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> n/a	<input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> n/a
Endometrial Biopsy	<input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> n/a	<input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> n/a
Excision of Minor Skin Lesions	<input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> n/a	<input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> n/a
Family Planning/Contraception	<input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> n/a	<input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> n/a
I & D of Abscess or Cyst	<input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> n/a	<input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> n/a
I & D of Bartholin's Gland/ Word Catheter Placement	<input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> n/a	<input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> n/a
I & D of External Hemorrhoids	<input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> n/a	<input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> n/a
Ingrown Toenail Removal	<input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> n/a	<input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> n/a
IUD Insertion	<input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> n/a	<input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> n/a
Removal of Foreign Bodies <del>From</del> from Ears	<input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> n/a	<input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> n/a
Removal of Foreign Bodies <del>From</del> from Eyes	<input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> n/a	<input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> n/a
Removal of Foreign Bodies <del>From</del> from Nose	<input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> n/a	<input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> n/a
Removal of Impacted Cerumen	<input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> n/a	<input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> n/a
Simple Fracture: Casting	<input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> n/a	<input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> n/a
Simple Fracture: Splinting	<input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> n/a	<input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> n/a
Suture of Lacerations	<input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> n/a	<input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> n/a
Treatment of Plantar Warts	<input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> n/a	<input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> n/a
Tympanometry	<input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> n/a	<input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> n/a
Venipuncture	<input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> n/a	<input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> n/a
Vulvar & Vaginal Biopsy	<input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> n/a	<input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> n/a
Prenatal Care	<input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> n/a	<input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> n/a
Anesthesia: (Types: )	<input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> n/a	<input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> n/a



**ATTACHMENT 3: HEALTH SERVICES AGENCY PRIVILEGE and  
PROCEDURE LIST FOR OTHER LICENSED OR CERTIFIED  
PRACTITIONERS (OLCP)**

Staff Name: \_\_\_\_\_

**Other Licensed or Certified Practitioner**

- Registered Nurse (RN, PHN, LPN)
- Medical Assistants
- Public Health Microbiologist
- Clinical Lab Scientist
- Laboratory Assistant (Phlebotomist)
- Radiologic Technologist
- Other: \_\_\_\_\_

**Privileges in Federally Qualified Health Center**

Age Group	Please Check Requested Privileges	Approved by Medical Director or Designee
Infants: 0-2 years	<input type="checkbox"/> yes <input type="checkbox"/> no	<input type="checkbox"/> yes <input type="checkbox"/> no
Children: 2-12 years	<input type="checkbox"/> yes <input type="checkbox"/> no	<input type="checkbox"/> yes <input type="checkbox"/> no
Adolescents: 12-18 years	<input type="checkbox"/> yes <input type="checkbox"/> no	<input type="checkbox"/> yes <input type="checkbox"/> no
18-65 Years	<input type="checkbox"/> yes <input type="checkbox"/> no	<input type="checkbox"/> yes <input type="checkbox"/> no
Seniors: 65 + Years	<input type="checkbox"/> yes <input type="checkbox"/> no	<input type="checkbox"/> yes <input type="checkbox"/> no

**Accrediting Body or Policy and Procedure**


	Please Check Requested Privileges	Approved by Medical Director or Designee
For Medical Assistants: As delineated in HSA Clinic Services Division Policy number 210.01-Supervision by Registered Nurse of Medical Assistant	<input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> n/a	<input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> n/a
For Radiologic Technologist: As delineated in the Scope of Practice and Responsibilities for CRT's as stated in the California Code of Regulations Sections 30100-30500.	<input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> n/a	<input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> n/a
For Nurses: As recognized by the Nursing Board of California and delineated in Scope of Practice and	<input type="checkbox"/> yes <input type="checkbox"/> no	<input type="checkbox"/> yes <input type="checkbox"/> no

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<b>SUBJECT:</b> <u>Patient Safety and Risk Management Plan</u>  <b>SERIES: 600</b> Risk Management  <b>APPROVED BY:</b> Amy Peeler, Chief of Clinic Services	<b>POLICY NO.:</b>  <b>620.03</b>  <b>PAGE: 1 OF 8</b>  <b>EFFECTIVE DATE:</b> January 2015  <b>REVISED:</b> March 2017/2020	  COUNTY OF SANTA CRUZ HEALTH SERVICES AGENCY  <b>Clinics and Ancillary Services</b>
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**PURPOSE**

The Risk Management Plan is designed to support the mission and vision of Health Services Agency-Clinics Services Division as it pertains to clinical risk and patient safety as well as visitor, third party, volunteer, and employee safety and potential business, operational, and property risks.

**GUIDING PRINCIPLES**

The Risk Management Plan is an overarching, conceptual framework that guides the development of a program for risk management and patient safety initiatives and activities. The plan is operationalized through a formal, written risk management and patient safety program.


The ~~Patient Safety and Risk Management Program~~ Patient Safety and Risk Management supports Plan supports the Health Services Agency-Clinics Clinic Services Division philosophy that patient safety and risk management is everyone's responsibility. Teamwork and participation among management, providers, volunteers, and staff are essential for an efficient and effective patient safety and risk management program. The program will be implemented through the coordination of multiple organizational functions and the activities of multiple departments.

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~~Health Services Agency-Clinics~~ Clinic Services Division supports the establishment of a just culture that emphasizes implementing evidence-based best practices, learning from error analysis, and providing constructive feedback, rather than blame and punishment. In a just culture, unsafe conditions and hazards are readily and proactively identified, medical or patient care errors are reported and analyzed, mistakes are openly discussed, and suggestions for systemic improvements are welcomed. Individuals are still held accountable for compliance with patient safety and risk management practices. As such, if evaluation and investigation of an error or event reveal reckless behavior or willful violation of policies, disciplinary actions can be taken.

The ~~Health Services Agency-Clinic~~ Clinic Services Division Patient Safety and Risk Management Plan stimulates the development, review, and revision of the organization's practices and protocols in light of ~~considering~~ identified risks and chosen loss prevention and reduction strategies. Principles of the Plan provide the foundation for developing key policies and procedures for day-to-day risk management activities, including:

- Claims management

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- Complaint resolution
- Confidentiality and release of information
- Event investigation, root-cause analysis, and follow-up
- Failure mode and effects analysis
- Provider and staff education, competency validation, and credentialing requirements
- Reporting and management of adverse events and near misses
- Trend analysis of events, near misses, and claims


#### Governing Body Leadership

The success of the ~~Health Services Agency-Clinic Services Division~~ Patient Safety and Risk Management Program-Plan requires top-level commitment and support. The governing board authorizes the formal program and adoption of this Plan through a resolution documented in board meeting minutes.

The governing board is committed to promoting the safety of all patients, visitors, employees, volunteers, and other individuals involved in organization operations. The Patient Safety and Risk Management ~~Program Plan~~ is designed to reduce system-related errors and potentially unsafe conditions by implementing continuous improvement strategies to support an organizational culture of safety. The ~~governing body~~ Integrated Community Health Center Commission ~~(empowers Commission)~~ empowers the organization leadership and management teams with the responsibility for implementing performance improvement and risk management strategies.


#### DEFINITIONS

- **Adverse event or incident:** An undesired outcome or occurrence, not expected within the normal course of care or treatment, disease process, condition of the patient, or delivery of services.
- **Claims management:** Activities undertaken by the ~~risk manager~~ Risk Manager (staff of the Personnel Department Risk Management Division) to exert control over potential or filed claims against the organization and/or its providers. These activities include identifying potential claims early, notifying the organization's liability insurance carrier and/or defense counsel of potential claims and lawsuits, evaluating liability and associated costs, identifying

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and mitigating potential damages, assisting with the defense of claims by scheduling individuals for deposition, providing documents or answers to written interrogatories, implementing alternate dispute-resolution tactics, and investigating adverse events or incidents.

- **Failure mode and effects analysis:** A proactive method for evaluating a process to identify where and how it might fail and for assessing the relative impact of different failures in order to identify the parts of the process that are most in need of improvement.
- **Loss control/loss reduction:** The minimization of the severity of losses through methods such as claims investigation and administration, early identification and management of events, and minimization of potential loss of reputation.
- **Loss prevention:** The minimization of the likelihood (probability) of a loss through proactive methods such as risk assessment and identification; staff and volunteer education, credentialing, and development; policy and procedure implementation, review, and revision; preventive maintenance; quality/performance review and improvement; root-cause analysis; and others.
- **Near miss:** An event or situation that could have resulted in an accident, injury, or illness but did not, either by chance or through timely intervention (e.g., a procedure almost performed on the wrong patient due to lapse in verification of patient identification but caught at the last minute by chance). Near misses are opportunities for learning and afford the chance to develop preventive strategies and actions. Near misses receive the same level of scrutiny as adverse events that result in actual injury.
- **Potentially compensable event (PCE):** An unusual occurrence or serious injury for which there is neither an active claim nor institution of formal legal action but that, in the organization's judgment, is reportable to the party (or parties) providing the medical malpractice insurance. Examples include a fall with injuries, delay or failure in diagnosing a patient's condition, an adverse reaction to treatment, significant complaints from a patient or family regarding care or treatment, and an attorney request for medical records.
- **Risk analysis:** Determination of the causes, potential probability, and potential harm of an identified risk and alternatives for dealing with the risk. Examples of risk analysis techniques include failure mode and effects analysis, systems analysis, root-cause analysis, and tracking and trending of adverse events and near misses, among others.
- **Risk assessment:** Activities undertaken in order to identify potential risks and unsafe conditions inherent in the organization or within targeted systems or processes.
- **Risk avoidance:** Avoidance of engaging in practices or of hazards that expose the organization to liability.

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- **Risk control:** Treatment of risk using methods aimed at eliminating or lowering the probability of an adverse event (i.e., loss prevention) and eliminating, reducing, or minimizing harm to individuals and the financial severity of losses when they occur (i.e., loss reduction).
- **Risk financing:** Analysis of the cost associated with quantifying risk and funding for it.
- **Risk identification:** The process used to identify situations, policies, or practices that could result in the risk of patient harm and/or financial loss. Sources of information include proactive risk assessments, closed claims data, adverse event reports, past accreditation or licensing surveys, medical records, clinical and risk management research, walk-through inspections, safety and quality improvement committee reports, insurance company claim reports, risk analysis methods such as failure mode and effects analysis and systems analysis, and informal communication with healthcare providers.
- **Risk management:** Clinical and administrative activities undertaken to identify, evaluate, prevent, and control the risk of injury to patients, staff, visitors, volunteers, and others and to reduce the risk of loss to the organization itself. Activities include the process of making and carrying out decisions that will prevent or minimize clinical, business, and operational risks.
- **Root-cause analysis:** A process for identifying the basic or causal factor(s) that underlie the occurrence or possible occurrence of an adverse event.
- **Sentinel event:** Defined by the Joint Commission as an unexpected occurrence involving death or serious physical or psychological injury, or the risk thereof. Serious injury specifically includes loss of limb or function. The phrase "or the risk thereof" includes any process variation for which a recurrence would carry a significant chance of a serious adverse event.
- **Trigger methodology:** A method of measuring harm related to the occurrence of — adverse events. The method utilizes a clearly defined list of patient events (also known as a "trigger tool") against which patient medical records are screened. Screening criteria are based on high-risk areas, or those areas identified as "red flags" through event reporting or as a result of a severe adverse event (e.g., new diagnosis of cancer, nursing home placement, use of more than five medications, high-risk pregnancy).
- **Unsafe and/or hazardous condition:** Any set of circumstances (exclusive of a patient's own disease process or condition) that significantly increases the likelihood of a serious adverse outcome for a patient or of a loss due to an accident or injury to a visitor, employee, volunteer, or other individual.

## 1. PROGRAM GOALS AND OBJECTIVES

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The Patient Safety and Risk Management ~~Program~~ Plan goals and objectives (monitored by the Peer Review and Risk Management Committee) are to:

- Continuously improve patient safety and minimize and/or prevent the occurrence of errors, events, and system breakdowns leading to harm to patients, staff, volunteers, visitors, and others through proactive risk management and patient safety activities.
- Minimize adverse effects of errors, events, and system breakdowns when they do occur.
- Minimize losses to the organization overall by proactively identifying, analyzing, preventing, and controlling potential clinical, business, and operational risks.
- Facilitate compliance with regulatory, legal, and accrediting agency requirements.
- Protect human and intangible resources (e.g., reputation).

## 2. SCOPE AND FUNCTIONS OF THE PROGRAM


The ~~Health Services Agency Clinics~~ Clinic Services Division ~~Patient Safety and Risk Management Program~~ Peer Review and Risk Management Committee interfaces with many operational departments and services throughout the organization.

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### 2.1 Functional Interfaces

Functional interfaces with the ~~patient safety and risk management program~~ Peer Review and Risk Management Committee include the following:


- Buildings and grounds
- Claims management
- Corporate/regulatory compliance
- Credentialing of providers
- Disaster preparation and management
- Employee health

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- Event/incident/accident reporting and investigation
- Finance/billing
- Human resources
- Infection control
- Information technology
- Legal and contracts
- Marketing/advertising/public relations
- Nutritional services
- Patient and family education
- Patient satisfaction
- Pharmaceuticals and therapeutics
- Product/materials management
- Quality/performance assessment and improvement
- Safety and security
- Social service programs
- Staff education
- Volunteers

**2.2 Peer Review and Risk Management Committee Program Functions**

Peer Review and Risk management functional responsibilities include:

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a) Developing systems for and overseeing the reporting of adverse events, near misses, and potentially unsafe conditions. Reporting responsibilities may include internal reporting as well as external reporting to regulatory, governmental, or voluntary agencies. This includes the development and implementation of event-reporting policies and procedures.

b) Ensuring the collection and analysis of data to monitor the performance of processes that involve risk or that may result in serious adverse events (e.g., preventive screening, diagnostic testing, medication use processes, etc.). Proactive risk assessment can include the use of failure mode and effects analysis, system analysis, and other tools.

c) Overseeing data collection and processing, information analysis, and generation of statistical trend reports for the identification and monitoring of adverse events, claims, finances, and effectiveness of the risk management program.

This system may utilize and include, but is not limited to, the following:

- Attorney requests for medical records, x-rays, laboratory reports
- Committee reports and minutes
- Criteria-based outcome studies
- Event, incident, or near miss reports
- Medical record reviews
- Monitoring systems based on objective criteria
- Notice letters, lawsuits
- Nursing reports
- Patient complaints
- Physician and other medical professionals' input
- Results of failure mode and effects analysis of ~~high-risk~~ high-risk processes
- Root-cause analyses of sentinel events

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d) Analyzing data collected on adverse events, near misses, and potentially unsafe conditions; providing feedback to providers and staff; and using this data to facilitate systems improvements to reduce the probability of occurrence of future related events. Root-cause analysis and systems analysis can be used to identify causes and contributing factors in the occurrence of such events.

e) Ensuring compliance with data collection and reporting requirements of governmental, regulatory, and accrediting agencies.

f) Facilitating and ensuring the implementation of patient safety initiatives such as improved tracking systems for preventive screenings and diagnostic tests, medication safety systems, and falls prevention programs.

g) Facilitating and ensuring provider and staff participation in educational programs on patient safety and risk management.

h) Facilitating a culture of safety in the organization that embodies an atmosphere of mutual trust in which all providers and staff members can talk freely about safety problems and potential solutions without fear of retribution. This ordinarily involves performing safety culture surveys and assessments.

i) Proactively advising the organization on strategies to reduce unsafe situations and improve the overall environmental safety of patients, visitors, staff, and volunteers.

j) Reducing the probability of events that may result in losses to the physical plant and facility and equipment (e.g., biomedical equipment maintenance, fire prevention).


k) Preventing and minimizing the risk of liability to the organization, and protecting the financial, human, and other tangible and intangible assets of the organization.

l) Decreasing the likelihood of claims and lawsuits by developing a patient and family communication and education plan. This includes communicating and disclosing errors and events that occur in the course of patient care with a plan to manage any adverse effects or complications.

m) Decreasing the likelihood of lawsuits through effective claims management, and management and investigating and assisting in claim resolution to minimize financial exposure in coordination with the liability insurer and its representatives.

n) Reporting claims to medical malpractice insurance providers and other insurers in accordance with the requirements of the insurance policy/contract.



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o) Supporting quality assessment and improvement programs throughout the organization.

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p) Implementing programs that fulfill regulatory, legal, and accreditation requirements.

q) ~~Establishing~~ ~~Convene~~ an ongoing patient safety Peer Review and Risk management committee composed of representatives from key clinical and administrative departments and services.

r) Monitoring the effectiveness and performance of risk management and patient safety actions. Performance monitoring data may include:


- Claims and claim trends
- Culture of safety surveys
- Event trending data
- Ongoing risk assessment information
- Patient's and/or family's perceptions of how well the organization meets their needs and expectations
- Quality performance data
- Research data

s) Completing ~~insurance, and~~ insurance and deeming applications (by Personnel Department).

t) Developing and monitoring effective handoff processes for continuity of patient care.

### 3. ADMINISTRATIVE AND COMMITTEE STRUCTURE AND MECHANISMS FOR COORDINATION

The Patient Safety and Risk Management ~~Program Plan~~ is administered through the ~~risk manager~~ Risk Manager and/or designee (Senior Health Services Manager), who reports to Chief of Clinic Services. The ~~risk manager~~ Risk Manager and Senior Health Services Manager interfaces with administration, staff, medical providers, and other professionals and has the authority to cross operational lines in order to meet the goals of the program. The ~~risk manager~~ Senior Health Services Manager (or alternate

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as designated by the Chief of Clinic Services) ~~chair~~ facilitates the activities of the Patient Safety/~~Risk~~ Peer Review and Risk Management Committee. The committee meets regularly and includes representatives from key clinical and services. The composition of the Patient Safety/~~Peer Review and Risk Management~~ Committee is designed to facilitate the sharing of risk management knowledge and practices across multiple disciplines and to optimize the use of key findings from risk management activities in making recommendations to reduce the overall likelihood of adverse events and improve patient safety. The Committee's activities are an integral part of a patient safety and quality improvement and evaluation system.

Documentation of the designation of the ~~risk manager~~ Risk Manager is contained in the Patient Safety Risk Management Plan. The ~~risk manager~~ Risk Manager is responsible for overseeing day-to-day monitoring of patient safety and risk management activities and for investigating and reporting to the insurance carrier actual or potential clinical, operational, or business claims or lawsuits arising out of the organization, according to requirements specified in the insurance policy and/or contract. The ~~risk manager~~ Risk Manager serves as the primary contact between the organization and other external parties on all matters relative to risk identification, prevention, and control, as well as risk retention and risk transfer. The ~~risk manager~~ Risk Manager oversees the reporting of events to external organizations, per regulations and contracts, and communicates analysis and feedback of reported risk management and patient safety information to the organization for action.


#### 4. MONITORING AND CONTINUOUS IMPROVEMENT

The Patient Safety/~~Peer Review and Risk Management~~ Committee reviews risk management activities regularly. The ~~Risk M~~anager or Senior Health Services Manager (designee) reports activities and outcomes (e.g., claims activity, risk and safety assessment results, event report summaries and trends) regularly to the ~~governing board~~ Commission. This report informs the governing board of efforts made to identify and reduce risks and the success of these activities and communicates outstanding issues that need input and/or support for action or resolution. Data reporting may include event trends, claims analysis, frequency and severity data, credentialing activity, relevant provider and staff education, and risk management/patient safety activities. ~~In accordance with the organization's bylaws, recommendations from the Patient Safety/Risk Management Committee are submitted as needed to the board for action or non-action.~~ Performance improvement goals are developed to remain consistent with the stated risk management and patient safety goals and objectives.

Documentation is in the form of quarterly risk management reports to the administrator/CEO and ~~governing board~~ Commission on risk management activities and outcomes.

#### 5. CONFIDENTIALITY

Any and all documents and records that are part of the patient safety and risk management process shall be privileged and confidential to the extent provided by state and federal law. Confidentiality protections can include attorney client privilege, attorney work product, and peer review protections.

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~~Medical providers may be able to apply the federal privilege and confidentiality protections granted by the Patient Safety and Quality Improvement Act of 2005 to its patient safety events, data, and reports referred to in the law as patient safety work product by creating a patient safety evaluation system, through which the organization collects patient safety work product with the intent of providing it to one or more patient safety organizations for analysis and feedback. Care must be taken to ensure that the patient safety evaluation system is developed within the context of the provider's state laws for legal privilege and peer review as well as any applicable federal regulations.~~

