The County of Santa Cruz
Integrated Community Health Center Commission
MEETING AGENDA

July 2, 2025 @ 1:00pm - 2:00pm

MEETING LOCATION: In-Person – 150 Westridge, Suite 101, Watsonville, Ca 95076 and 1080 Emeline Ave., Bldg. D, Admin Conference Room, Santa Cruz, CA 95060, 40 Eileen Street, Watsonville CA 95076, will connect through Microsoft Teams Meeting or call in (audio only) +1 831-454-2222,191727602# United States, Salinas Phone Conference ID: **191 727 602#**

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. June 11, 2025, Meeting Minutes – Action Required
4. Chronic Pain Management Policy – Action Required
5. Adding Dientes Penny Lane Site – Action Required
6. Quality Management Plan - Action Required
7. Approve new Policy and Procedure "False Claims Act Requirements" – Action Required
8. Motion to Rescind
9. Quality Management Update
10. Financial Update
11. CEO Update

Action Items from Previous Meetings: Action Item	**Person(s) Responsible**	**Date Completed**	**Comments**
Proposition 35 passed. Report back next couple of months what does that mean on revenues that will be coming into the clinic system.	Julian		

Next meeting: Wednesday, August 6, 2025, 1:00pm - 2:00pm **Meeting Location: In-Person** - 150 Westridge, Suite 101, Watsonville, Ca 95076 and 1080 Emeline Ave., Bldg. D, Admin Conference Room, Santa Cruz, CA 95060. Commission will connect through Microsoft Teams Meeting or call in (audio only) +1 831-454- 2222,191727602# United States, Salinas Phone Conference ID: **191 727 602#**

The County of Santa Cruz Integrated Community Health Center Commission

Minute Taker: Mary Olivares

Minutes of the meeting held July 2, 2025

TELECOMMUNICATION MEETING: Microsoft Teams Meeting - or call-in number +1 916-318-9542 – PIN# 500021499#

Attendance	
Len Finocchio	Executive Board – Co-Chair
Rahn Garcia	Member
Dinah Phillips	Member
Marco Martinez-Galarce	Member
Michelle Morton	Member
Amy Peeler	County of Santa Cruz, Chief of Clinics
Raquel Ruiz	County of Santa Cruz, Senior Health Services Manager
Julian Wren	County of Santa Cruz, Admin Services Manager
Mary Olivares	County of Santa Cruz, Admin Aide
Meeting Commenced at 1:00 pm and concluded at 2:10 pm	

Excused/Absent:

Excused: Christina Berberich
Absent: Maximus Grisso
Absent: Nicole Pfeil

1. Welcome/Introductions

Introductions were done at this time.

2. Oral Communications:

Marco mentioned he had visited the Watsonville clinic and usually he takes the plastic bands for blood draws home. At this last visit he was told that he could not take the band home, and he wanted to know if there was a rule to prevent this from happening. Amy to find out if there is a regulation on medical waste and will update Marco.

Rahn stated he will be sending Mary an article for her to send out to commissioners.

3. June 11, 2025, Meeting Minutes – Action Required

Review of June 11, 2025, Meeting Minutes – Recommended for approval. Marco motioned to accept minutes as presented. Rahn second, and the rest of the members present were all in favor.

4. Chronic Pain Management Policy – Action Required

Raquel presented the new chronic pain management policy to commissioners. Currently, clinicians refer to the Safe RX Pain Management Guidelines that was created by Santa Cruz County Health Improvement Partnership and is used throughout Santa Cruz County. Commissioners had questions and concerns with duplicate information on the policy and the Safe RX Pain Management Guidelines. This draft policy appears to be written as a procedure with granular level of detail. The policy should only have information not included in the Safe RX Pain Management Guidelines. Raquel will update the Policy Committee with the commission concerns. Raquel to come back to commissioners in one year with assessment on how the policy is working. Rahn moved to adopt the policy. Dinah second, and the rest of the members present were all in favor.

5. Adding Dientes Penny Lane Site – Action Required

Raquel reported Dientes acquired a new space located in Watsonville on Penny Lane to expand their services. The commission needs to approve adding a site to our HRSA scope because we have a written agreement with Dientes to provide dental care to eligible patients. Dinah moved to approve. Marco second, and the rest of the members present were all in favor.

6. Quality Management Plan - Action Required

Raquel presented the Quality Management Plan to commissioners for approval. Raquel went over updates and changes with commissioners. Rahn motioned to accept the Quality Management Plan with changes. Dinah second, and the rest of the members present were all in favor.

7. Approve new Policy and Procedure "False Claims Act Requirements" – Action Required

Julian presented the new False Claims Act Requirement draft policy and procedure. He started to review the new policy with commissioners, and the question if this new policy has been reviewed by County Counsel. Commissioners would like this reviewed by County Counsel before approving it. Julian will return a draft after County Counsel reviews at a future meeting for approval.

8. Motion to Rescind
Commissioners stated this item will be taken off the agenda. Maximus can ask at any meeting if he has any questions about this item.
9. Quality Management Update
Raquel reported at the last Quality Management Committee Meeting they finalized the Quality Management Plan (action item on the agenda). She also reported they reviewed the Quality Management detailed calendar. Raquel presented the Care Based Incentive (CBI) quality care measures. She stated there are three lower performing measures that include breast cancer screening, cervical cancer screening and child and adolescent well care visits. Raquel reported they were allocated funding in the amount of $220,000.00 which will be used to allocate staffing to assist with outreach to schedule patients. Raquel reported on the Mobile Mammography Pilot project with the Alliance and Alinea. She stated screenings are provided on a mobile van, and they aim to schedule 7 patients per hour and a minimum of 30 per day with a goal of 40. She reported that Alinea is providing screening mammograms to patients, and they will receive a $50 Target gift card after completing the screening (day of service). Raquel reported on the two successful events at the Watsonville Health Center on 6/26/2025 with 37 completed mammograms and Emeline Health Center and Homeless Persons Health Project on 6/30/2025 with 34 completed mammograms. Raquel reported on Peer Review & Risk Management Committee. Raquel reported that 79 chart audits were completed on June 18th at the all-provider meeting. The theme of the chart audits were patients with diabetes and overweight pediatric patients. She reported the providers had virtual break out rooms and that worked well for small group discussions. The action items from this chart review where: education on pediatric overweight, collaboration with Parks Rx, problem-based training in our Electronic Health Record and standardized rooming for people with diabetes.
10. Financial Update
Julian reported on year-to-date financials for year 2024 vs. 2025. He reported revenue has increased by approx. 18.4% compared to the same period last year. Julian reported the year-to-date deficit has been reduced by 2.63 million. Julian reported that some of the potential contributing factors may include increased patient volume, expanded templates, reduction in no shows, increased operational efficiency, improved billing practices, and receipt of new or enhanced grant funding or supplemental programs. Lastly, Julian reported total expenditures YTD: $50.93 million, this reflects operational and program-related outflows. The current operating deficit is: Approximately $9.1 million. He reported on the observations: The revenue collected is trailing behind expenditures by 18%, it is important to monitor whether this is due to: delayed reimbursements or grants, shortfall in projected service delivery or encounter volumes, and significant increase in Personnel costs. At this time Rahn moved to add an additional 5 minutes to this meeting. Dinah second and all the other members present were all in favor.
11. CEO Update
Amy reported that she and Julian are working on a presentation, sustainability as an organization. She lastly reported there is a transition leadership staff either retiring or moving to a different organization. Dinah and Commissioners thanked Amy and staff for all their hard work and how much they all are appreciated.

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☐ Minutes approved _____ ___/___/___

(Signature of Board Chair or Co-Chair) (Date)

SUBJECT: **Chronic Pain Management Policy**	POLICY NO.: **300.29**	COUNTY OF SANTA CRUZ HEALTH SERVICES AGENCY
SERIES: 300 **Patient Care and Treatment**	PAGE: 1 EFFECTIVE DATE: **July 2025**	
APPROVED BY: **Amy Peeler, Chief of Health Centers**	REVISED:	**Health Centers Division**

POLICY STATEMENT:

The County of Santa Cruz Health Services Agency Health Centers Division (Health Centers) provides standardized treatment and care to patients requiring chronic pain management services. This policy outlines evidence-based best practices and guidelines for providers when prescribing opioid analgesics for chronic, non-cancer pain management. Providers should always use their best clinical judgment when deciding whether to prescribe controlled medications and ensure compliance with all applicable state and federal laws and regulations.

DEFINITIONS:

Chronic Pain Medication Management: The receipt of opioid analgesics for pain lasting three months or longer.

Non-Cancer Pain: Headaches, low back pain, fibromyalgia, abdominal pain, diabetic neuropathy, etc.

PROCEDURE:

A. Standard Goals of Chronic Pain Therapy

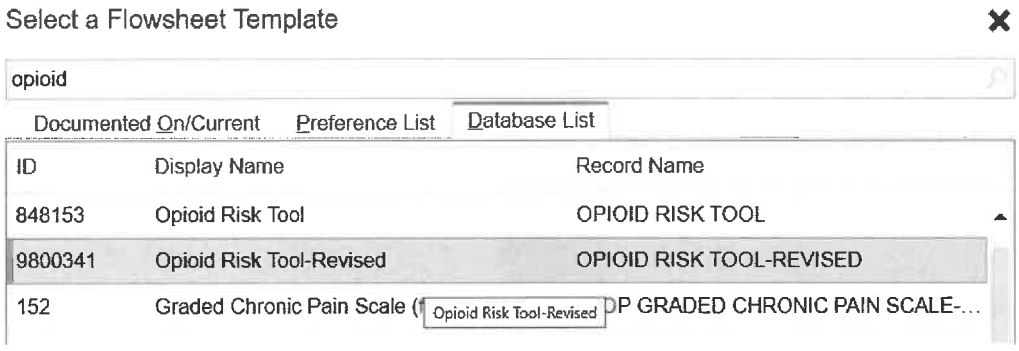
1. Provide appropriate access to pain medication management modalities
2. Increase function and decrease pain for the patient
3. Reduce unnecessary hospitalizations and Emergency Room (ER) visits
4. Decrease morbidity and mortality
5. Minimize overuse, abuse, and diversion of prescribed pharmaceuticals
6. Follow current CDC and Medical Board of California guidelines for pain medication management

B. Initial Assessment and Risk Evaluation

1. Prior to Initiating Opioid Therapy

a. Complete comprehensive pain assessment documenting:
   i. Location, intensity, quality, and duration of pain
   ii. Impact on function and quality of life
   iii. Previous treatments and response
   iv. Psychosocial factors including trauma history

b. Conduct thorough risk assessment:
   i. Obtain CURES Patient Activity Report
   ii. Request and review prior medical records
   iii. Screen for mental health conditions
   iv. Assess substance use history including alcohol and tobacco
   v. Complete standardized risk assessment tool using EPIC Flowsheet Opioid Risk Tool-Revised (ID 9800341) or EPIC Flowsheet DIRE Score (ID 293) in EHR. (Refer to Appendix A)



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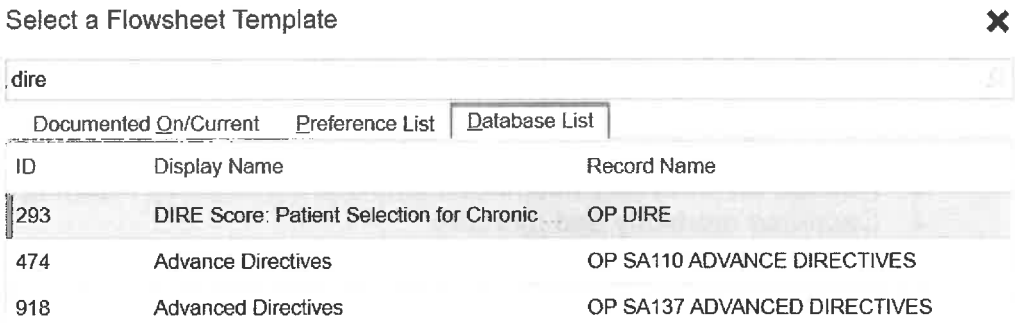
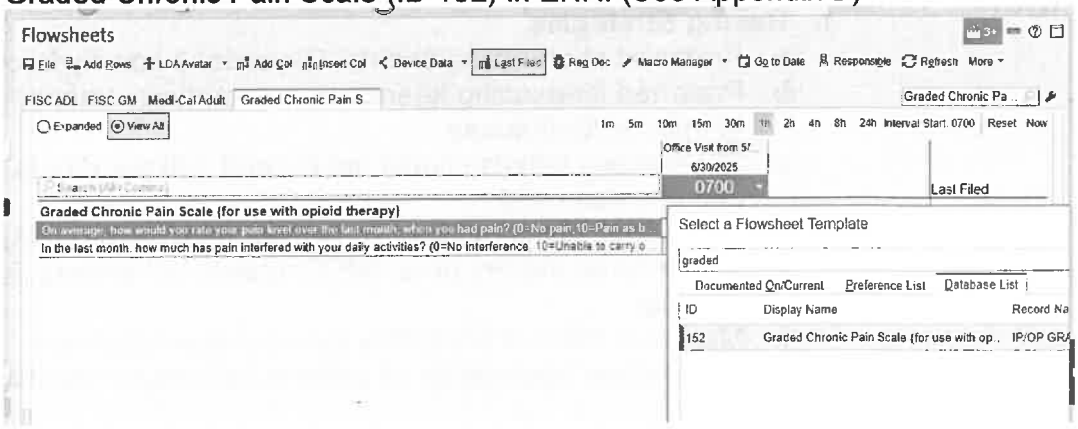


c. Establish clear diagnosis and document in EHR problem list
d. Complete a detailed history and physical exam
e. Document informed consent regarding risks and benefits

2. **First Visit Prescribing Guidelines**
   a. Opioid prescriptions at first visit require:
      i. Complete CURES review
      ii. Documentation of low risk assessment
      iii. Sufficient prior medical records
      iv. No concern about behavioral history
   b. Consider non-opioid and non-pharmacological options first
   c. Document clinical rationale for opioid initiation

C. Treatment Planning and Monitoring

1. **Required Documentation**
   a. The patient must sign an annual medication management agreement in EHR
      i. Document using EPIC communications letter named "SA11 MED MGMT AGREEMENT ENG" or "SA11MED MGMT AGREEMENT SPA"
   b. Specific medications and visit schedule
   c. Initial behavioral health evaluation
   d. Annual depression assessment
   e. Complete regular functional assessment using EPIC Flowsheet Graded Chronic Pain Scale (ID 152) in EHR. (See Appendix B)



   f. Electronic prescribing for all scheduled medications

2. **Monitoring Requirements**
   a. Minimum patient visits every three months
   b. CURES report review before each prescription
   c. Non-scheduled urine toxicology screening every six months
   d. More frequent monitoring for high-risk patients
   e. Annual comprehensive physical examination
   f. Documentation of the "5 A's" at each visit:
      i. Analgesia: 0-10 pain scale
      ii. Activity Level: Function metrics
      iii. Adverse Effects: Side effects monitoring
      iv. Aberrant Behaviors: Assess for concerning behaviors
      v. Accurate medication log

3. **Treatment Approach**
   a. Implement multimodal approach including:
      i. Non-opioid pharmacotherapy (NSAIDs, acetaminophen, anticonvulsants, etc.)
      ii. Non-pharmacological interventions (PT, exercise, TENS, etc.)
      iii. Behavioral health integration
      iv. Pain education and self-management strategies
   b. Consider opioids as time-limited therapeutic trial with clear goals
   c. Discontinue if goals are not achieved or risks outweigh benefits

D. Dosing Guidelines and Limitations

1. **Dosing Strategies**
   a. Preferred short-acting agents: Oxycodone and Hydrocodone
   b. Preferred long-acting agents: Buprenorphine, extended-release Morphine, Methadone
   c. Short-acting tablets should not exceed 120 per month unless documented need
   d. Avoid prescribing multiple immediate-release formulations
   e. Morphine equivalent dose (MED) should not exceed 30mg/day for new patients
   f. Maximum MED of 50mg/day for established patients
   g. Taper plans required for all patients currently exceeding 50mg/day MED
   h. Higher doses require pain specialist consultation and written justification

2. **Methadone Guidelines (last resort, in conjunction with Pain specialist and documented reason)**
   a. Methadone will only be used when all the following criteria are met:
      i. As a last resort
      ii. In conjunction with a Pain Specialist
      iii. With a documented reason for the use of Methadone treatment
   b. Start at 5-15 mg split BID (2x a day) or TID (3x a day)
   c. Adjust dose no more frequently than every 7 days
   d. Baseline EKG required for doses exceeding 40 mg daily
   e. Contraindicated with concurrent benzodiazepines
   f. Check for drug-drug interactions
   g. Do not transfer patients from methadone maintenance programs

3. **Morphine Equivalent Dose Conversion Chart**

Drug	100mg Morphine Equivalent Dose		Other	Maximum Daily Dose
Morphine	100mg		Tramadol (Immediate Release)	400mg
Codeine	670mg		Tramadol (Extended Release)	300mg
Hydrocodone	100mg			
Hydromorphone	25mg			
Oxycodone	67mg			

Methadone	25mg			

4. **Concomitant Medication Restrictions**
   a. Mandatory co-prescribing of naloxone for:
      i. Patients on ≥50mg MED daily
      ii. Concurrent use of benzodiazepines
      iii. History of overdose
      iv. Substance use disorder
   b. Acetaminophen: Total daily dose not to exceed 4g; in the case of liver disease 2g
   c. AVOID concurrent prescribing of:
      i. Benzodiazepines
      ii. Muscle relaxants (especially carisoprodol)
      iii. Sedative-hypnotics (zolpidem, etc.)
      iv. Promethazine
      v. Barbiturates
   d. Document clinical justification if any contraindicated combinations are necessary

E. Prescription Management

1. **Prescribing Guidelines**
   a. All controlled substances must be e-prescribed
   b. Standard 30-day prescription cycle
   c. Limit initial opioid prescriptions for acute pain to 7 days
   d. No early refills (>2 days) except for documented medical necessity
   e. No replacement of lost or stolen prescriptions
   f. No after-hours, weekend, or holiday refills
   g. Document MED calculation in chart for all opioid prescriptions

2. **Cross-Coverage Protocol**
   a. Covering providers may honor refills only if:
      i. Valid medication management agreement is documented
      ii. No agreement violations are evident
      iii. Patient has been seen within 3 months
      iv. CURES report shows no discrepancies
      v. No dose increases are requested
   b. Covering providers may:
      i. Provide partial prescriptions

ii. Order toxicology screening
iii. Deny refills if conditions are not met

F. Discontinuation and Tapering

1. **Medication Management Agreement Violations**
   a. Document all violations in EHR and through Health Centers's Incident ticketing system
   b. Respond to each violation with appropriate intervention
   c. Consider tapering opioids for patients with active substance use
   d. Termination of medication management agreement can occur at any time and is subject to the clinician's medical discretion and the Medical Director's review and approval following the SafeRX Santa Cruz County Prescriber Practice Guidelines.
2. **Termination of Medication Management Agreement**
   a. Document in patient chart using the Health Centers' EHR system
   b. Offer appropriate referrals
   c. No further opioid prescriptions without Medical Director approval

3. **Opioid Tapering Guidelines**
   a. Individualized tapering plans documented in EHR
   b. Recommended taper rate: 10% of original dose per week
   c. Consider slower taper of 5-10% per month for long-term users
   d. Never reverse taper, but may pause for withdrawal management
   e. Coordinate with specialists for high-risk patients
   f. Provide psychosocial support during taper
   g. Offer naloxone for overdose prevention
   h. Implement structured follow-up schedule during tapering
   i. Consider buprenorphine for patients with withdrawal difficulties

G. Quality Assurance and Oversight

1. **Opioid Oversight Review Process**
   a. Daily doses exceeding thresholds require Peer Review:
      i. Morphine: ≥100mg/day
      ii. Methadone: ≥40mg/day
   b. Annual auditing of chronic pain management cases
      i. A Peer Review meeting will be designated for the annual audit
      ii. There will be an annual audit of patient charts that exceed the designated thresholds of controlled substances
   c. Provider-specific prescribing pattern reports

i. Concerns can be sent to Peer Review

2. **Chronic Pain Peer Review Questions (Appendix C)**
   a. Clear diagnosis consistent with chronic opioid therapy
   b. Documentation of substance use history
   c. Pain and function assessments
   d. Valid medication management contract and treatment plan
   e. Regular Health Center Clinician follow-up every six months at a minimum
   f. Periodic treatment plan review
   g. Appropriate referrals
   h. Toxicology screening compliance

REFERENCES:

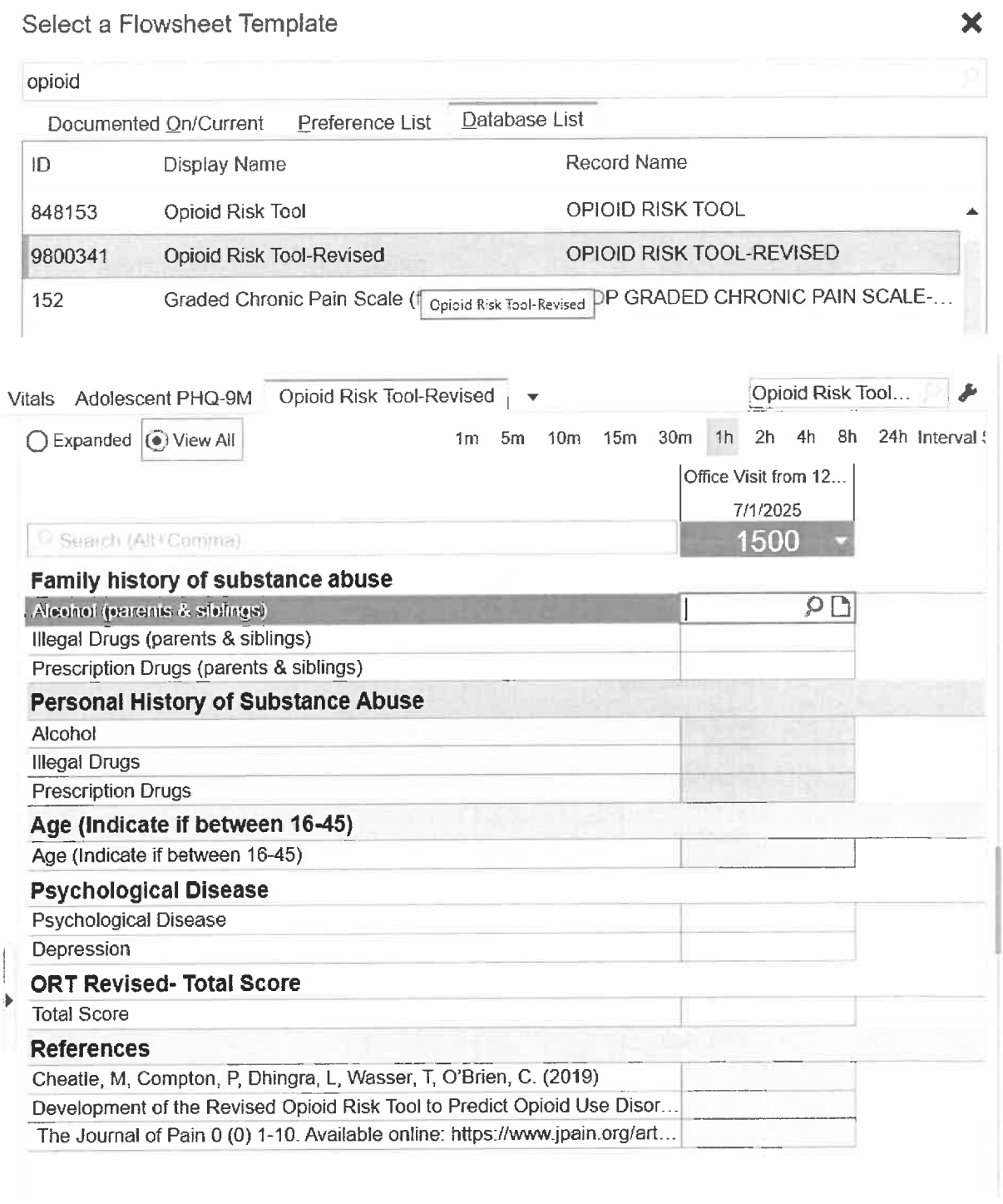
CDC Guideline for Prescribing Opioids for Chronic Pain
DIRE Score: Patient Selection for Chronic Opioid Analgesia:
https://bup.clinicalencounters.com/
Health Improvement Partnership of Santa Cruz County | SafeRx:
https://www.hipscc.org/prescriber-practice-guidelines Medical Board of California Guidelines for Prescribing Controlled Substances for Pain
Opioid Risk Tool:
https://www.drugabuse.gov/sites/default/files/files/OpioidRiskTool.pdf

APPENDICES

Appendix A: Risk Assessment Tools: Opioid Risk Tool-Revised or DIRE Score
Appendix B: Functional Assessment: Graded Pain Scale
Appendix C: Chronic Pain Peer Review Questions

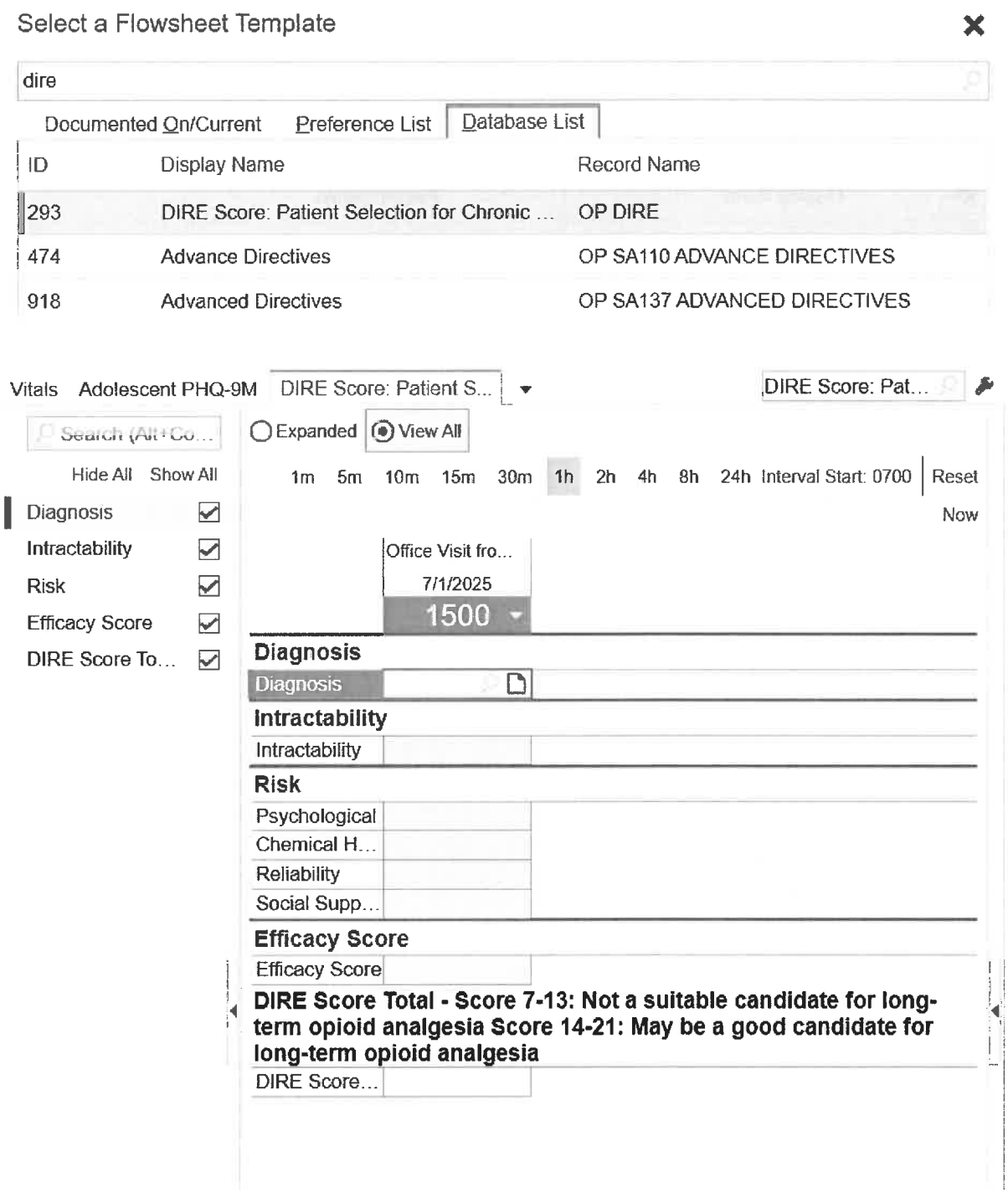
APPENDIX A: Risk Assessment Tools

Opioid Risk Tool – Revised



APPENDIX A: Risk Assessment Tools

DIRE Score



APPENDIX B: Functional Assessment – Graded Pain Scale

GRADED PAIN AND FUNCTION SCALE

Pain Intensity and Interference

In the last month, on average, how would you rate your pain? Use a scale from 0 to 10, where 0 is "no pain" and 10 is "pain as bad as could be"? (That is, your usual pain at times you were in pain.)

No Pain										Pain as bad as could be
0	1	2	3	4	5	6	7	8	9	10

In the last month, how much has paininterfered with your daily activities? Use a scale from 0 to 10, where 0 is "no interference" and 10 is "unable to carry on any activities"?

No Interference										Unable to carry on any activities
0	1	2	3	4	5	6	7	8	9	10

APPENDIX C: Chronic Pain Peer Review Questionnaire

Chronic Pain Management Plan Peer Review Questionnaire

Patient Information & Review Details

Patient ID/Initials: _____
Reviewer Name: _____
Review Date: _____
Plan Creation Date: _____
Primary Diagnosis: _____

Section 1: Assessment & Diagnosis (20 points)

1.1 Pain Assessment Completeness

Score: ___/5

- **Excellent (5):** Comprehensive pain history including onset, duration, quality, intensity, location, aggravating/alleviating factors
- **Good (4):** Most pain characteristics documented with minor omissions
- **Satisfactory (3):** Basic pain assessment present but lacks detail
- **Needs Improvement (2):** Minimal pain assessment documentation
- **Inadequate (1):** Insufficient or missing pain assessment

Comments: _____

1.2 Functional Impact Assessment

Score: ___/5

- **Excellent (5):** Thorough evaluation of impact on ADLs, work, sleep, relationships, mood
- **Good (4):** Good assessment of functional impact with minor gaps
- **Satisfactory (3):** Basic functional assessment completed
- **Needs Improvement (2):** Limited functional impact documentation
- **Inadequate (1):** Functional impact not adequately assessed

Comments: _____

1.3 Psychosocial Evaluation

APPENDIX C: Chronic Pain Peer Review Questionnaire

Score: ___/5

- **Excellent (5):** Comprehensive mental health screening, coping mechanisms, social support assessed
- **Good (4):** Good psychosocial evaluation with minor omissions
- **Satisfactory (3):** Basic psychosocial factors addressed
- **Needs Improvement (2):** Limited psychosocial assessment
- **Inadequate (1):** Psychosocial factors inadequately evaluated

Comments: _____

1.4 Diagnostic Workup Appropriateness

Score: ___/5

- **Excellent (5):** Appropriate diagnostic tests ordered, results integrated into plan
- **Good (4):** Generally appropriate workup with minor questions
- **Satisfactory (3):** Basic diagnostic approach adequate
- **Needs Improvement (2):** Some inappropriate or missing diagnostics
- **Inadequate (1):** Diagnostic workup insufficient or inappropriate

Comments: _____

Section 2: Treatment Plan Development (25 points)

2.1 Goal Setting

Score: ___/5

- **Excellent (5):** SMART goals (Specific, Measurable, Achievable, Relevant, Time-bound) clearly defined
- **Good (4):** Goals mostly well-defined with minor clarity issues
- **Satisfactory (3):** Basic goals established
- **Needs Improvement (2):** Goals present but vague or unrealistic
- **Inadequate (1):** Goals missing or inappropriate

Comments: _____

APPENDIX C: Chronic Pain Peer Review Questionnaire

2.2 Multimodal Approach

Score: ___/5

- **Excellent (5):** Comprehensive plan incorporating pharmacological, non-pharmacological, and psychological interventions
- **Good (4):** Good integration of multiple treatment modalities
- **Satisfactory (3):** Some multimodal elements present
- **Needs Improvement (2):** Limited treatment modalities considered
- **Inadequate (1):** Single-modality approach or inadequate variety

Comments: _____

2.3 Evidence-Based Treatment Selection

Score: ___/5

- **Excellent (5):** All interventions supported by current evidence and guidelines
- **Good (4):** Most treatments evidence-based with good rationale
- **Satisfactory (3):** Generally evidence-based approach
- **Needs Improvement (2):** Some treatments lack evidence support
- **Inadequate (1):** Treatments not supported by evidence

Comments: _____

2.4 Individualization

Score: ___/5

- **Excellent (5):** Plan clearly tailored to patient's specific needs, preferences, and circumstances
- **Good (4):** Good individualization with minor generic elements
- **Satisfactory (3):** Some individualization evident
- **Needs Improvement (2):** Limited individualization
- **Inadequate (1):** Generic, one-size-fits-all approach

Comments: _____

2.5 Risk-Benefit Analysis

APPENDIX C: Chronic Pain Peer Review Questionnaire

Score: ___/5

- **Excellent (5):** Thorough consideration of risks, benefits, and alternatives for all interventions
- **Good (4):** Good risk-benefit assessment with minor omissions
- **Satisfactory (3):** Basic risk-benefit considerations present
- **Needs Improvement (2):** Limited risk-benefit analysis
- **Inadequate (1):** Inadequate consideration of risks and benefits

Comments: _____

Section 3: Medication Management (20 points)

3.1 Pharmacological Appropriateness

Score: ___/10

- **Excellent (9-10):** Medications appropriate for condition, evidence-based, proper dosing
- **Good (7-8):** Generally appropriate medication choices
- **Satisfactory (5-6):** Adequate medication selection
- **Needs Improvement (3-4):** Some inappropriate medication choices
- **Inadequate (1-2):** Inappropriate or dangerous medication regimen

Comments: _____

3.2 Opioid Stewardship (if applicable)

Score: ___/10

- **Excellent (9-10):** Appropriate opioid use, proper monitoring, addiction risk assessment
- **Good (7-8):** Good opioid management practices
- **Satisfactory (5-6):** Adequate opioid considerations
- **Needs Improvement (3-4):** Some opioid management concerns
- **Inadequate (1-2):** Inappropriate opioid prescribing or monitoring

- **N/A:** No opioids prescribed

Comments: _____

Section 4: Non-Pharmacological Interventions (15 points)

4.1 Physical Therapy/Rehabilitation

Score: ___/5

- **Excellent (5):** Appropriate PT referral with specific goals and parameters
- **Good (4):** Good PT integration
- **Satisfactory (3):** Basic PT considerations
- **Needs Improvement (2):** Limited PT integration
- **Inadequate (1):** PT inappropriately excluded or applied

Comments: _____

4.2 Psychological/Behavioral Interventions

Score: ___/5

- **Excellent (5):** Appropriate mental health referrals, CBT, mindfulness, or other evidence-based approaches
- **Good (4):** Good psychological intervention integration
- **Satisfactory (3):** Some psychological approaches included
- **Needs Improvement (2):** Limited psychological interventions
- **Inadequate (1):** Psychological needs inadequately addressed

Comments: _____

4.3 Complementary Therapies

Score: ___/5

- **Excellent (5):** Appropriate consideration of acupuncture, massage, etc. based on evidence
- **Good (4):** Good integration of complementary approaches
- **Satisfactory (3):** Some complementary therapies considered

- **Needs Improvement (2):** Limited complementary therapy consideration
- **Inadequate (1):** Inappropriate inclusion/exclusion of complementary therapies

Comments: _____

Section 5: Monitoring & Follow-up (10 points)

5.1 Monitoring Plan

Score: ___/5

- **Excellent (5):** Clear monitoring schedule with specific parameters and outcome measures
- **Good (4):** Good monitoring plan with minor gaps
- **Satisfactory (3):** Basic monitoring plan present
- **Needs Improvement (2):** Vague or inadequate monitoring plan
- **Inadequate (1):** No clear monitoring plan

Comments: _____

5.2 Contingency Planning

Score: ___/5

- **Excellent (5):** Clear plans for treatment failures, side effects, or complications
- **Good (4):** Good contingency planning
- **Satisfactory (3):** Some contingency considerations
- **Needs Improvement (2):** Limited contingency planning
- **Inadequate (1):** No contingency planning evident

Comments: _____

Section 6: Communication & Documentation (10 points)

6.1 Patient Education & Engagement

Score: ___/5

APPENDIX C: Chronic Pain Peer Review Questionnaire

- **Excellent (5):** Comprehensive patient education plan, shared decision-making evident
- **Good (4):** Good patient engagement strategies
- **Satisfactory (3):** Basic patient education addressed
- **Needs Improvement (2):** Limited patient education
- **Inadequate (1):** Patient education inadequate

Comments: _____

6.2 Interdisciplinary Communication

Score: ___/5

- **Excellent (5):** Clear communication plan with all team members and specialists
- **Good (4):** Good team communication strategies
- **Satisfactory (3):** Basic team communication present
- **Needs Improvement (2):** Limited team communication
- **Inadequate (1):** Poor or missing team communication

Comments: _____

Overall Assessment

Total Score: ___/100

Overall Rating:

- **Excellent (90-100):** Exemplary pain management plan
- **Good (80-89):** Strong plan with minor areas for improvement
- **Satisfactory (70-79):** Adequate plan meeting basic standards
- **Needs Improvement (60-69):** Plan requires significant revision
- **Inadequate (Below 60):** Plan requires major restructuring

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Key Strengths:

APPENDIX C: Chronic Pain Peer Review Questionnaire

1. _____
2. _____
3. _____

Priority Areas for Improvement:

1. _____
2. _____
3. _____

Specific Recommendations:

_____

_____

_____

_____

Additional Comments:

_____

_____

_____

_____

Reviewer Signature & Credentials

Reviewer Name: _____
Credentials: _____
Signature: _____
Date: _____

_____

This peer review questionnaire is designed to promote evidence-based, comprehensive chronic pain management through systematic evaluation and continuous quality improvement.

Santa Cruz County Health Services Agency
Health Centers Division
Quality Management Plan

June 2025

Introduction and Statement of Purpose 2

Scope of Work 4

Program Structure and Accountability 4

Defining Quality and Quality Management 5

Quality Assessment 7

Quality Improvement 9

Quality Assurance Activities 10

Resource Assessment 11

Strengthening Institutional Consensus 11

Process for Revision of Quality Management Plan 12

Attachment 1: Quality Management Work Plan Template 13

Attachment 2: Quality Management Committee Meeting Agenda and Minutes 14

Introduction and Statement of Purpose

Santa Cruz County Health Services Agency's Health Centers Division (HCD) is committed to ensuring access to high quality patient-centered health care for all members of our community. Our Mission, embodied in the work of all staff who support patient care at HSA HCD, ***is to promote and protect the health and wellbeing of our community by providing access to quality, comprehensive and affordable primary and integrated behavioral health care services.*** Our collaborative approach fosters teamwork between clinicians, support staff, patients and outside community resources. As part of this commitment, our organization embarked upon a vigorous review of our existing Quality Management system. This has been a collaborative effort that includes administrators, clinicians, and support staff from Homeless Persons Health Project (HPHP), Watsonville Health Center and Santa Cruz Health Center.

HCD has clearly defined our division-wide goal for Quality Management, identified current barriers to reaching this goal, and developed a comprehensive approach to overcoming these barriers and providing consistent, high quality health care to all who are served at each of Santa Cruz County Health Service Agency's primary care health facilities. Throughout our planning process, HCD has included activities to ensure maintenance of the quality standards for primary health care that have been established by the Health Resources and Services Administration's Bureau of Primary Health Care. Specifically, our Quality Management Plan will provide leadership and guidance in support of the division's mission and for ensuring that the health centers are operating in accordance with applicable Federal, State, and local laws and regulations. This Quality Management document reflects the outcomes of our extensive planning work and provides a framework for continual reassessment of our Quality Management program over time.

Purpose:

The Purpose of our Quality Management Plan is to ensure high quality care and services for our patients that is reflected in a holistic set of indicators that are objectively measured and trusted and driven by stakeholder engagement and institutional value of providing high quality care.

Background:

Our Health Center Division established a Steering Committee in 2012 to improve communication between health centers and across the wide variety of Quality Improvement (QI) activities being conducted within the Health Services Agency. Despite improved communication, our organization continued to lack a systematic means of determining the quality of care our patients receive or a consistent approach to enacting change. Although QI projects were being successfully performed, there was no framework for expanding the new process at an institutional level. In addition, our organization was reporting on clinical indicators to various upstream stakeholders without clearly defined and agreed upon processes to regularly review clinical measures, design improvements or track changes over time. Because of the disconnect between health care providers and data reporting, the Steering Committee found that the accuracy of data generated from the Electronic Health Record (EHR) was inconsistent due to variability in data entry and access to discrete fields for data extraction. This had contributed to the devaluing of the Quality Management process amongst health care providers because the data did not consistently reflect the work being performed. Furthermore, we found that there has not been a clear process in place for reporting problems that arise from a staff or patient perspective.

Our Theory of Change

Our Quality Management team has defined a clear set of objectives that will allow us to overcome barriers and reach our goal of consistently high-quality patient care that is confirmed through objective measures.

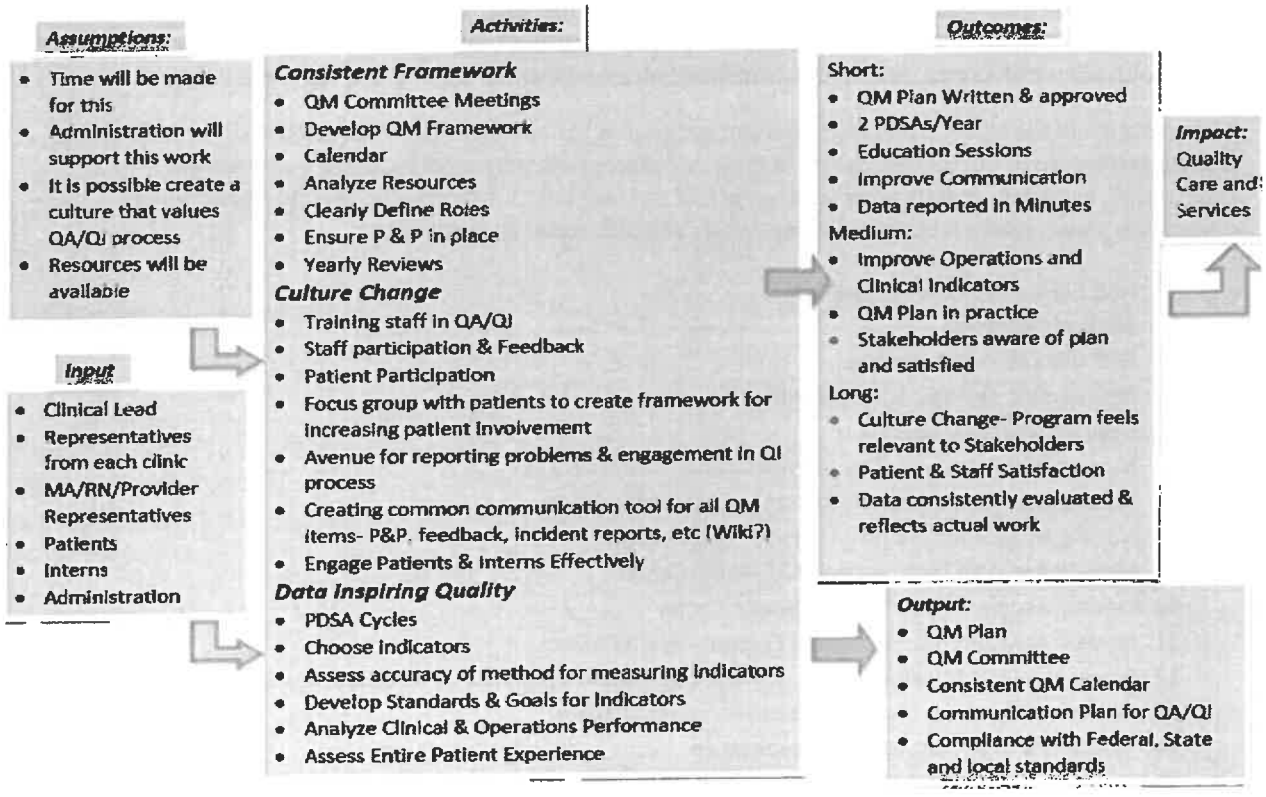
We will reach our goal by focusing on the following three Objectives:

1. ***Develop and Maintain a Cohesive and Comprehensive Framework that includes a plan for engagement of and communication to all stakeholders, as well as a playbook for change that provides a structured process for implementing improvements.***
2. ***Create an institutional consensus around shared definitions of Quality Assurance and Quality Improvement that provides the foundation for improving the perceived value of this process by all stakeholders.***
3. ***Utilize trustworthy data from our robust EHR to drive improvements in quality and efficiency of care and services to our patients.***

Our Logical Framework:

The Quality Management team has developed a logic model that will serve as a framework for continual reassessment of our Quality Management plan. The model is considered a fluid process that is open for stakeholder feedback and will be reevaluated yearly to ensure we are meeting our goals.

Quality Management Logic Model



Scope of Work

The scope of work within our Quality Management plan is comprehensive, and includes all stakeholders, including but not limited to patients, involved in the direct or indirect experience of clinical care to patients seen at our four health facilities. Our goal is to provide a quality experience for all patients, including sub-populations such as those experiencing homelessness or living with HIV, throughout the entire process of accessing, receiving and continuing care. To this end, the scope includes all persons receiving care, administrative and clinical departments who participate in providing primary care, in-house specialty services such as HIV, Orthopedics, Tuberculosis, Behavioral Health, Dental, Acupuncture Immunizations, street medicine, health care for people experiencing homelessness, Medication Assisted Treatment and any support services. To ensure quality care is provided to HSA patients who are seen by outside service providers, we will undergo a due diligence process when signing contracts and perform intermittent quality reviews that include patient satisfaction surveys.

Program Structure and Accountability

Organizational Structure and Accountability

The Co-Applicant Board is ultimately accountable for the quality of care and services provided to the patients cared for at the health centers overseen by the HCD. The Co-Applicant Board has delegated oversight responsibility for the effectiveness and efficiency of care and services to the Chief of Clinic Services, who has assigned responsibility for implementation of policies to the Medical Directors. The Medical Directors has designated the Senior Health Services Manager to facilitate the Quality Management Committee and the Clinical Director of Quality to work directly with medical directors at each health center to ensure quality and implement all aspects of the Quality Management Program.

The operation of the HCD Quality Management program is the collaborative responsibility of the HCD Quality Management Committee, which involves all appropriate personnel including management, clinical staff, and support staff representing each of our four health centers. The Quality Management Committee may consist of the following members and other staff as necessary:

1. HCD Clinical Director of Quality
2. Medical Directors
3. HCD Chief of Health Centers
4. Data Analyst and Epic Site Specialist
5. Health Center Managers
6. Nursing (RN) Representative for Watsonville Health Center
7. Nursing Representative (RN) for Santa Cruz Health Center
8. Nursing Representative (RN) for HPHP Health Center
9. Medical Assistant from Watsonville Health Center
10. Medical Assistant from Emeline Health Center
11. Medical Assistant from Homeless Persons Health Project
12. Representatives At-Large (Intern, patient, registration supervisor or designee, or community partner)
13. Representative from Integrated Behavioral Health team
14. Ryan White Part C Grantee Representative
15. Senior Health Services Manager

The Senior Health Services Manager acts as the facilitator of the Quality Management Committee and prepares the Committee Agendas and Meeting Minutes. These documents are contained within a shared

drive on the HCD computer system. A quorum is defined as the presence of 4 core members representatives of the committee are re-assessed on an annual basis. The Quality Management Committee is responsible for:

- Developing priorities and setting thresholds for Quality Indicators
- Ensuring that all sub-populations are represented in Quality indicators and activities
- Requesting further investigation into specific topics
- Analyzing data and audits
- Recommending membership of Quality Improvement Teams
- Participating in and assessing patient satisfaction surveys
- Reporting committee findings and recommendations to all stakeholders
- Facilitating an annual evaluation of the Quality Management Program.

Meeting Structure

Meetings are conducted on the same day and time monthly. A Yearly Calendar has been created to ensure that the Quality Management Committee meets all its objectives for the year. The template includes key operational and clinical indicators, reporting expectations, and quality improvement activities. As this is an iterative process, we utilize our experience in prior years to improve upon our processes for the following year.

A template for the meeting Agenda and Minutes can be found in Attachment 2. An annual 'open house' or presentation to provide all stakeholders with the opportunity to learn more about the committee, presentations at all staff meetings to share the work of the committee, post information on the county Intranet page, monthly presentations to the Commission, contribute additional ideas and consider membership. This provides the committee with an opportunity to further engage stakeholders and promotes the ability to strengthen the institutional value of quality assurance and quality improvement. To this end, the Quality Management Committee has identified the following key stakeholders:

- Patients
- Clinic Providers
- Nurses, Medical Assistants
- Front Office Staff
- Administrators
- Community Partners
- Co-Applicant Commission

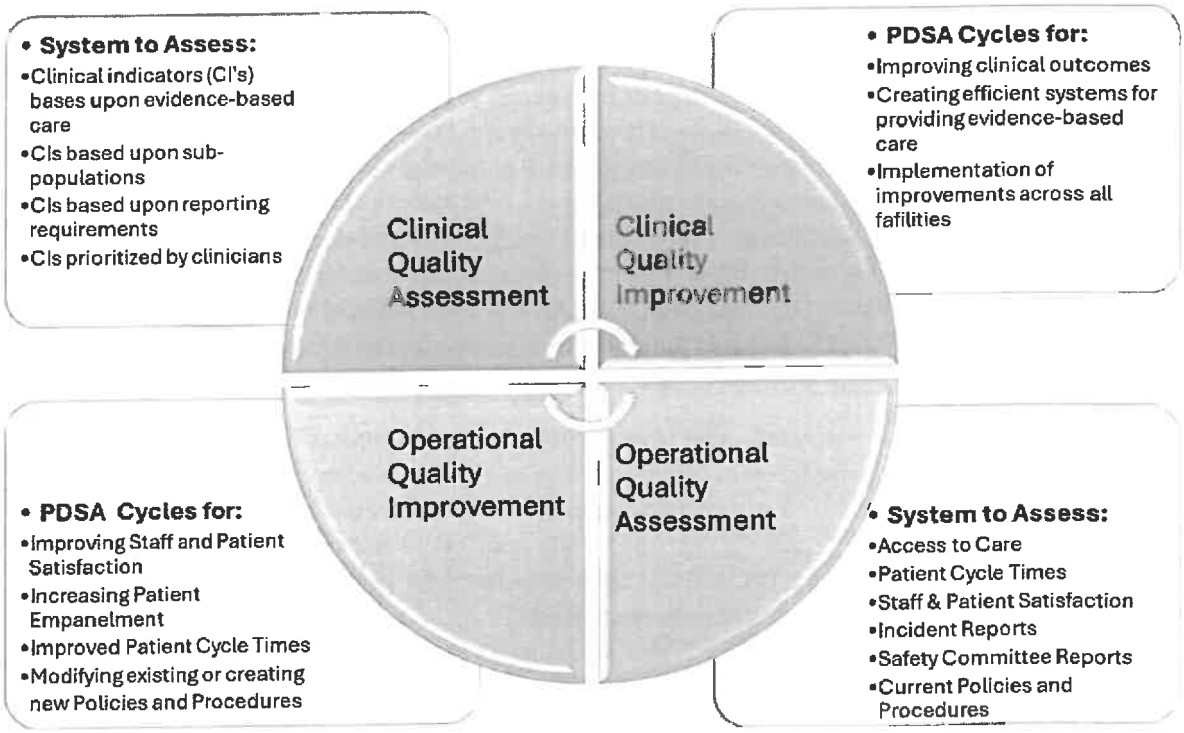
Defining Quality and Quality Management

Developing a comprehensive Quality Management Plan requires a commonly agreed upon definition of Quality. This is particularly important as we engage stakeholders in the integration of quality management into our institutional work. For this plan, HCD has chosen to adopt the World Health Organization (WHO) and Institute of Medicine (IOM) definition of quality as it pertains to health systems. The definition emphasizes a whole-system perspective that reflects a concern for the outcomes achieved for both individual service users and whole communities. This is particularly applicable given our dual role of providing individual clinical care and protecting public health. The WHO and IOM definition suggests that a health system should seek to make improvements in six areas of quality.

Our shared definition of Quality requires that health care be:

- ***Effective***- delivering health care that is adherent to an evidence base and results in improved health outcomes for individuals and communities, based on need.
- ***Efficient***- delivering health care in a manner which maximizes resource use and avoids waste.
- ***Accessible***- delivering health care that is timely, geographically reasonable, and provided in a setting where skills and resources are appropriate to medical need.
- ***Acceptable/Patient-Centered***- delivering health care which considers the preferences and aspirations of individual service users and the cultures of their communities.
- ***Equitable***- delivering health care which does not vary in quality because of personal characteristics such as gender, race, ethnicity, geographical location, or socioeconomic status.
- ***Safe***- delivering health care which minimizes risks and harm to service users.

Santa Cruz Health Services identifies three major components to Quality Management that include Quality Assessment, Quality Improvement and Quality Assurance. By addressing these three separate and essential components to Quality Management, the Quality Management Committee strives to meet all these dimensions of quality health care. Because the committee recognizes that the entire health system from both an Operational and Clinical perspective must work collaboratively to achieve our goals, we consider quality indicators across all departments. The diagram below provides a simple illustration of the intersection of Quality Assessment and Quality Improvement across both Operations and Clinical Care.



Quality Assessment

Quality Assessment involves the identification of indicators that best reflect quality clinical and operational performance and review of these indicators to ensure that all our health facilities are meeting Standards and Goals that we have set for ourselves. Quality Assessment includes a thorough review of the process by which to measure these indicators to ensure accuracy.

Indicator Selection

Indicators are identified through a variety of internal and external processes that reflect a patient's ability to efficiently access high quality health care. For this reason, indicators often reflect both operational and clinical service provision. The following categories, along with specific examples, are major drivers in indicator selection:

- Indicators reflecting timely Access to Care
  - Time to next appointment
  - Timely phone responses
- Indicators reflecting efficient Provision of Care
  - Patient Cycle times
  - Use of My Chart EHR functionality

  - Departmental Communication Systems
- Indicators reflecting Evidence-based Clinical Care
  - Clinical Indicators identified by external sources such as the Uniform Data System (UDS) Clinical Outcomes and Quality Care measures and other Clinical Guidelines
  - Clinical Indicators reflecting health of special populations served by HCD such as those living with HIV, homelessness, mental illness, or substance abuse
  - Key performance indicators (KPIs) will be carefully selected to contextualize the challenges that each of these respective special populations faces.
  - Clinical Indicators identified by HCD clinicians to be key to quality care provision
- Indicators driven by Patient and Staff Satisfaction via surveys and informal feedback
- Indicators reflecting Safe provision of care as identified through Safety and Incident Reports

In many cases, similar indicators may fall under several categories. For example, UDS measures Pap smear utilization and our HIV Quality Management Committee follows a similar indicator. It is the responsibility of the HCD QM Committee to create a streamlined means of selecting indicators that can efficiently serve all our patients and simultaneously address the needs of sub-populations and various reporting entities. To improve integration and efficiency, the HCD QM Committee facilitates collaboration to ensure that system improvements follow a similarly streamlined approach.

Indicator Measurement

It is the responsibility of the HCD QM Committee to review methods of measuring indicators. The Data Analyst effectively extracts data from our robust EHR system and depends upon all stakeholders to consistently enter data into discrete data fields. The QM Committee reviews the data fields used and the process for determining if an indicator has been met. These processes must then be communicated to stakeholders and reviewed for user functionality. Adjustments are then made, and stakeholders are trained in the final process.

Indicator Analysis

The HCD QM Committee is responsible for developing standards and goals for the indicators we have chosen to follow. Results will be compared to HSA HCD' internal goals and to external benchmarking standards. Indicators are reviewed by the HCD QM Committee at intervals determined by our yearly calendar and as indicated by stakeholder request. Results are available to all stakeholders upon request.

Indicator Reporting

Indicators are reported at QM Committee meetings based upon our set yearly calendar. All data reports reviewed at each meeting are included in the Meeting Minutes, and these Minutes are distributed to all HSA HCD staff members. Meeting Minutes are also made available upon request to patients and community partners.

Indicator Tracking

Indicators that have not met our internal goals or external benchmarking standards are identified and quality improvement activities are developed. It is the responsibility of the QM Committee to facilitate quality improvement teams, track progress, and determine successful outcomes.

Quality Improvement

Once gaps in quality care have been identified through the process of Quality Assessment, the QM Committee chooses priority indicators to focus improvement efforts. A Process Improvement Team is appointed by the committee and tasked with first addressing the following three questions:

1. What are we trying to accomplish? (Setting our AIM)
2. How will we know that a change has led to improvement? (Establishing Measures)
3. What changes can we make that will result in improvement? (Selecting Change)

Once these questions are addressed, a pilot 'change' project is designed and implemented by the Process Improvement Team through a Plan, Do, Study, Act (PDSA) cycle. Baseline measures should be established prior to the PDSA cycle, and appropriate comparison measures should be obtained to assess the success of the intervention. The Process Improvement Team presents their findings to the QM Committee, and successful interventions are implemented throughout all health facilities. The QM Committee is responsible for ensuring consistent implementation, which includes communication to and training of appropriate staff members. This may also include the establishment or revision of Policies and Procedures. In this case, the QM Committee is responsible for appointing appropriate personnel to develop and implement the policy or procedure in a systematic way.

Clinic Level Quality Improvement

Although most system improvements will be expanded throughout all HCD health facilities, each health facility has unique sub-populations and system challenges. In these cases, the QM Committee representative from each health facility is responsible for choosing Process Improvement Teams for their sites and then reporting results to the QM Committee. When appropriate, system improvements may be replicated across all sites.

Provider Level

Since our EMR system allows health care providers to run reports on their individual patient panels, some providers have conducted their own internal improvement activities in collaboration with their team members (medical assistant and RN). Providers are encouraged to present their experiences to the QM Committee via their health center QI representative so that all providers can learn from their experience.

Effective Teams: Roles and Responsibilities

Effective teams include members representing three different kinds of expertise within the Health Services Division: system leadership, technical expertise, and day-to-day leadership. There may be one or more individuals on the team with each kind of expertise, or one individual may have expertise in more than one area, but all three areas should be represented to drive improvement successfully.

Clinical Leader (Medical Director, Health Center Manager, Clinic Nurse III, IBH Director or designee)
Teams need someone with enough authority in the organization to test and implement a change that has been suggested and to deal with issues that arise. The team's clinical leader understands both the clinical implications of proposed changes and the consequences such a change might trigger in other parts of the system.

Technical Expertise (IT Data Analyst or Epic Site Specialist)
A technical expert is someone who knows the subject intimately and who understands the processes of care. An expert on improvement methods can provide additional technical support by helping the team determine what to measure, assisting in design of simple, effective measurement tools, and providing

guidance on collection, interpretation, and display of data.

Day-to-Day Leadership (Clinician, Clinic Nurse, Medical Assistant, Health Center Manager, and Reception Staff)
A day-to-day leader is the driver of the project, assuring that tests are implemented and overseeing data collection. It is important that this person understands not only the details of the system, but also the various effects of making changes in the system. This person also needs to be able to work effectively with the physician champion(s).

Project Sponsor (Senior Health Services Manager, Clinical Director of Quality, Medical Director, or Health Center Manager)
In addition to the working members listed above, a successful improvement team needs a sponsor, someone with executive authority who can provide liaison with other areas of the organization, serve as a link to senior management and the strategic aims of the organization, provide resources and overcome barriers on behalf of the team, and provide accountability for the team members. The Sponsor is not a day-to-day participant in team meetings and testing but should review the team's progress on a regular basis.

Quality Assurance Activities

For the purposes of HCD Quality Management, Quality Assurance is considered a process of ensuring basic standard practices within the health system from both an operational and clinical standpoint. In addition to indicators that are chosen by the QM Committee, routine audits will be conducted. Audits may also be triggered by challenges brought to the committee through a variety of channels. When areas of deficit are noted, we follow the workflows described below ***and*** determine the most appropriate action. In some cases, a new Policy or Procedure may be developed. In other cases, the QM Committee may consider quality improvement activities that will improve the system of care.

SOURCES OF AUDIT TOPICS

Audit and data collection may be directed at problem areas identified by:

1. Needs assessment data
2. Clinical Guidelines Audits
3. Licensing and funding standards
4. Data reports from internal and external sources
5. Peer Review
6. Prescribing patterns
7. Billing data
8. Scheduling and staffing plans
9. Incident/occurrence reports, and
10. Patient satisfaction surveys/grievance forms

Quality Assurance activities may also be triggered by:

1. Patient Complaint
2. Staff Complaint
3. Community Complaint
4. Provider variability in terms of meeting clinical indicators or utilization of services
5. Malpractice Data

Quality Assurance Workflow for Issues Brought to the Committee:

1. Comes to the attention of the committee
2. Committee will:
    a. Determine who will investigate (internal or external auditor)
    b. Gather data (either committee members or investigator)
    c. Formulate plan of action
    d. Designated investigator reports back to committee with results and recommendations

Quarterly Audit Activities will be conducted, and may include 1-2 of these topics:

1. Registration
2. Clinical Care
3. Epic Documentation
4. Prescriptions
5. Referrals

Resource Assessment

Although quality care should not be driven by financial incentives alone, financial resources are essential to providing quality care and promoting health center program sustainability. The Quality Management Committee is tasked with ensuring that the quality of care we provide is reflected in the data that is presented to reporting and funding entities. When funding opportunities are missed, this must be reviewed to assess for avoidable causes and addressed by the QM Committee. In addition, the Quality Management Committee is tasked with advocating the need for the Health Services Agency to commit resources towards Quality Management for the promotion of consistency in the quality of care we provide across all health facilities and patient populations.

Strengthening Institutional Consensus

To maintain a successful Quality Management Program, it is essential that all stakeholders trust in the process we have created. The QM Committee is committed to building and maintaining an institutional consensus around Quality Improvement that promotes a shared definition of quality and unified approach to reaching our goals. To this end, we are developing a plan that will foster and maintain a culture shift within our organization that inspires stakeholder value in Quality Assessment and Improvement. This plan includes the following processes:

- Training staff in Quality Assessment, Quality Improvement, and Quality Assurance
- Develop training as determined by staff satisfaction survey
- Staff participation & Feedback
- Direct patient participation via patient focus groups such as the Patient Family Advisory Panel (PFAP)
- Avenue for reporting problems and involvement in QI process
- Create common communication tools such as an Intranet page for all QM items
- Engage Patients, Interns and Community Partners Effectively
- Data Quality- ensuring accuracy and communicating measurement process

Additional Components of Quality Management

Utilization Management

The HCD Utilization Management program provides a comprehensive process through which review of services is performed in accordance with both quality clinical practices and the guidelines and standards of local, state, and federal regulatory entities. The Utilization Management program is designed to monitor, evaluate, and manage the quality and timeliness of health care services delivered to all health center patients. The program provides fair and consistent evaluation of the medical necessity and appropriateness of care through the use of nationally recognized standards of practice and internally developed clinical practice guidelines. This work is integrated into the QM Committee's ongoing assessment of Operational Indicators.

Credentialing, Recredentialing, and Privileges

Our credentialing and privileging processes accomplish initial credentialing, required recredentialing, and specific privileging for all contracted, voluntary, and employed providers. This ensures appropriate qualifications to provide care and services and verifies the absence of any State and Centers for Medicare and Medicaid Services (CMS)-imposed sanctions. Specific quality indicators addressing the credentialing and privileging processes are part of HCD QM Program.

Risk Management and Patient Safety

The Health Centers Division Risk Management program monitors the presence and effectiveness of patient risk minimization activity, including incident reports, sentinel events, infection control, lab quality control and patient safety. These risk minimization activities will be proactive whenever possible. Improvements to related processes and policies will also result from QM activities based upon triggers listed in the Quality Assurance section. The Santa Cruz County Health Services Agency's Safety Committee is ultimately responsible for monitoring the breadth of patient and staff safety within our Agency. The Safety Committee reports their findings to the Quality Management Committee, and the QM Committee will respond when appropriate and when the issue is within our Scope of Work. The total Risk Management program is closely integrated with the HCD Quality Management Program.

Health Records

Santa Cruz Health Services Agency HCD will achieve continued excellence with respect to its health records. These records will be maintained in a manner that is current, detailed, secure, and enabling of effective, confidential patient care and quality review. Health records will reflect all aspects of care and will be complete, accurate, systematically organized, legible, authenticated, and readily available to all appropriate health care practitioners and other necessary parties, in strict accordance with the Health Information Portability and Accountability Act (HIPAA) guidelines.

Process for Revision of Quality Management Plan

Each year, the Quality Management Committee will facilitate the review and update of our Quality Management Plan and logical framework. We will invite all stakeholders identified previously in this document to participate in this review. This annual review will be scheduled into our Yearly Calendar to ensure its prioritization.

Board approved Signed by: Christina Berberich 6F0C6316E24EE4BF... 7/15/2025

(Signature of Board Chair or Co-Chair) (Date)

Attachment 1: Quality Management Work Plan Template

County of Santa Cruz, Health Services Agency, Health Centers Division

Our goal is to refine and further standardize our process for evaluating current practices and improving upon the quality of our services. The Quality Management Committee has identified three key categories to focus on outlined in the Health Centers Division Operational Plan. These categories include Organizational Culture, Operational Excellence and Community Collaboration. Throughout the year, we will focus on clarifying key indicators within each of these categories and on improving the quality of the data we record, collect, and analyze. We will strive to build upon prior work and conduct PDSAs within each category per year as documented in the Patient Centered Medical Home (PCMH) Quality Improvement Worksheet which is submitted to the National Committee for Quality Assurance (NCQA) on an annual basis. In addition, Quality Assurance activities will be conducted throughout the year.

Attachment 2: Quality Management Committee Meeting Agenda and Minutes

QM Committee:	
Date/Time:	-------, 8:30 to 9:30 am
Meeting Location:	
Leader:	
Facilitator/Transcriber:	
Attending:	
Guest(s):	

Persistent Focus on Excellence in Patient Care in a Compassionate Environment

Agenda Items	Discussion	Data/Trends Reviewed	Action/Decision	Who	Date Due
Agenda review and announcements				Committee	n/a
Approve minutes				Committee	Today
Review incident reports				Committee	Today
Calendar Activities for Month					
Other Action Items Due					

☐ Minutes approved _____

__/__/____ (Signature of committee facilitator) (Date)

Next Meeting

Date/Time:	
Meeting Location:	1080 Emeline, Room 200

docusign

Certificate Of Completion

Envelope Id: 1D39B10A-F6EF-46FD-AAEB-728C240D33E5
Subject: Complete with Docusign: HSA_QM_Plan_2025-26 Commision Approved.docx
Source Envelope:
Document Pages: 14
Certificate Pages: 4
AutoNav: Enabled
EnvelopeId Stamping: Enabled
Time Zone: (UTC-08:00) Pacific Time (US & Canada)

Signatures: 1
Initials: 0

Status: Completed

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Santa Cruz, CA 95060
Mary.Olivares@santacruzcountyca.gov
IP Address: 66.215.113.127

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Mary.Olivares@santacruzcountyca.gov
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Location: Docusign

Signer Events	Signature	Timestamp
Christina Berberich Christina@hibobbie.com VP of R&D, Regulatory Affairs Bobbie Baby, Inc. Security Level: Email, Account Authentication (None)	Signed by: Christina Berberich 8F9C634824EE4BF... Signature Adoption: Pre-selected Style Using IP Address: 147.0.211.46	Sent: 7/14/2025 4:29:16 PM Viewed: 7/15/2025 7:48:27 AM Signed: 7/15/2025 7:48:46 AM

Electronic Record and Signature Disclosure:
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In Person Signer Events	Signature	Timestamp
Editor Delivery Events	**Status**	**Timestamp**
Agent Delivery Events	**Status**	**Timestamp**
Intermediary Delivery Events	**Status**	**Timestamp**
Certified Delivery Events	**Status**	**Timestamp**
Carbon Copy Events	**Status**	**Timestamp**
Witness Events	**Signature**	**Timestamp**
Notary Events	**Signature**	**Timestamp**

Envelope Summary Events	Status	Timestamps
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Completed	Security Checked	7/15/2025 7:48:46 AM

Payment Events	Status	Timestamps

Electronic Record and Signature Disclosure

Health Centers Division

Quality Management Report

July 2025

Quality Management Committee

- Finalized Quality Management Plan (action item on the agenda)
- Reviewed Quality Management Detailed Calendar
- CCAH 2025 Quarter 1 Data (slide 3)
- Mobile Mammography (slide 4)

Alliance Care Based Incentive Data

Quality of Care Measures	Your Practice	Plan Benchmark	Plan Goal	Improvement Rate (%) *	Percentile Group	Eligible for Measure	Possible Points	Practice Points
Breast Cancer Screening	Your Practice							
Members eligible	924							
Members screened	528							
Rate (%)	57.14%	52.68%	63.48%	0.42%	Between 50th and 74th	Yes	4.42	3.09
Cervical Cancer Screening	Your Practice							
Members eligible	2,963							
Members screened	1,702							
Rate (%)	57.44%	57.18%	67.46%	0.05%	Between 50th and 74th	Yes	4.42	3.09
Child and Adolescent Well-Care Visits	Your Practice							
Members eligible	2,330							
Members with a visit	1,329							
Rate (%)	57.04%	51.81%	64.74%	-5.98%	Between 50th and 74th	Yes	4.42	3.09
Chlamydia Screening in Women	Your Practice							
Members eligible	337							
Members screened	243							
Rate (%)	72.11%	55.95%	69.07%	N/A	≥90th percentile	Yes	4.42	4.42
Colorectal Cancer Screening	Your Practice							
Members eligible	2,944							
Members screened	1,477							
Rate (%)	50.17%	38.07%	49.35%	N/A	≥90th percentile	Yes	4.42	4.42
Depression Screening for Adolescents and Adults	Your Practice							
Members eligible	7,776							
Members screened	2,813							
Rate (%)	36.18%	7%	17%	-7.10%	≥75th percentile	Yes	4.42	4.42
Diabetic Poor Control >9% ↓	Your Practice							
Members eligible	1,122							
Members in poor control	325							
Rate (%)	28.97%	33.33%	27.01%	-0.47%	Between 75th and 89th	Yes	4.42	4.42
Immunizations: Adolescents	Your Practice							
Members eligible	137							
Members immunized	86							
Rate (%)	62.77%	34.3%	48.66%	5.63%	≥90th percentile	Yes	4.42	4.42
Immunizations: Children (Combo 10)	Your Practice							
Members eligible	43							
Members immunized	18							
Rate (%)	41.86%	27.49%	42.34%	-3.42%	Between 75th and 89th	Yes	4.42	4.42
Lead Screening in Children	Your Practice							
Members eligible	44							
Members screened	34							
Rate (%)	77.27%	63.84%	79.51%	10.60%	Between 75th and 89th	Yes	4.42	4.42

Mobile Mammography Pilot

- Pilot project with the Alliance and Alinea
- Mobile Van
- 7 patients per hour- minimum of 30 per day with a goal of 40
- Screening mammograms only
- Ages 50-74 with no mobility issues
- Alliance patients receive a $50 Target gift card after completing the screening (day of service)

Mobile Mammography Pilot

- Watsonville Health Center 6/26/2025:
  - 37 completed mammograms
- Emeline Health Center and Homeless Persons Health Project 6/30/2025:
  - 34 completed mammogram

Mammogram Unit

Peer Review & Risk Management Committee

- 79 chart audits were completed on the June 18th all provider meeting
  - Diabetes
  - Overweight
- Teams break out rooms worked well for small group discussion
- Action Items: Education on pediatric overweight, collaborate with Parks Rx, Problem based training in our Electronic Health Record and standardized rooming for people with Diabetes.

Questions?

Thank You

Health Centers Division

Integrated Health Care Commission Financial Report

7-2-25

YTD Financial Comparison: FY 2024 vs. FY 2025 (Through May)

Row Labels	FY 2024 YTD Actual	FY 2025 YTD Actual	Sum of Variance
REVENUE	(34,350,229)	(40,677,831)	(6,327,602)
05-LICENSES, PERMITS AND FRANCHISE FEES	0	0	0
15-INTERGOVERNMENTAL REVENUES	(3,458,456)	(2,301,189)	(1,157,267)
19-CHARGES FOR SERVICES	(28,144,473)	(37,657,249)	(9,512,776)
23-MISC. REVENUES	(2,747,300)	(719,393)	2,027,906
EXPENDITURE	46,858,993	50,561,312	3,702,320
50-SALARIES AND EMPLOYEE BENEF	30,117,187	34,076,084	3,958,898
60-SERVICES AND SUPPLIES	8,029,091	5,868,430	(2,160,661)
70-OTHER CHARGES	48,402	45,296	(3,106)
80-FIXED ASSETS	63,228	871,966	808,739
90-OTHER FINANCING USES	0	0	0
95-INTRAFUND TRANSFERS	8,601,086	9,699,536	1,098,450
Grand Total	12,508,764	9,883,481	(2,625,282)

FY 2025 Year-to-Date Estimated Financials: Revenue vs. Expenditure (excluding BH passthrough)

Row Labels	FY 2025 YTD Estimated Actuals
REVENUE	(41,836,179)
05-LICENSES, PERMITS AND FRANCHISE FEES	0
15-INTERGOVERNMENTAL REVENUES	(6,303,916)
19-CHARGES FOR SERVICES	(34,787,567)
23-MISC. REVENUES	(744,696)
EXPENDITURE	50,928,118
50-SALARIES AND EMPLOYEE BENEF	37,880,085
60-SERVICES AND SUPPLIES	6,638,428
61-SERVICES AND SUPPLIES-ISF	1,250,587
70-OTHER CHARGES	48,404
80-FIXED ASSETS	872,789
90-OTHER FINANCING USES	0
95-INTRAFUND TRANSFERS	4,237,825
Grand Total	9,091,939

Including CCAH Grant WFCG $220,000

Previous Year End $30,323,257

Live Review of Completed Billable Appointments

https://portal.medicaladvantage.com/reports/view/354

Is there anything that is unclear for you?