Contra Costa County Health Care for the Homeless (HCH) Quality Improvement & Assurance Program

I. PURPOSE:

The Health Care for the Homeless Quality Improvement & Assurance Program is designed to monitor and improve the quality of health care delivered at Contra Costa County Health Centers. Guided by the organization's vision and mission statements, the Quality Improvement & Assurance Program responds to the community's needs. HCH and CCHS will collaborate to ensure quality care is delivered at the health centers.

II. REFERENCES:

Medical Staff By-Laws
Contra Costa Health Services Hospital Policy 616
Contra Costa Health Services Hospital Policy 436
Contra Costa Health Services Hospital Policy 109

III. POLICY:

The HCH QA/QI Committee will oversee the quality of health care delivered through measurement, analysis, and changes for improvement as needed. The Committee will accomplish these actions through proper documentation, tracking, and review of measures set forth by HRSA, as well as those identified as needs in the community as written on the strategic plan on a regular and ongoing basis.

IV. PROCEDURE:

A. Structure & Accountability

1. Co-Applicant Governing Board
   The County Board of Supervisors shall maintain the sole authority to set general policy on fiscal and personnel matters pertaining to all County facilities and programs. The HCH Project Director makes an annual oral report to the County Board of Supervisors Family and Human Services Committee.

2. Internal Committee
   The HCH QA/QI committee is responsible for maintaining and reviewing key program metrics regularly. The committee meets quarterly to discuss trends in these metrics that will be shared with the Governing Board.
   - **a.** Medical Director
   - **b.** Lead Clinician & Quality Improvement Coordinator
   - **c.** Program Director
   - **d.** Planning & Policy Manager
   - **e.** Nurse Manager
   - **f.** Planner/Evaluator
   - **g.** Other staff will attend as needed

B. Committee Meeting Schedule

1. Meets quarterly, or more frequent as needed.

C. Framework

The framework of the HCH Quality Improvement Program is targeted improvement cycles utilizing the Plan, Do, Study, Act (PDSA). A popularized by the Institute for Healthcare Improvement, is a scientifically tested method of using data to test small changes. Resources for major quality improvement efforts are limited, but to the extent possible HCH improvement projects will be guided by the Model for Improvement. To improve patient outcomes, the organization must design processes well and systematically monitor, analyze, and improve its performance. The essential processes for improvement are Plan, Do, Study, Act.

D. Committee Responsibilities

1. Develop a Quality Improvement Plan based on the Strategic Plan to be reviewed and shared with the Governing Board annually. Develop performance improvement and patient safety measures from high risk, high volume, or problem prone processes unique to the homeless population. Utilize data to provide useful information for decision making.

a. Core Elements of the QI Plan include:

i. Behavioral Health Metrics
ii. Clinical Measures based on HRSA requirements
iii. Communicable Disease Screenings & Follow Ups
iv. Provider & Staff Training Measures
v. Medication Assisted Treatment Data
vi. Funding
vii. Insurance Status

2. Quality Improvement Plan Evaluation

a. The plan's objectives, organization, and scope will be reviewed annually for effectiveness. Findings will be considered for incorporation into the following plan.

3. UDS Measure Evaluation

a. The Committee will review all clinical measures as required by HRSA on a quarterly basis. Findings will be considered for sharing with the Governing Board annually with the exception of measures identified as program priorities which will be shared twice a year. During quarterly committee meetings, any measure found to have change in trend from the previous review will be shared with the governing board.

4. Quality Improvement Activities Include:

a. Quarterly review of HRSA Clinical and Financial Measures as part of Uniform Data System (UDS) reporting through use of internal dynamic data dashboards
    i. All program data metrics review will be documented through discussions in quarterly meeting minutes.
b. Annual evaluation of process measures to identify improvement opportunities and create new program priorities for improvement
c. Annual evaluation of outcome measures for Strategic Plan and reporting requirements
d. Annual Patient Satisfaction/ Feedback Surveys
e. Annual consumer meetings and/or focus groups
f. Regular reports of program clinic productivity as needed

g. Monthly staff meetings
h. Weekly case rounds at Homeless shelters and clinics
i. Daily "huddles" among clinic team to discuss cases scheduled
j. Fiscal report on Financial Performance measures as needed

The Medical Director or Lead Clinician shall be accountable for the quality of patient care

5. Quality Assurance Activities Include:
Any data collected from below will be reviewed and analyzed by the Medical Director, the Project Director, the Lead Clinician, the Nurse Program Manager, the Planning and Policy Manager and the Health Planner Evaluator. QI and risk management reports will be reviewed by the internal committee quarterly and provided to the board annually with the exception of measures identified as program priorities which will be shared twice a year. During quarterly committee meetings, any measure found to have a change in trend from the previous review will be shared with the governing board.

a. Perform Professional Practice Evaluation (OPPE) Every 6 Months & Focused Professional Practice Evaluation (FPPE) processes as needed conducted by HCH Medical Director or Lead Clinician. *(See Hospital Policy No. 436)*
b. Monthly case rounds and Formal Peer Review according to standard practice guidelines.
c. Annual Patient Satisfaction/ Feedback Surveys
d. Consumer meetings and/or focus groups
e. Patient Complaints & Grievances *(See Hospital Policy No.616)*

E. Adverse Events and Near Miss Reviews

All unusual, unexpected, or untoward adverse events, including "near misses" at HCH sites are reported to the Nurse Program Manager or Lead Clinician & Quality Improvement Coordinator by staff witnessing the event using an unusual occurrence form. Unusual Occurrences include falls, medication errors, equipment failures, assaults, property theft, treatment events, etc. including events which have the potential to harm a patient or staff member even if no harm occurs.

HCH is a small program and unusual occurrences and errors are rare. Unusual occurrences and errors are analyzed immediately by the Program Manager and sent to Risk Management as appropriate. They are also reviewed for trends quarterly by the Program Manager and discussed with the board. Reports are filed for three to five years to trend infrequent occurrences. High risk and high-volume unusual occurrence events are used to identify quality improvement initiatives.

a. The Committee will provide oversight of the Safety Event Reporting System and adverse event reviews including interventions and root cause analysis, when indicated, see: *Hospital Policy 109*
b. The Committee will provide oversight of and develop any necessary corrective action plans based on the adverse reviews, looking for systems issues that were identified, and correct physical or procedural issues uncovered.

V. DOCUMENTATION

A. Records of all quality improvement activities will be maintained for at least three (3) years.

1. These records will include results/discussions of monitoring activity, the Quality Improvement Plan, and the QA/QI Committee meeting minutes. Should records be confidential, they shall only be accessed by authorized personnel for the purpose of improving the quality of care of the patient population.

2. A large majority of program metrics are reviewed through use of internal dynamic data dashboards, and therefore documentation of review will be included within meeting minutes and other tracking documents.

VI. CREDENTIALING & PRIVILEGING

All staff are to provide care and perform duties according to the Credentialing and Privileging Policy.

VII. ATTACHMENT(S)/ FORMS USED:

Medical Staff By-Laws
Contra Costa Health Centers Credentials Policy
Contra Costa Health Services Hospital Policy 616
Contra Costa Health Services Hospital Policy 436
Contra Costa Health Services Hospital Policy 109

APPROVED BY:
Governing Board 9/15/2021

REVIEWED: