
Contra Costa Health Care for the Homeless (HCH), Quality Assurance and Performance Improvement Plan 2019-2021

Table of Contents

MISSION 2

VISION..... 2

2019-2021 STRATEGIC PLAN GOALS 2

 Clinical Services & Quality Improvement..... 2

 Program Finances & Staffing..... 2

 Partnerships & Communication..... 3

 Planning & Oversight 3

STRUCTURE AND ACCOUNTABILITY 3

 Co-Applicant Governing Board..... 3

FRAMEWORK..... 4

 Quality Improvement activities include: 4

 Quality Assurance activities include:..... 5

RISK MANAGEMENT..... 5

CREDENTIALING & PRIVILEGING 6

HCH QUALITY IMPROVEMENT 7

 Priorities for 2019-2021 7

APPENDICES 12

 Appendix A - Hospital Policy No. 436..... 12

 Appendix B – AC Nursing Policy No. 1019..... 13

 Appendix C - Hospital Policy No.616 17

 Appendix D – Hospital Policy No.109 – Adverse Event Reporting..... 19

 Appendix E – HRSA Clinical Measures – 2019 - 2021 Health Plan..... 26

MISSION

Our mission is to improve the health of the homeless population in Contra Costa County by increasing access to health care and by providing a team-oriented approach to health care that focuses on harm reduction and integration of behavioral and medical services.

VISION

All persons experiencing homelessness in Contra Costa County are able to access comprehensive health care services in order to improve health status, effectively manage any chronic conditions and thrive as community members.

2019-2021 STRATEGIC PLAN GOALS

Clinical Services & Quality Improvement

1. Develop detailed plan for fixed and mobile services in East Contra Costa County in collaboration with the Health, Housing and Homeless Division, Contra Costa Health Services Ambulatory services and community partners.
2. Collect additional data on location and needs of elderly homeless, develop and implement a plan in collaboration with partners, to address needs.
3. Update Quality Assurance and Performance Improvement plan to include additional analysis of key clinical process and quality outcome data; identify resources required to implement plan.
4. For identified service gaps:
 - Access and, if appropriate, respond to funding and/or reimbursement opportunities.
 - a. Identify regulatory or other structural barriers to implement services and assess ability to remove barriers.

Program Finances & Staffing

1. Continue to ensure all patients are enrolled in the best insurance/coverage programs possible.
2. Monitor state and national reimbursement and funding opportunities to support and augment current services.
3. Develop capital plan to ensure adequate facilities and equipment for service delivery model including mobile options.
4. Identify resources needed for programing changes.
5. Include discussion of programmatic changes in monthly staff meetings.
6. Provide staff continued core competency, trauma informed care and cultural humility training.

Partnerships & Communication

1. Identify 2-3 areas to improve coordination with key County partners including CCHS divisions:
 - a. Health, Housing and Homeless
 - b. Ambulatory
 - c. Emergency
 - d. Behavioral Health
2. Develop a “Community Partnership Plan” that includes a guiding vision, identification of key partners and specific goals and objectives for each partner.

Planning & Oversight

1. Identify key questions and issues requiring data to ensure effective planning.
2. Review existing needs assessments available through other county entities and identify data gaps to address key questions and issues.
3. Conduct internal system analysis of overlapping homeless population data within the Contra Costa Health Services Department.
4. Conduct Board assessment; develop Board Development and Training Plan
5. Develop dashboard for routine Board reports to include key clinical, operational and financial metrics.

STRUCTURE AND ACCOUNTABILITY

Co-Applicant Governing Board

The Co-Applicant Board is the consumer- and community-oriented board whose role it is under regulations applicable to these grants from Health Resources and Services Administration (HRSA) to provide guidance and oversight of the Program included in the HRSA scope of project. The Co-Applicant Board is necessary because the County cannot independently meet all applicable HRSA governance requirements. The Co-Applicant Board shall set priorities and policies for the HCH Program, assist the Program in promoting its goals, provide input and feedback to generally assist the development, implementation, and evaluation of the Program, and serve as the governing board of the HCH Program, carrying out the responsibilities in coordination with the County Board of Supervisors and Contra Costa County Health Services Department.

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.

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.

PLAN

Measure current performance
Analyze information gathered
Improvement Opportunity identified
Design improvement w/ performance expectations

DO

Test/Implement

STUDY

Leadership collects, analyzes, and measures against standard
Feedback to team
Expectations met?

ACT

Yes, expectations met: educate staff & standardize
No, expectations not met: re-design

Quality Improvement activities include:

1. HRSA Clinical and Financial Measures as part of Uniform Data System (UDS) reporting
2. Quarterly evaluation of process measures to identify improvement measures and create new program priorities for improvement
3. Annual evaluation of outcome measures for Strategic Plan and reporting requirements
4. Bi-Annual Patient Satisfaction Surveys
5. Quarterly consumer meetings and focus groups
6. Quarterly reports of program clinic productivity to HCH Co-Applicant Governing Board (*creation of dashboards*)
7. Monthly staff meetings
8. Weekly case rounds at Homeless shelters and clinics
9. Daily "huddles" among clinic team to discuss cases scheduled
10. Monthly fiscal report on Financial Performance measures to the CCHS Chief Financial Officer and annual report to HCH Co-Applicant Board. Report will include year to date fiscal data relating to operations and revenue.

The Medical Director and Nurse Program Manager shall be accountable for the quality of patient care:

Quality Assurance activities include:

1. Ongoing (bi-annually) Professional Practice Evaluation (OPPE) & Focused Professional Practice Evaluation (FPPE) processes conducted by HCH Medical Director. *(Appendix A – Hospital Policy No. 436)*
2. Monthly case rounds and Formal Peer Review (PAVISEE) according to standard practice guidelines.
3. Monthly focused chart reviews by HCH Providers
4. Patient Satisfaction Surveys
5. Consumer meetings and focus groups
6. Patient Complaints & Grievances *(Appendix B – AC Nursing Policy No. 1019& Appendix C - Hospital Policy No.616)*
7. Medical Error Reduction:
 - a. If trends are identified the Medical Director and Nurse Program Manager shall assure there is measurable improvement in indicators with a demonstrated link to the reduction of medical errors.
 - b. The Medical Director and Nurse Program Manager shall review the experiences of other Health Care for the Homeless Programs as they become available and assure that measures shown to be effective in reducing medical errors are implemented within the organization.

Any data collected from above will be reviewed and analyzed by the Medical Director, the Project Director, the Nurse Program Manager, the Planning and Policy Manager and the Health Planner Evaluator.

RISK MANAGEMENT

All unusual, unexpected, or untoward occurrences, including “near misses” at HCH sites are reported 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 even if no harm occurs.

HCH is a small program and unusual occurrences and errors are unusual. Unusual occurrences and errors are analyzed immediately by the Nurse Program Manager and sent to Risk Management as appropriate. They are also reviewed for trends annually by the Nurse Program Manager and discussed with the team. 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.

Adverse Event Reporting
(Appendix D – Hospital Policy No.109)

It shall be the policy of Contra Costa Regional Medical Center and Health Centers (CCRMC&HC) to report events, as defined within Health and Safety Code §1279.1(b), §1280.15(b), 1317.4(c), 42 CFR §482.13(g), or CCR §70737(a) and 71535, to the California Department of Public Health (CDPH) or the Centers for Medicare and Medicaid Services (CMS), as appropriate, within the time frame directed by the regulation. It is also our policy to investigate the source of the event, initiate any mitigation actions that may be indicated and cooperate fully with CDPH or CMS throughout the process.

Adverse Events, Restraint and Seclusion Deaths, Unusual Occurrences, EMTALA, and other Safety Events will be internally reported using the online Safety Events Reporting System (SERS).

CREDENTIALING & PRIVILEGING

Care provided by Physicians and Psychiatrists:

Care provided by a Physician or Psychiatrist is authorized by their Medical Board of California license and as an authorized employee of Contra Costa Health Services.

Care provided by Nurse Practitioners:

Care provided by an NP is authorized by their California NP license and as an authorized employee of Contra Costa Health Services.

Care provided by Dentists:

Care provided by a Dentist is authorized by their Dental Board of California license and as an authorized employee of Contra Costa Health Services.

Care provided by Registered Dental Assistants:

Care provided by a Registered Dental Assistant is authorized by their Dental Board of California license and as an authorized employee of Contra Costa Health Services.

Care provided by Registered Nurses and Public Health Nurses:

RNs and PHNs providing clinical care operate within the scope of their nursing license. For straightforward common situations when there is no doctor or nurse practitioner available, they also operate under Standing Orders from the licensed Medical Director. They also have access to the Medical Director and HCH FNPs who can give verbal orders for urgently needed care. Such orders are cosigned by adding a note to the electronic medical record.

Care provided by licensed Behavioral Health staff:

Licensed Clinicians Social Workers (LCSW) and/or Marriage Family Therapists (MFT) providing clinical care are authorized by their California Board of Behavioral Sciences license and as an authorized employee of Contra Costa Health Services.

Care provided by non-licensed staff:

Unlicensed staff such as Community Health Workers, Substance Abuse Counselors, and Mental Health Specialists are restricted to activities permitted for non-licensed personnel and all care is performed under the supervision of licensed personnel.

HCH QUALITY IMPROVEMENT

Priorities for 2019-2021

1. Improve outcomes on all HRSA Clinical Measures

(Appendix E – HRSA Clinical Measures – Health Plan)

2. Strategically design a Behavioral Health (BH) Integration plan to identify goals and services our patients need

Measures:

- a. Percent of HCH Behavioral Health patients who received the Screening, Brief Intervention, Referral and Treatment (SBIRT) during the reporting year
- b. Percent of HCH Behavioral Health patients with an active Behavioral Health Episode during the reporting year
- c. Percent of HCH Behavioral Health patients with a Psychiatric Emergency Services (PES) visit during the reporting year
- d. Percent of HCH Behavioral Health patients with a Detention stay during the reporting year

Behavioral Health Integration Plan				
Measure	2018 (Baseline)	2019	2020	2021
SBIRT Screening	31.6%			
Connected to BHS	34.4%			
PES Visits	40.2%			
Detention Stays	27.3%			

3. Diabetes: Create individualized improvement plans for diabetics seen in HCH department with a Hemoglobin Test (A1c) over 9 or missing an A1c

Measures:

- a. Percent of HCH diabetic patients whose most recent A1c was over 9.0 or missing
- b. Percent of HCH patients with an A1c over 9.0 or missing who received a telephone follow up from HCH during the reporting year

Diabetic Improvement Plans				
Measure	2018 (Baseline)	2019	2020	2021
A1c 9.0+ or missing	46.8%			
Diabetic Follow Up	N/A - Workflow not Established			

Contributing Factors:

- a. *The HCH team has begun an initiative to identify diabetic patients either with poor control (A1c >9) or without appropriate follow up within the last year. In an effort to address this;*
 - i. *a referral queue has been created for providers to refer poorly controlled diabetics to our community health workers to arrange meetings and focus on healthier eating and opportunities to improve their blood glucose management,*
 - ii. *a list of patients is generated identifying those that meet the above criteria every 6 months and review their care plans to ensure they are getting appropriate follow up and management,*
 - iii. *the HCH team is participating in a NHCH learning collaborative to develop innovative way to manage diabetes in patients experiencing homelessness.*

4. Congestive Heart Failure (CHF): Create individualized plans for those seen in HCH department diagnosed with CHF

Measures:

- a. Percent of HCH patients with a CHF diagnosis who have a CHF checklist documented in their chart during the reported year.

Diabetic Improvement Plans				
Measure	2018 (Baseline)	2019	2020	2021
CHF Checklist	N/A - Workflow not Established			

Contributing Factors:

- a. *The HCH team is seeking to ensure that all of our patients with S-CHF are being managed appropriately. In an effort to address this;*
 - i. *a check-lists for our patients with S-CHF has been created to ensure their treatment plans were optimized and they have been offered all of the appropriate interventions to best manage their disease.*

5. Increase Communicable Disease screening with Point of Care Tests (POCT)

Measures:

- a. Number of completed screening orders for Human Immunodeficiency Virus (HIV), Hepatitis C Virus (HCV), and syphilis during the reporting year
- b. Percent of HCH patients due for screening during the reporting year with a completed screening order for HIV, HCV, and syphilis.
- c. Percentage of positive HIV, HCV, and syphilis POCTs with completed follow up labs

Communicable Disease Screening – HIV				
Measure	2018 (Baseline)	2019	2020	2021
Number of Screenings	681			
Percent of Patients Screened	25.3%			
Follow up labs complete	N/A - No Positive POCTs			

Communicable Disease Screening – HCV				
Measure	2018 (Baseline)	2019	2020	2021
Number of Screenings	166			
Percent of Patients Screened	6.9%			
Follow up labs complete	16.7%			

Communicable Disease Screening – Syphilis				
Measure	2018 (Baseline)	2019	2020	2021
Number of Screenings	524			
Percent of Patients Screened	20.0%			
Follow up labs complete	N/A - No POCTs conducted			

Contributing Factors:

- a. *The HCH team seeks to ensure all patients have the opportunity for early identification, referral and treatment of communicable diseases in the moment. In an effort to address this;*
 - i. *Over the past 2 years HCH has made an effort to increase the availability or POCTs for CDs. We have introduced POC HIV, Hepatitis C and, in the next month will introduce, syphilis testing.*

6. Increase Screening and Treatment for Hepatitis C virus (HCV) for those seen in HCH department

Measures:

- a. Percent of HCH patients due for HCV screening during the reporting year with a completed screening order for HCV
- b. Percent of HCH patients with a detectable viral load that were prescribed HCV treatment

HCV Screening and Treatment				
Measure	2018 (Baseline)	2019	2020	2021
HCV Screening	6.9%			
Prescribed Treatment	44.0%			

Contributing Factors:

- a. *Hepatitis C is the leading cause of liver transplants in America and new medications are available with cure rates in the 95-99%. Patients experiencing homelessness experience higher rates of hepatitis C but lower rates of being offered treatment. In effort to address this;*
 - i. *The HCH team began offering treatment to all patients that are able to complete appropriate pre-treatment lab testing.*

7. Pilot patient self-Papanicolaou (PAP) Test within HCH department to validate for larger CCHS system

Measures:

- a. Percent of HCH patients due for a PAP test with a completed PAP test during the reporting year.

Completed PAP Test				
Measure	2018 (Baseline)	2019	2020	2021
Completed PAP	47.2%			

Contributing Factors:

- a. *Cervical cancer screening rates are lower and rates of cervical cancer are higher among homeless women. This is due to the invasive nature of acquiring a PAP smear from women, which traditionally has required a provider to perform a pelvic exam to collect a sample. In an effort to address this;*
 - i. *increase cervical cancer screening among our patients, HCH piloted a project to allow patients to self-collect PAP smears.*

8. Increase availability for addiction treatment in all HCH Clinics (i.e. Drug Enforcement Administration (DEAx) waiver for all providers, knowledge of medication assisted treatment alcohol/opiate dependence, mental health staff comfortable with addiction counseling, trainings, and screening)

Measures:

- a. Percent of HCH providers with a DEAx waiver
- b. Percent of HCH clinical staff receiving annual motivational interviewing and Sublocade injection training
- c. Percent of HCH patients with an opioid use disorder that were offered buprenorphine or referred to methadone clinic during the reporting year
- d. Percent of HCH patients with an opioid use disorder that received a prescription for buprenorphine or methadone during the reporting year.

Medication Assisted Treatment (MAT) for Addiction				
Measure	2018 (Baseline)	2019	2020	2021
DEAx providers	90.9%			
MI/Sublocade Training	MI = 100% Sublocade = not offered			
Offered MAT	86.5%			
Prescribed MAT	73.1%			

Contributing Factors:

- a. *Recent data supports the effectiveness of medication assisted treatment (MAT) for several substance use disorders. In particular, treatment of opioid-use disorder with a buprenorphine. In effort to address this;*
 - i. *HCH has made it the goal that all providers will be waived to offer buprenorphine in every treatment setting and will be comfortable with "low threshold" buprenorphine, meaning that they will offer MAT on the first visit in an effort to lower barriers to treatment and save lives from day one of meeting a patient.*
 - ii. *The HCH Medical Director will offer trainings on MAT for alcohol use disorder and ensure all providers are comfortable prescribing MAT.*

9. Increase ratio of external non-revenue funding to patients served by 3% annually

Measure:

- a. Dollars of external non-revenue funding received during the reporting year

External Non-Revenue Funding				
Measure	2018 (Baseline)	2019	2020	2021
Funding Amount	\$3,194, 520			

10. Decrease uninsured patients by 2.5%

Measure:

- a. Percent of HCH patients with an insurance status of uninsured as of their last visit during the reporting year.

Uninsured Patients				
Measure	2018 (Baseline)	2019	2020	2021
Uninsured	22.6%			

APPENDICES

Appendix A - Hospital Policy No. 436

CONTRA COSTA REGIONAL MEDICAL CENTER
HOSPITAL AND HEALTH CENTERS

HOSPITAL POLICY NO. 436

ONGOING PROFESSIONAL PRACTICE EVALUATION

I. PURPOSE:

The intent of the policy is to provide medical staff with performance data for all practitioners with privileges on an ongoing basis rather than at the two-year reappointment process. This will allow for a timelier assessment of professional practice, and provide an opportunity to improve performance as indicated.

II. REFERENCES:

The Joint Commission: 2015 Hospital Accreditation Standards, MS.08.01.03

III. PROCEDURE:

- Department chairs will review performance data for their department members every 11 months. The medical staff president will review performance data for department chairs every 11 months. Data would include but not be limited to core measures scores by department, delinquency rates by provider, summary of peer review by provider, patient complaints by provider. A decision will be made during the review to continue, limit or revoke privileges.

Department chairs have the authority to continue privileges or to issue oral or written counseling or warnings. Limitation or revocation of privileges would require the chair to summarize practitioner findings at a closed session of the Medical Executive Committee (MEC). Upon hearing the findings, the MEC can decide to, among other actions, continue, limit or revoke privileges, or to investigate the matter in more detail through formal investigation.

An Ongoing Professional Practice Evaluation (OPPE) form will be completed at the time of the review. This, along with the performance data reviewed will be maintained in the practitioners credentials file until the two-year reappointment process has been completed. The type of data collected will be defined by the medical staff and approved by the Medical Executive Committee.

IV. FORMS:

Ongoing Professional Practice Evaluation (OPPE) Form – (Attachment A.)

V. RESPONSIBLE STAFF:

Medical Staff President
Medical Staff Department Chairs

REVIEWED/REVISED: 11/2009

PATIENT COMPLAINTS

I. PURPOSE:

To outline the procedure to be followed for handling patient complaints in ambulatory care.

II. REFERENCES:

CCRMC Policy #616, “Patient Grievance/Complaint Policy.”

TJC 2016 Standard RI.01.07.01, “The patient and his or her family have the right to have complaints reviewed by the hospital.”

III. POLICY:

The principal individuals designated as grievance coordinators for Ambulatory Care are the Clinic Coordinators* with the Patient Relations Coordinator being responsible for following-up, tracking and maintaining records of all complaints. Any minor complaint or inquiry which may be easily handled when it is brought to the attention of a staff member is not considered to be a patient complaint, unless the patient requests a more formal process for addressing the expressed concern. Complaints which require some investigation or follow-up are forwarded to the appropriate individuals who are responsible for finding of fact and resolution:

- Complaints involving nursing – Clinical Services Manager
- Complaints involving medical staff – Department Chair or designee
- Complaints involving ancillary departments, including registration and appointments
Ancillary Department Manager
- All other complaints – Clinic Coordinator*
- Complaints involving billing – Credit and Collections Department in Patient Accounting (925-313-6512)

These individuals are responsible for finding of fact and resolution according to the following time frames:

- For CCHP members: Within 14 business days for non-quality of care complaints, and 14 calendar days for quality of care complaints.
- For non-CCHP members: Within 30 calendar days.

For CCHP members, the summary of findings and resolution is sent to CCHP Member Services, who responds in writing to the CCHP member. For non-CCHP members, the responsible individual or the Patient Relations Coordinator responds in writing directly to the patient or the patient’s representative.

All written responses to non-CCHP patient complaints shall have the following included in the response: “You also have the right to file this complaint with the California Department of Health Services Licensing and Certification Program, Santa Rosa/Redwood Coast District Office, 2170 Northpoint Parkway, Santa Rosa, CA 94507 (phone 707-576-6775, fax: 707-576-2418). Or you can file with the Quality

Improvement Organization (QIQ): Health Services Advisory Group (HSAG), 5201 West Kennedy Blvd, #900, Tampa FL 33609-1822 (phone: 800-842-1602 extension 3512, TTY# 800-881-5980. The Medical Board of California has the authority in the state to take disciplinary action against a provider's license. You can contact them at 2005 Evergreen Street, Suite 1200, Sacramento, CA 95815, or by calling 1-800-633-2322.

When there is any issue of health center or provider liability, the Patient Relations Coordinator or the Risk Management Patient Safety Officer must review the response to the patient in advance. A "finding of fact" which implies a significant issue of liability must be referred to the Safety Officer (925-370-5195).

All ambulatory care complains will be recorded in the log or database, maintained by the Patient Relations Coordinator.

IV. AUTHORITY/RESPONSIBILITY:

All Ambulatory Care Clinic staff

V. PROCEDURE:

A. Face-To-Face and Telephone Complaints:

1. The ambulatory care employee made aware of the patient complaint should contact one of the following administrative representatives to speak to the patient:
 - a. Clinic Coordinator* (telephone complaints only in MTZ, AHC/AOAC, and ECOAC).
 - b. Clinical Services Manager
 - c. Lead Clerk (BHC only)
 - d. Patient Relations Coordinator (MTZ only, face-to-face complaints)
 - e. CCHP Member Services Representative (All CCHP members should be informed of their option of filing their complaint with a CCHP Member Services Representative.)

In the event that the individuals above are not available to talk with the patient, the patient may be offered a Patient Complaint/Grievance form (A-546). The employee may assist the patient with completion of the form, if available to do so. CCHP members should be referred to file their complaint directly with CCHP at 1-877-661-6230.

2. The administrative representative receiving the face-to-face and/or telephone complaint should do the following:
 - a. Listen to the patient (without interrupting);
 - b. Attempt to defuse patient anger/frustration;
 - c. Address the patient's concern as quickly as possible;
 - d. For complaints which take time for investigation:
 - 1) Explain to the patient our complaint procedure;
 - 2) Offer CCHP members the option of filing their complaint with CCHP.
 - e. Complete, assist patient with completion or have patient complete A-546 (make certain form has patient's identification label on it, or hand-write the patient's name and financial class in upper right hand corner);

- f. If patient is a CCHP member, the Clinic Coordinator will email via ccLink a copy of the complaint to the Patient Relations Coordinator and CCHP Member Services on the same day.

B. Written Complaints

The Clinic Coordinator* is responsible for coordinating responses to (1) face-to-face and telephone complaints which cannot be easily handled and are, therefore recorded on an A-546; and (2) other written complaints received via mail or transmittal.

1. The Clinic Coordinator* will:
 - a. Receive all written complaints, documenting the date of receipt.
 - b. Forward via ccLink all complaints (side 2 only) to Patient Relations Coordinator for follow-up action.
2. The Patient Relations Coordinator will:
 - a. Maintain database of all patient complaints.
 - b. Upon receipt of complaint form from Clinic Coordinators and/or CCHP Member services, forward to the manager for investigation and follow-up.
 - c. Work with the responsible manager to ensure that a final written response is prepared and sent as outlined in Section III of this policy.
 - d. On a quarterly basis, send Clinic Coordinators a list of all resolved and unresolved complaints.
 - e. On an annual basis, send Ambulatory Care Administrator summary of calendar year complaints in Ambulatory care.
3. The responsible manager will:
 - a. Investigate complaint, including any employee involved in the process and take the appropriate action.
 - b. For CCHP member complaints, do not respond directly to the patient. The finding of fact and resolution should be summarized in writing and sent to the Patient Relations Coordinator to forward to CCHP.
 - c. For non-CCHP member, work directly with the Patient Relations Coordinator to ensure that a written response is sent to the patient within 30 days. The manager should send a draft response to Patient Relations Coordinator, who will coordinate finalizing and sending response to the patient.
4. CCHP Member Services or Quality Management will:
 - a. Send via fax all CCHP member grievances involving CCRMC/CCHC.
 - b. Send via e-mail a copy of final responses involving CCHP members to the Patient Relations Coordinator.
 - c. Work with the Patient Relations Coordinator to ensure that a final written response is prepared and sent as outlined in the Policy section.

C. Retention of Records

Both the completed complaint forms and the computerized log shall be retained for a period of five years and shall be open to inspection by the appropriate accreditation and regulatory agencies.

VI. FORMS:

“Patient Complaint/Grievance” form (A-546)

REVIEWED: 9/2012, 11/2016

REVISED: 8/2013

Appendix C - Hospital Policy No.616

Patient not currently with Contra Costa Health Plan

Paciente SIN el Plan de Salud de Contra Costa

- Mail to: Contra Costa Regional Medical Center
Patient Relations Department
2500 Alhambra Ave
Martinez, Ca. 94553
(925) 370-5144 Fax (925) 370-5992

Patient with Contra Cost Health Plan

Paciente CON el Plan de Salud de Contra Costa

- Mail to: Contra Costa Health Plan
Member Services
595 Center Ave., Suite 100
Martinez, CA 94553
1-877-661-6230 (Press 2) Fax: 925-313-6047

Patient Complaint / Grievance Form
Formulario de quejas / reclamos de pacientes

Patient Name: _____ **Date of Birth:** _____
Nombre del miembro Fecha de nacimiento

Patient Medical Record Number: _____ **Telephone #:** _____
Número de identificación Teléfono

Address: _____
Dirección

Location of Service: _____ **Date of Service:** _____
Lugar de Servicio Fecha de Servicio

Did another person assist you with completing this form? ¿Alguna otra persona le ayudó a completar este formulario?
Yes/Sí No/No

Name of person completing this form: _____ **Relationship to patient:** _____
Nombre de la persona que completa este formulario: Relación con el paciente:

Signature of person completing this form: _____ **Date:** _____
Firma de la persona que completa este formulario: Fecha:

Briefly Describe Complaint: *(Please include as much detail as possible including names of the people involved, the circumstances leading up to the conflict, and any information you feel is important to the complaint):*

Descripción breve de la queja *(Por favor describa con detalle el incidente incluyendo los nombres de personas envueltas, las circunstancias que causaron el conflicto, y cualquiera información pertinente a la queja):*

What action are you requesting?
¿Cuál acción está usted pidiendo?

The patient or patient legal guardian must sign the Patient Complaint/Grievance Form. We are unable to process this request without the patient's explicit agreement. /El paciente, o el tutor del paciente, deben firmar el Formulario de Quejas y Reclamaciones. Esta solicitud no se puede procesar sin el acuerdo explícito del paciente.

I authorize that all information pertaining to this grievance, possibly including medical records and clinical information, be shared with the Contra Costa Health Plan for the express purpose of resolution of this grievance. / Yo autorizo a que toda la información concerniente a este reclamo, posiblemente incluyendo los datos en el expediente médico e información clínica, sea compartida únicamente con el Plan de Salud de Contra Costa, con el propósito expreso de encontrar una solución para este reclamo.

Patient Signature/Firma del miembro

Date/Fecha

Your complaint will be thoroughly investigated and you will receive an answer within thirty (30) days or before.
Su queja se investigará minuciosamente y recibirá una respuesta dentro de treinta (30) días o antes.

PATIENTS NOT CURRENTLY WITH CONTRA COSTA HEALTH PLAN FILING A COMPLAINT OR GRIEVANCE
PACIENTES SIN EL PLAN DE SALUD DE CONTRA COSTA QUE PRESENTAN UNA QUEJA O RECLAMO

If you have a complaint or grievance that has not been satisfactorily resolved for more than 30 days you may call Contra Costa Regional Medical Center, Patient Relations Office at (925) 370-5144 for further assistance. / Si usted tiene una queja o reclamo que no se haya resuelto de manera satisfactoria durante más de 30 días, puede comunicarse con el Centro Médico Regional de Contra Costa, Oficina de Relaciones del Paciente llamando al (925) 370-5144 para obtener ayuda.

CONTRA COSTA HEALTH PLAN PATIENTS FILING A COMPLAINT PLEASE READ YOUR RIGHTS BELOW
PACIENTES CON EL PLAN DE SALUD DE CONTRA COSTA QUE PRESENTEN UNA QUEJA, FAVOR DE LEER SUS DERECHOS A CONTINUACIÓN

The California Department of Managed Health Care is responsible for regulating health care service plans. If you have a grievance against your health plan, you should first telephone your health plan at (Contra Costa Health Plan) 1-877-661-6230 (Press 2) and use your health plan's grievance process before contacting the department. Utilizing this grievance procedure does not prohibit any potential legal rights or remedies that may be available to you. If you need help with a grievance involving an emergency, a grievance that has not been satisfactorily resolved by your health plan, or a grievance that has remained unresolved for more than 30 days, you may call the department for assistance. You may also be eligible for an Independent Medical Review (IMR). If you are eligible for IMR, the IMR process will provide an impartial review of medical decisions made by a health plan related to the medical necessity of a proposed service or treatment, coverage decisions for treatments that are experimental or investigational in nature and payment disputes for emergency or urgent medical services. The department also has a toll-free telephone number (1-888-HMO-2219) and a TDD line (1-877-688-9891) for the hearing and speech impaired. The department's Internet Website <http://www.hmohelp.ca.gov> has complaint forms, IMR application forms and instructions online." / El Departamento de Atención Administrada de la Salud de California (DMHC) reglamenta planes del cuidado de salud. Si usted tiene una queja en contra del plan de salud, usted primero debería llamar al plan al 1-877-661-6230 (Oprima 2) y usar el proceso de quejas formales del plan antes de llamar al DMHC. Utilizar este proceso de reclamo no se le prohíbe cualquier derecho legal o soluciones disponibles a usted. Si usted necesita ayuda con un reclamo que está relacionado a una emergencia, una queja que no ha sido resuelta satisfactoriamente por el Plan de Salud, o una queja que no ha sido resuelta por más de 30 días, usted puede llamar al DMHC para recibir ayuda. Usted también podría ser elegible para una Evaluación Médica Independiente (IMR). Si usted califica para una IMR, el proceso de IMR proveería una evaluación imparcial de las decisiones médicas tomadas por el plan de salud relacionadas con la necesidad médica de un servicio o tratamiento propuesto, con terapias experimentales o de investigación, o con reclamaciones rechazadas por servicios médicos de emergencia o de urgencia. El DMHC también tiene un número de teléfono gratis (1-888-HMO-2219). Personas que tienen problemas de oír o de hablar pueden llamar al 1-877-688-9891 (TDD). El domicilio del Internet <http://www.hmohelp.ca.gov> tiene formularios con instrucciones para presentar quejas o pedir una IMR.

Appendix D – Hospital Policy No.109 – Adverse Event Reporting

CONTRA COSTA REGIONAL MEDICAL CENTER
HOSPITAL AND HEALTH CENTERS

HOSPITAL POLICY NO. 109

ADVERSE EVENT REPORTING

I. PURPOSE:

To comply with the mandated reporting requirements of Health and Safety Code §1279.1(b), §1280.15(b), 42 CFR §482.13(g), and CCR §70737(a) and 71535, and to support the improvement of patient safety and quality improvement initiatives.

II. REFERENCES:

Adverse Events: California Health and Safety Code §1279.1, 1279.2, 1279.3, 1280.4
EMTALA reporting: California Health and Safety Code §1317.4(c)
EMTALA: 42 CFR §489.20-489.24
Restraint & Seclusion Deaths: 42 CFR §482.13(g)
Unusual Occurrences: Title 22, California Code of Regulations §70737(a) and 71535,
CCHSD 611-ES, CCHSD 501-PCC
The Joint Commission (TJC) Standards LD.04.04.05,EP 7

III. POLICY:

It shall be the policy of Contra Costa Regional Medical Center and Health Centers (CCRMC&HC) to report events, as defined within Health and Safety Code §1279.1(b), §1280.15(b), 1317.4(c), 42 CFR §482.13(g), or CCR §70737(a) and 71535, to the California Department of Public Health (CDPH) or the Centers for Medicare and Medicaid Services (CMS), as appropriate, within the time frame directed by the regulation. It is also our policy to investigate the source of the event, initiate any mitigation actions that may be indicated and cooperate fully with CDPH or CMS throughout the process.

Adverse Events, Restraint and Seclusion Deaths, Unusual Occurrences, EMTALA, and other Safety Events will be *internally* reported using the online Safety Events Reporting System (SERS).

Exceptions, not reported in SERS:

- Employee injuries are reported to Contra Costa County Risk Management using forms AK-30 and DWC-1.
- Child abuse or neglect, see CCHSD Policy 400-PCS, CCRMC Policy 566
- Domestic violence, see CCHSD Policy 401-PCS, CCRMC Policy 575
- Adult/elder abuse, see CCHSD Policy 405-PCS, CCRMC Policy 565
- IT Security incidents, see CCHSD Policy 702-C
- Code Blue, RRT, Behavioral Response, and OB Response calls, in and of themselves, will not be reported in SERS.

CCRMC&HC will also comply with the reporting requirements of the Safe Medical Device Act (CCRMC Policy 347) when an event causes patient death or serious disability involving the use or function of equipment or devices.

Whenever an event warrants an investigation, the investigation will be conducted under the auspices of the Performance Improvement Committee (PIC) and afforded Peer Review, Evidence Code §1157, protection from discovery. CCRMC Policy [172](#) describes the investigation process. The investigation does not replace the physician peer review process and referrals will be made to the involved Medical Staff Department, as appropriate.

IV. AUTHORITY/RESPONSIBILITY:

CCRMC & HC employees and contractors witnessing an event
CCRMC & HC Administration
Performance Improvement Committee and Chairperson
Health Care Risk Manager
Department Managers (Clinical, Patient Services)

V. DEFINITIONS:

A. “Adverse Event” includes any of the following: **(These events are also considered sentinel events by the TJC. Please see policy 172 – Responding to Sentinel Events.)**

1. Surgery performed on a wrong body part that is inconsistent with the documented informed consent for that patient. A reportable event does not include a situation requiring prompt action that occurs in the course of surgery or a situation that is so urgent as to preclude obtaining informed consent
2. Surgery performed on the wrong patient.
3. The wrong surgical procedure performed on a patient that is inconsistent with the documented informed consent for that patient. A reportable event does not include a situation requiring prompt action that occurs in the course of surgery, or a situation that is so urgent as to preclude the obtaining of informed consent.
4. Retention of a foreign object in a patient after surgery or other procedure, excluding objects intentionally implanted as part of a planned intervention and objects present prior to surgery that are intentionally retained.
5. Death during or up to 24 hours after induction of anesthesia after surgery of a normal, healthy patient who has no organic, physiologic, biochemical, or psychiatric disturbance and for whom the pathologic processes for which the operation is to be performed are localized and do not entail a systemic disturbance.
6. Patient death or serious disability associated with the use of a contaminated drug, device, or biologic provided by the health facility when the contamination is the result of generally detectable contaminants in the drug, device, or biologic, regardless of the source of the contamination or the product.
7. Patient death or serious disability associated with the use or function of a device in patient care in which the device is used or functions other than as intended. For purposes of this subparagraph, “device” includes, but is not limited to, a catheter, drain, or other specialized tube, infusion pump, or ventilator.
8. Patient death or serious disability associated with intravascular air embolism that occurs while being cared for in a facility, excluding deaths associated with neurosurgical procedures known to present a high risk of intravascular air embolism.

9. An infant discharged to the wrong person.
10. Patient death or serious disability associated with patient disappearance for more than four hours, excluding events involving adults who have competency or decision-making capacity.
11. A patient suicide or attempted suicide resulting in serious disability due to patient actions after admission, excluding deaths resulting from self-inflicted injuries that were the reason for admission to the health facility.
12. A patient death or serious disability associated with a medication error, including, but not limited to, an error involving the wrong drug, the wrong dose, the wrong patient, the wrong time, the wrong rate, the wrong preparation, or the wrong route of administration, excluding reasonable differences in clinical judgment on drug selection and dose.
13. A patient death or serious disability associated with a hemolytic reaction due to the administration of ABO-incompatible blood or blood products.
14. Maternal death or serious disability associated with labor or delivery in a low-risk pregnancy, including events that occur within 42 days post-delivery and excluding deaths from pulmonary or amniotic fluid embolism, acute fatty liver of pregnancy, or cardiomyopathy.
15. Patient death or serious disability directly related to hypoglycemia, the onset of which occurs while the patient is being cared for in a health facility.
16. Death or serious disability, including kernicterus, associated with failure to identify and treat hyperbilirubinemia in neonates during the first 28 days of life. "Hyperbilirubinemia" means bilirubin levels greater than 30 milligrams per deciliter.
17. A Stage 3 or 4 ulcer, acquired after admission, excluding progression from Stage 2 to Stage 3 if Stage 2 was recognized upon admission.
18. A patient death or serious disability due to spinal manipulative therapy performed at the health facility.
19. A patient death or serious disability associated with an electric shock while being cared for in a health facility, excluding events involving planned treatments, such as electric counter shock.
20. Any incident in which a line designated for oxygen or other gas to be delivered to a patient contains the wrong gas or is contaminated by a toxic substance.
21. A patient death or serious disability associated with a burn incurred from any source while being cared for in a health facility.
22. A patient death associated with a fall while being cared for in a health care facility.
23. A patient death or serious disability associated with the use of restraints or bedrails while being cared for in a health care facility.
24. Any instance of care ordered by or provided by someone impersonating a physician, nurse, pharmacist, or other licensed health care provider.
25. The abduction of a patient of any age.
26. The sexual assault on a patient within or on the grounds of the facility.
27. The death or significant injury of a patient or staff member resulting from a physical assault that occurs within or on the grounds.
28. An adverse event or series of adverse events that cause the death or serious disability of a patient, personnel, or visitor.
29. Rape, assault (leading to death or permanent loss of function), or homicide of a staff member, licensed independent practitioner, visitor or vendor that occurs within or on the grounds of the facility.

- B. "Safety Event" includes:
 1. Any unlawful or unauthorized access, use, or disclosure of, patient medical information. This includes inappropriate access to, review or viewing patient medical information without a direct need for medical diagnosis, treatment or other lawful use.
 2. AMA, AWOL, and events involving Patient Behaviors, Communication, Diet, Equipment, Falls, Patient injuries, Isolation, Infection Prevention, IV, Medications, Adverse Drug Reactions, Providers, Property, Transfusions, Treatment or Procedures, and other events listed within SERS.

- C. "Restraint or Seclusion Deaths"
 1. Any death that occurs while a patient is in restraint or seclusion.
 2. Any death that occurs within 24 hours after the patient was removed from restraint or seclusion.
 3. Any death that occurs within one week after restraint or seclusion where it is reasonable to assume that use of restraint or seclusion contributed directly or indirectly to a patient's death. "Reasonable to assume" includes deaths related to restrictions of movement for prolonged periods of time, or related to chest compression, restriction of breathing or asphyxiation

- D. "Unusual Occurrences" include:
 1. Epidemic outbreak, poisoning, fire, major accident, disaster, other catastrophe or unusual occurrence which threatens the welfare, safety, or health of patients, personnel, or visitors.

- E. "EMTALA" (Emergency Medical Treatment and Active Labor Act)
 1. Patient transfers from other hospitals that violate EMTALA regulations, such as:
 - a. Patient is medically unstable for transfer
 - b. CCRMC has not consented to the transfer
 - c. Patient did not consent to transfer
 - d. Other regulatory violations

- F. "Serious disability"

Serious disability means a physical or mental impairment that substantially limits one or more of the major life activities of an individual, or the loss of bodily function, if the impairment or loss lasts more than 7 days or is still present at the time of discharge from an inpatient health care facility, or the loss of a body part.

VI. GENERAL PROCEDURE APPLICABLE TO ALL EVENT TYPES

- A. Initial Report to Administration and Risk Management

An event that contributes to or results in death or permanent harm to the patient must be verbally reported to the immediate, on-duty supervisor, and called into the Risk Management Hotline (925-370-5190) immediately, but no later than the end of shift, by the person completing the online SERS application. The immediate supervisor, upon receipt of the verbal report, will notify (page) the Administrator of the Day (AOD), 6034-118, CEO-Hospital, and/or CEO-Ambulatory Care.

- B. Completion of the online SERS application

1. Events are reported and documented utilizing the online SERS application by the employee or county contractor who first becomes aware of the incident.
 2. Once the initial SERS form is completed on-line. The form is automatically (electronically) sent to the immediate supervisor for review. The supervisor will take any necessary corrective actions, conduct additional fact-finding as needed, complete the manager's section of the SERS form, and forward it (assign a task) to his/her supervisor or department manager.
 3. The form is also automatically sent to the CEO-Hospital, CEO-Ambulatory Care, COO-Hospital, SPI Director, Facility Director, and Health Care Risk Manager whenever the event is potentially reportable.
 4. The department manager or supervisor will review the form for completeness and adequacy of corrective action and fact-finding, and "close" the event within the form.
 5. The Health Care Risk Manager and designee have access to all SERS events from the point of initial entry.
- C. Examination of Patient/Visitor and Documentation in the Medical Record Following any incident which has any potential for injury:
1. Any involved inpatient will be assessed or examined. The occurrence of the incident, its effect on the patient, and outcomes of the examination will be documented in the medical record.
 2. Any involved outpatient/visitor will be offered an exam at no charge. During normal working hours, the manager responsible for the area where the injury occurred should facilitate the patient or visitor's exam in the Emergency Department or Health Center, as applicable. The occurrence of the incident, its effect on the patient, and outcomes of the examination should be documented in the medical record. Should the outpatient/visitor refuse the examination, the refusal should be noted in the SERS application and in the medical record, as applicable.
- D. Confidentiality
- Events reported in SERS are confidential and should not be copied to paper, or given to the patient or representative. The report, itself, should not be specifically referred to in the patient's medical record.
- E. Determining whether the event is reportable
1. The determination of whether the event is reportable under Health and Safety Code §1279.1(b), §1280.15(b), 42 CFR §482.13(g), or CCR §70737(a) and 71535, will be made by the CEO-CCRMC or CEO-Ambulatory Care, or designee. These individuals will also have the responsibility to submit the initial report to the CDPH or CMS, as well as serve as liaison with that agency during the subsequent investigation process.
 - a. All reports made to regulatory authorities under the above stated regulations will be stored with the Director of Safety & Performance Improvement.
 2. Staff may consult with the CCRMC Privacy Coordinator(s) to determine if an unlawful or unauthorized access to PHI is reportable. The determination of whether an unlawful or unauthorized access to PHI is reportable to CDPH and the patient will be made by the Contra Costa County Privacy Officer. The Privacy Officer will have the responsibility to submit the initial report to CDPH. The

Privacy Coordinator(s) will serve as the liaison with that agency. (CCHSD Policy 506-PCC)

- a. All reports made to CDPH with regard to the unlawful or unauthorized access to PHI will be stored with the Contra Costa County Privacy Officer.

VII. SPECIFIC PROCEDURES BY EVENT TYPE

A. Adverse Event: Report to CDPH

1. Time frame for report: No later than five (5) days after the event has been detected; or, if the event is an ongoing urgent or emergent threat to the welfare, health, or safety of patients, personnel, or visitors, not later than twenty-four (24) hours after the adverse event has been detected.
2. How to report: The report shall be submitted pursuant to the requirements set forth by CDPH
 - a. The report will be typed on hospital letterhead and faxed to: California Department of Public Health 510-620-5821
 - b. The body of the report will follow the language as agreed to by CHA and the California Department of Public Health
3. Communication with affected patient
 - a. The patient, or the party responsible for the patient, will be notified by their attending physician of the nature of the adverse event by the time the report to the CDPH is made.
 - b. All of the above disclosures shall be reflected in the patient's record. The patient or the party responsible for the patient shall **not** be provided with a copy of the report.

B. Restraint or Seclusion Deaths: Report to CMS

1. Time frame for report: No later than close of business the next business day following knowledge of the patient's death.
2. How to report: The report shall be submitted pursuant to the requirements set forth by CMS.
 - a. The report will be faxed to: CMS San Francisco 415-744-2692
 - b. The body of the report will follow the language required by CMS
3. Documentation in the patient's medical record
 - a. The date and time of when the report was made to CMS must be documented in the patient's medical record.

C. Reportable Unusual Occurrences: Report to CDPH and local health officer

1. Time frame for report: As soon as reasonably practicable.
2. How to report:
 - a. Phone CDPH #=
 - b. Call local health officer #?

D. Any unlawful or unauthorized access, use, or disclosure of, patient medical information: Report to CCRMC Privacy Coordinator(s) and Contra Costa County Privacy Officers. The Contra Costa County Privacy Officer will report to CDPH, as appropriate (CCHSD Policy 506-PCC)

1. Time frame for reporting to the Privacy Officer: Immediately upon knowledge of breach
 2. How to report: SERS
 3. Letter to the patient or representative (last known address) regarding the unauthorized or unlawful access will be made by the Privacy Officer.
- E. Appeal of Penalty issued by CDPH
If a penalty is imposed and the decision is made to contest it, the CEO shall be contacted within 10 days of our notice of the penalty, to request an adjudicative hearing, pursuant to Health and Safety Code §100171 or 131071 and the provisions of Government Code 11400 and 11500 et seq. Payment of outstanding penalties will be paid only if, 1) the findings have not been reversed in whole or in part, and 2) the appeal process has been exhausted.

VIII. RESPONSIBLE STAFF PERSON:
CCRMC&HC Health Care Risk Manager

REVIEWED/REVISED: 6/07, 10/07; 7/08; 12/08; 10/09, 8/13

Appendix E – HRSA Clinical Measures – 2019 - 2021 Health Plan

- A. Early Entry into Prenatal Care: Percentage of prenatal care patients who entered prenatal care during their first trimester
- B. Childhood Immunization Status: Percentage of children 2 years of age who received age appropriate vaccines by their 2nd birthday
- C. Cervical Cancer Screening: Percentage of women 23-64 years of age who were screened for cervical cancer
- D. Weight Assessment and Counseling for Nutrition and Physical Activity Of Children and Adolescents: Percentage of patients 3-17 years of age with a BMI percentile and counseling on nutrition and physical activity documented
- E. Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up Plan: Percentage of patients 18 years of age and older with (1) BMI documented and (2) follow-up plan documented if BMI is outside normal parameters
- F. Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention: Percentage of patients aged 18 years of age and older who (1) were screened for tobacco use one or more times within 24 months, and (2) if identified to be a tobacco user received cessation counseling intervention
- G. Use of Appropriate Medications for Asthma: Percentage of patients 5 through 64 years of age identified as having persistent asthma and were appropriately ordered medication
- H. Coronary Artery Disease (CAD) Lipid Therapy: Percentage of patients 18 years of age and older with a diagnosis of CAD who were prescribed a lipid lowering therapy
- I. Ischemic Vascular Disease (IVD) Use of Aspirin or Another Antiplatelet: Percentage of patients 18 years of age and older with a diagnosis of IVD or AMI, CABG, or PCI procedure with aspirin or another antiplatelet
- J. Colorectal Cancer Screening: Percentage of patients 50 through 75 years of age who had appropriate screening for colorectal cancer
- K. HIV Linkage to Care: Percentage of patients whose first ever HIV diagnosis was made by health center staff between October 1, of the prior year and September 30, of the measurement year and who were seen for follow-up treatment within 90 days of that first-ever diagnosis
- L. Screening For Depression And Follow-Up Plan: Percentage of patients 12 years of age and older who were (1) screened for depression with a standardized tool and, if screening was positive,(2) had a follow-up plan documented
- M. Dental Sealants for Children Between 6-9 Years: Percentage of children 6 through 9 years of age at moderate to high risk of caries who received a sealant on a first permanent molar