# AGENDA

<table>
<thead>
<tr>
<th>Item</th>
<th>Presenter</th>
<th>TAB</th>
<th>Time</th>
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<tbody>
<tr>
<td><strong>A. CALL TO ORDER</strong></td>
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<td>9:00 AM</td>
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<tr>
<td>1. Welcome</td>
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<td>2. Introductions</td>
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<td>3. Adopt agenda</td>
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<tr>
<td><strong>B. CLOSED SESSION</strong></td>
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<tr>
<td>1. No closed session this meeting</td>
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<tr>
<td><strong>C. PUBLIC COMMENT</strong></td>
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<td>Persons wishing to address items on or off agenda</td>
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<tr>
<td><strong>D. CONSENT AGENDA</strong></td>
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<td>TAB 1</td>
<td>5 min</td>
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<tr>
<td>Review and Approve Minutes of 9/30/16 Meeting</td>
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<tr>
<td><strong>E. BOARD ORIENTATION</strong></td>
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<tr>
<td>a. HCH Program Staff and Org Chart Review</td>
<td>Suzanne Warner, HCH Deputy Director</td>
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<td>b. Training and Orientation Needs Brainstorm for Commission</td>
<td>Joel Ginsberg, HCH Program Svcs Coordinator</td>
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<td><strong>F. REGULAR AGENDA</strong></td>
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<td>TAB 2</td>
<td>10 min</td>
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<tr>
<td>1. Consumer Input - no item this meeting</td>
<td>Kathleen Clanon MD, HCH Interim Director</td>
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<tr>
<td>2. Board Ad Hoc Committee reports - no reports this meeting</td>
<td>Jeffrey Seal, MD Interim HCH Medical Director</td>
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<td>3. HCH Program report: Hiring Process for new HCH Director</td>
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<tr>
<td>4. Review HCH Quality Plan</td>
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<tr>
<td><em>Action Item: Approve 2017 HCH Quality Plan</em></td>
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<tr>
<td><strong>G. OTHER ITEMS</strong></td>
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<tr>
<td>1. Items for upcoming agenda</td>
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<td>2. Upcoming officer election</td>
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<td>3. Housekeeping</td>
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<tr>
<td><strong>H. ADJOURNMENT</strong></td>
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*Meetings are accessible to people with disabilities. Individuals who need special assistance or a disability-related modification or accommodation (including auxiliary aids or services) to participate in this meeting, or who have a disability and wish to request an alternate format for the agenda, meeting notice, or other documents that may be distributed at the meeting, should contact the HCH Grant Manager at least five working days before the meeting at (510) 667-4487 in order to make reasonable arrangements to ensure accessibility to this meeting and the materials related to it. The HCH Commission regular meeting documents are posted at least 72 hours prior to the meeting and are accessible online at: [http://www.achch.org/](http://www.achch.org/).**

**Any person may address the HCH Commission during its Public Comments period. Presentations must not exceed three (3) minutes in length. HCH Commission members may not take actions or respond immediately to any Public Comments presented, but may choose to follow up at a later time, either individually, or on a subsequent Commission Agenda.**
TAB 1

Minutes of September 30, 2016
Commission Meeting
## Alameda County Health Care for the Homeless Commission
### Meeting Minutes
#### Friday, September 30, 2016
Alameda County Health Care Services Agency 1000 San Leandro Blvd #325, San Leandro

<table>
<thead>
<tr>
<th>HCH Commissioners Present</th>
<th>County Staff/Partners Present</th>
<th>Absent:</th>
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<tbody>
<tr>
<td>Lynette Lee</td>
<td>David Modersbach, Grants Manager</td>
<td>boona cheema</td>
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<td>Fr. Rigo Caloca-Rivas</td>
<td>Joel Ginsberg, Program Specialist</td>
<td>Gay McDaniel</td>
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<td>Betty DeForest</td>
<td>Quyen Tran, Fiscal Manager</td>
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<td>Samuel Weeks</td>
<td>Jennifer Martinez, Interim Operations Mgr</td>
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<td>Jean Prasher</td>
<td>Jeffrey Seal MD HCH Medical Director</td>
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<td>Adria Walker</td>
<td>Dee Ghosh MD, AHS SDC &amp; Mobile Services Medical Director</td>
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<td>Kathleen Clanon MD, HCH Interim Director (Ex Officio)</td>
<td>Vanessa Cedeno, County Supervisor Wilma Chan’s Office</td>
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<td>Joe DeVries AHS Board of Trustees</td>
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<td>Mike Moye, AHS General Counsel</td>
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<tr>
<th>Item</th>
<th>Discussion/Recommendation</th>
<th>Action</th>
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| CALL TO ORDER | • HCH interim Director Kathleen Clanon MD called meeting to order at 2:05pm.  
• Consensus agreement that Dr. Clanon will informally facilitate Commission meetings until the Commission elects officers by its November 2016 meeting.  
• Everyone present introduced themselves.  
• Representatives of the Clerk of the Board of Supervisors swore in Commissioners Prasher, DeForest, Caloca-Rivas, Weeks and Lee. Commissioners cheema and Walker had already been sworn in.  
• Dr. Clanon explained that Commissioners selected by County Supervisors (Prasher, DeForest, Lee, McDaniel and cheema) were appointed for initial 4 year terms, and At-Large Commissioners (Walker, Weeks and Caloca-Rivas) were appointed for 2 year terms. All Commissioner terms are renewable for 4 years after that, for a maximum of 12 years of service.  
• HCH staff and partners are seeking a ninth HCH Commissioner with expertise in hospital systems to round out the Commission. | |
| CLOSED SESSION | There was no closed session this meeting. | |
| PUBLIC COMMENT | Public comments were invited; none were made. | |
| CONSENT AGENDA | There were no consent items for this meeting. | |
| BOARD ORIENTATION | • HCH staffer David Modersbach presented an overview of the Alameda County Health Care for the Homeless health center.  
• HCH staff will continue to provide in-depth orientation on topics of interest relating to the health center at future meetings. | |
| REGULAR AGENDA | 5. Consumer Input - no item this meeting.  
6. Board Ad Hoc Committee reports - no reports this meeting.  
7. HCH Program report (e.g., Program Director, QI, contracts, finance, etc.) - No reports this meeting.  
8. Review ordinance creating Commission  
   Joel Ginsberg presented an overview of County Ordinance 2016-27 adopted by the Alameda County Board of Supervisors on 6/28/16, establishing the Alameda County Health Care for the Homeless Commission. | |
9. **Proposed Bylaws**

Joel Ginsberg presented a review of the draft Bylaws for the HCH Commission, as required by HRSA and approved by the Count of Alameda Board of Supervisors on 6/28/16. The Bylaws will guide the process of the HCH Commission and may be modified by the Commission so long as changes are consistent with the ordinance establishing the Commission and applicable federal, state and local law.

**Action Item: Approve Bylaws**

10. **Proposed Co-Applicant Agreement**

Joel Ginsberg reviewed the Co-Applicant Agreement which was developed based on HRSA guidelines and with collaboration between the Alameda Health System (AHS) Board of Trustees and the Alameda County Board of Supervisors. This Agreement delimits the authorities of AHS, BOS and the HCH Commission in governing the ACHCH health center.

**Action Item: Approve Co-Applicant Agreement**

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**OTHER ITEMS**

Discussion:

- **Board Insurance** – Does Commission need Board/Commission malpractice insurance? Staff to get back to Commission after consulting County counsel.
- **Brown Act Training** – Commissioners would like Brown Act training. Mike Moye (AHS County Counsel) volunteered to help train, and David Modersbach will seek resources from Alameda County counsel to present at the next meeting.
- **Regular Time for Commission Meetings** – Commissioners proposed 2nd or 3rd Wednesday from 9am to 11 am or the 3rd Friday at 9am to 11am. David Modersbach will look into room availability and poll Commissioners. All agreed on San Leandro as the location for meetings.
- **Discussion of Commissioners’ Charge and Purposes in Serving on the Commission** - Responses included:
  - To meet HRSA governance requirements
  - To elevate the discussion and actions around homelessness and health disparities
  - To support Alameda Health Services’ Board of Trustees in their oversight of homeless care, through the Commissioners’ homeless-specific expertise and insight.
  - To help HCH staff continually improve the work they do with the board’s guidance.
  - To improve the health of the most dispossessed residents of the County and to save lives.

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**ADJOURNMENT**

Time: 3:55 p.m.

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President, HCH Commission  
October 21, 2016

HCH Program  
October 21, 2016
Tab 2

2017-2019 ACHCH Quality Structure and Quality Plan
Introduction

The purpose of the Alameda County Health Care for the Homeless (HCH) Quality Program and Plan is to present a clearly outlined process to complete the following activities:

- **Measure** success in meeting utilization targets,
- **Document** achievement of clinical and financial performance objectives
- **Evaluate** and ensure the effectiveness of the health care services provided to homeless health center patients, and
- **Ensure** high levels of patient satisfaction.

The following document provides information on the organization of the HCH quality management program (Section I) and an annual quality plan (Section II). The Quality Plan includes both specific goals to be accomplished during 2017 and areas of focus for 2018 and 2019 which will be refined by the results of the first year. This includes improving data completeness and integrity, contractor quality improvement efforts as they are in current contracts, and foundational alignment work that the Alameda County Health Care for the Homeless Quality Committee (QC) deems critical to future success in integrating quality improvement into the HCH. The Quality Plan will be revised as it is implemented, and as consensus is built amongst the Health Center’s network of providers and contractors around performance measurement and a vision of quality improvement.

Section I: HCH Quality Management Program

**Mission**

To assure ongoing excellence in the quality of care provided by Alameda County Health Care for the Homeless (HCH) and meet quality management requirements set forth by HRSA.

**Scope**

Applies to all services within the HRSA-approved scope of the Health Care for the Homeless Program. See Attachment A for an HCH programmatic overview, along with other Alameda County resources used to provide services to homeless patients.

**Definitions and Principles**

1. HCH uses the Institute of Medicine (IOM) definition of quality—
   “The degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge.”

2. The following principles guide quality improvement and quality assurance activities—
a. Data-driven decisions  
b. Teamwork  
c. Focus on entire processes of care or systems of care delivery, rather than individual performance

Roles and Responsibilities

1. Through its oversight of HCH, the Health Care for the Homeless Commission (formerly Joint Co-Applicant Board) is responsible for the quality of services within the HRSA-approved scope of project.
2. The HCH Quality Committee is responsible for updating the Quality Program Plan annually and responding to quality questions and concerns of the HCH Commission.
3. The AHS Ambulatory Quality Committee will be responsive to the questions, concerns, and requests of the HCH Quality Committee and the HCH Commission.
4. The Health Care Services Agency (HCSA) Privacy and Security Officers oversee the privacy and security of clinical information throughout HCSA, including within the HCH program.
5. The Risk Management Unit of the County Administrator’s Office and HCSA Departmental Human Resources staff oversee occupational safety and health of HCSA employees, including those within the HCH program.
6. The HCH Medical Director serves as the HCH liaison to HCSA Privacy and Security Officers and Alameda County Risk Management and HCSA Departmental Human Resources.

Quality Committee Participation

The HCH QC is composed of 8-11 persons from varying aspects of the HCH program; including the sub-recipient Alameda Health System (AHS), contractors and program direct services providers. Quality Committee members serve 2-year terms. Nomination and selection occurs annually. The Quality Committee meets at least 6 times per year. Quality Committee responsibilities include but are not limited to the following:

a. Reporting to the HCH Commission (i.e. Co-Applicant Board) at least twice a year on health outcomes and quality measures;  
b. Reporting to the HCH Commission (i.e. Co-Applicant Board) on quality improvement activities and outcomes throughout the program;  
c. Recommending changes to measures and goals for monitoring and reporting;  
d. Recommending interventions to respond to quality deficiencies or improvement opportunities; and  
e. Recommending resources to support quality assurance and quality improvement activities.  
f. QC members will review key elements of the quality program. This includes:  
i. Periodically reviewing the status of risk management activities (e.g. credentialing and staff privileges, clinician malpractice insurance, OSHA incidents, adverse patient events, patient confidentiality, patient satisfaction/experience, etc.),
ii. Providing input to HCH staff regarding the development/revision of Quality Management policies and procedures,
iii. Conducting a periodic review of HCH quality data, and
iv. Developing and monitoring an annual quality plan including quality improvement activities.

See Attachment B for overview of Quality structure within ACHCH health center. See Table 1 for roles assigned to specific QC members' positions as well as specific expertise they bring to the group:
<table>
<thead>
<tr>
<th>Position</th>
<th>Person</th>
<th>Committee Role and Specific Experience</th>
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<tbody>
<tr>
<td>HCH Medical Director</td>
<td>Jeffrey Seal, MD (Interim)</td>
<td>Functions as the HCH Quality Committee Chair and provides general oversight to HCH quality management program.</td>
</tr>
<tr>
<td>HCH Director</td>
<td>Kathleen Clanon, MD (interim)</td>
<td>Responsible for administrative and financial oversight of HCH, especially as it applies to QA/QI activities.</td>
</tr>
<tr>
<td>HCH QI Coordinator</td>
<td>Jennifer Martinez, MPH</td>
<td>Responsible for convening meetings, preparing any required documentation, and keeping minutes. Background is in quality assurance.</td>
</tr>
<tr>
<td>HCH Direct Services Manager</td>
<td>New hire to be in place November 2016</td>
<td>Oversees HCH-provided Direct Services including Mobile Health, Case Management, Enabling Services, nursing services, and outreach.</td>
</tr>
<tr>
<td>HCH Contracts Manager</td>
<td>Harit Agroia, MPH</td>
<td>Oversees contractual compliance with quality assurance/quality improvement deliverables. Reviews and presents HCH Contractor data and narrative summaries to QC.</td>
</tr>
<tr>
<td>HCH Grant Manager</td>
<td>David Modersbach</td>
<td>Responsible for updating members on HRSA requirements and required reporting including UDS.</td>
</tr>
<tr>
<td>AHS Health Services Manager, Homeless Coordination Office</td>
<td>Heather MacDonald-Fine</td>
<td>This position functions as a liaison to the AHS Ambulatory Quality Committee for HCH QC. Also represents AHS HCH-funded projects and ambulatory clinics and facilitates Homeless Coordinating Office Steering Committee</td>
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<tr>
<td>AHS Complex Care Program, Medical Director</td>
<td>David Moskowitz, MD</td>
<td>This is a AHS clinician position. The current member has expertise in chronic disease management and complex patient care. Knowledgeable about AHS as a care delivery system.</td>
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<tr>
<td>ROOTS Street Medicine</td>
<td>Jason Reinking, MD</td>
<td>Community Health Center Clinician providing front-line medical care to homeless individuals.</td>
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<tr>
<td>HCH Consumer/Community Advisory Board (CCAB) Member</td>
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<td>Contractor Representative</td>
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Table 1: HCH Quality Committee Members
Quality Measures

The Alameda County Health Care for the Homeless Quality Committee (QC) will develop an annual quality plan through which it will select specific objectives aligned with program strategic goals, including patient access, quality of care, clinical and financial performance.

1. At a minimum, quality measures include current required measures for the annual Uniform Data System report. ([http://bphc.hrsa.gov/qualityimprovement/performance_measures/index.html](http://bphc.hrsa.gov/qualityimprovement/performance_measures/index.html))
2. Each HCH program or contracted service also reports measures of patient experience based on patient surveys or other agreed upon tools.
3. Other quality measures may include those required by other funders or regulators or adopted by the QC.

HCH staff works with program direct services, the AHS sub-recipient and its contractors to clarify program expectations regarding quality assurance/quality improvement activities for homeless patients accessing their services. The QC will oversee the collection and analysis of data from them on a quarterly basis, to measure progress in reaching annual performance goals. The QC will provide timely feedback to promote an environment of continuous quality improvement throughout the HCH service delivery system. See Attachment B for an overview of the HCH quality structure.

HCH QC is committed to exercising the highest standards in coordinating the exchange of information among key stakeholders regarding clinical performance and quality of care for homeless patients. The HCH QC will periodically report its quality related findings to the HCH Commission, the HCH Consumer/Community Advisory Board (CCAB), and other interested parties.

Approach to Performance and Quality

The HCH Quality Committee is committed to building a robust program/clinic performance and quality improvement program that addresses the diversity of activities/services among contractors and the sub-recipient. Based on data garnered from key stakeholder interviews as well as a review of contractor data and narratives, HCH QC is supporting the implementation of Results Based Accountability (RBA) as the overarching conceptual framework in all HCH-funded projects and sites. Participation in RBA allows programs, agencies, or services to identify key performance measures, based on answering three critical questions: 1) How much did we do?; 2) How well did we do it?; and 3) Is anyone better off? RBA supports community-based service providers in successfully following an accessible, practical process to implement and evaluate its work.

RBA will help HCH establish a strong programmatic foundation from which relevant quality improvement activities can be prioritized more effectively. RBA will also assist HCH in establishing a common language for discussing program outcomes among a very diverse set of HCH contractors and the AHS Homeless Coordinating Office programs. The Quality Committee will support the organization of the data it receives into this framework, which will clarify which elements the Committee will monitor regularly. In addition, it will highlight where quality improvement activities should be targeted. The
QC’s use of an RBA framework aligns with other departments within Alameda County (e.g. public health, behavioral health care services, and indigent health) currently using this approach. (See Attachment C for overview of RBA)

Quality Improvement Activities

The Quality Program incorporates three distinct types of activities—quality assessment, quality improvement, and quality improvement reporting. Each activity is described below, including who is responsible in the case of both directly provided services and contracted services.

1. **Quality assessment** includes determination of measures of program quality within the RBA framework, determining standards for those measures, and monitoring of those measures over time by the QC. Quality assessment within each program is the responsibility of the program manager for services involving HCH- or AHS-employed staff, and the assigned contract monitor for services that are fully contracted. If these individuals are not licensed professional staff with applicable expertise (i.e. dentists for dental care, psychologists for therapy, etc.), such staff must be included in the quality assessment.

2. **Quality improvement** includes activities defined in the Model for Improvement popularized by the Institute for Healthcare Improvement (http://www.ihi.org/resources/Pages/HowtoImprove/default.aspx). Quality improvement areas (sometimes referred to as process improvement) will be identified through the ongoing quality assessment of data in the RBA framework. Activities are undertaken by improvement teams, which must include licensed and unlicensed staff that care for clients or patients, whether they are directly employed or working under contract.

3. **Quality improvement reporting** is distinct from programmatic reporting of outcomes and processes, and refers specifically to the activities and results of process improvement efforts. For example, a clinic manager may report hypertension outcomes and the number of visits for hypertensive patients at baseline. However, a multidisciplinary team may undertake a quality improvement effort, such as conducting a root-cause analysis, and as a result instituting reminder calls to improve hypertension control. Quality improvement reporting would include reporting on the additional activities (e.g. outcome of root-cause analysis and reminder calls) and intermediate or targeted outcomes (e.g. changes in visits for uncontrolled patients, and related changes in hypertension outcomes). Data for quality improvement reporting may be collected through the electronic health record, other centrally-managed databases, and/or data collection systems developed by staff and supervisors (e.g. Excel spreadsheet, paper based surveys, etc.).

For services directly delivered by HCH or AHS staff, quality reporting is the responsibility of the program manager or designated staff. For contracted services, quality reporting is the responsibility of the contractor as defined in the contract.
Section II: HCH Quality Plan

The HCH Quality Committee agreed to formulate a three-year quality plan to enable all stakeholders to have time to create a strong foundational structure that builds on existing efforts. Specific goals are listed for Calendar Year 2017 that are aimed at developing capacity to use the RBA methodology for performance measures and beginning PDSA quality improvement efforts for the programs within the AHS Homeless Coordinating Office. Items listed under 2018 and 2019 will be refined as the data is organized and opportunities for impact are revealed through the work of Year 1.

2017 Goals

Alameda County Health Care for the Homeless Program

1) By 1/30/17, set in place a schedule for HCH QC to complete a review of current program data and narratives related to utilization and quality improvement, initially focused on the AHS homeless program(s) and later the HCH Contractors. (See Attachment DC for summary of current quality improvement goals from five of the HCH contractor sites as an example of this work).

2) By 3/31/17, HCH Ad Hoc Training Subcommittee will create a training schedule through 2019 for HCH staff, AHS staff, and HCH contractors to be reviewed and updated annually. Potential topics may include patient experience, results-based accountability measures, integrating measures to track social determinants of health, etc.

3) By 3/31/17, at least three HCH management staff will complete Results-based Accountability 101 training.

4) By 3/31/17, update and finalize written document outlining HCH Quality Management Program (including QC bylaws, roles and responsibilities, electronic file structure for information storage, risk management [credentialing/privileging, adverse incident reporting/evaluation], patient client grievances, and annual quality plan).

5) By 5/30/17, complete recruitment of two new members for HCH Quality Committee, representing contractors, consumers, and relevant specialists.

6) By 5/30/17, HCH will update AHS sub-recipient contract to include specific written content relating to its expectations regarding quality assurance/improvement activities aimed at improving health care and enabling services delivery for homeless patients.

7) By 6/30/17, HCH will have completed documentation of current safety procedures and protocol(s) for a) HCH staff, b) AHS and Contractor staff, and c) patients (including patient record confidentiality).

8) By 6/30/17, available patient experience (satisfaction) data will be provided to the HCH Consumer/Community Advisory Board (CCAB) on a quarterly basis, and the CAB will be engaged in the development of new patient experience data methodologies as the need arises.
Alameda Health System (subrecipient)

9) By 1/30/17, the AHS Ambulatory Quality Committee will create a plan and schedule for sharing homeless patient data with HCH Quality Committee from its four wellness centers, Same Day Clinic, and the Mobile Clinic, to be implemented in FY2017-18. This includes homeless data dashboards, PRIME-associated data for homeless populations, and the process to respond to additional quality data inquiries as they arise.

10) By 5/30/17, the four health center programs under the AHS Homeless Coordinating Office will complete a comprehensive Results-based Accountability training module resulting in the development of RBA performance measures for each one. Their programs are: Health Advocates, Mobile Health, Medication Assisted Treatment/Substance Abuse Services Expansion (SASE), and Substance-use Care Management (Homeless Action Team (HAT)).

11) By 6/30/17, AHS will provide to the HCH Quality Committee, a mutually agreed upon dataset of clinic and utilization performance measures for homeless patients seen in its four wellness centers (Eastmont, Highland, Hayward and Newark), Same Day Clinic, and/or the Mobile Clinic for ongoing Quality Assessment and Monitoring. This dataset will be curated from the AHS dashboard dataset.

12) By 8/30/17, AHS will provide data/narrative and analysis for at least four clinical performance measures, aligned with PRIME metrics, for homeless patients served by its four wellness centers (Eastmont, Highland, Hayward and Newark), Same Day Clinic and Mobile Clinic, TBD by Ambulatory Quality Committee/Homeless Coordinating Office and HCH Quality Committee.

13) By 12/31/17, AHS will provide the QC with a proposal for collecting and providing patient experience data from its ambulatory division.

HCH Contractors

14) By 6/30/17, all HCH Contractors will produce “low tech” patient experience and patient satisfaction data and analysis on a quarterly basis, to be reviewed by the HCH QC and the HCH Consumer/Community Advisory Board.

15) By 10/30/17, all HCH Contractors will provide data and analysis to the HCH QC, through the HCH Contract Manager, from at least one quality improvement goal.
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<th>Goal</th>
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<td>Schedule training program through 2019</td>
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<td>HCH Management Staff Complete RBA Training</td>
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<td>QC Review/Approval of Risk Management Plan</td>
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<td>QC complete recommendations for HCH Contract Changes related to QA/QI</td>
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<td>QC Review/Approval of Patient Safety Protocol</td>
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<td>QC review of patient satisfaction/experience data</td>
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<td>AHS plan, measure selection, and provision of homeless data</td>
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<td>RBA training and measure development for AHS homeless programs</td>
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<td>Ash Patient Experience Plan</td>
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<td>HCH Contractor low-tech patient experience data</td>
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<td>HCH Contractor Quality Improvement Data</td>
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2018 and 2019: Next Steps

The HCH Quality Committee will prioritize the following items and set deadlines as they move forward with their charge to create a strong quality program during Year 1.

- Work closely with AHS sub-recipient and contractors to begin to establish crossover relationships to generate meaningful discussion on data integrity, as well as quality of care issues/solutions across the delivery system. This includes strengthening the quality of data denoting homelessness and housing status on a per visit basis within the AHS system. (See Attachment E for overview of local environmental conditions affecting progress of this item.)

- Establish agreement and consensus of 2018 and 2019 QI goals from both of the two quality committees representing Alameda County Health Care for the Homeless Program and Alameda Health System Ambulatory Care. Potential areas for quality improvement are data integrity, patient experience, ensuring inclusion of HEDIS measures, and identifying measures tracking social determinants of health.

- Re-evaluate the data quality the Quality Committee is monitoring for any changes needed to meaningfully ensure the quality of services provided through the program.

- Continue to organize available data relating to key areas in quality management e.g. risk management (credentialing, professional liability, adverse patient events).

- Establish reporting schedule on Quality Management to the HCH Commission.

- The HCH Quality Committee is committed to documenting any innovative approaches that contractors and the sub-recipient are using, now and in the near future, that improve the quality of care for homeless individuals and families, as part of tracking quality practices.
Attachment B: Quality Structure -- Alameda County Health Care for the Homeless

**Alameda County Board of Supervisors**

**HCH Commission (HCH Co-Applicant Board)**
- HCH Director
- Grants Manager
- Contracts Manager
- Direct Services Manager
- AHS HCO Coordinator
- AHS Clinician
- HCH direct svcs staff
- HCH CCAB member

**HCH Quality Committee**
- HCH Medical Director (Chair)

**HCH Consumer/Community Advisory Board**

**Health Care for the Homeless**

**Alameda Health System Board of Trustees**

**Alameda Health System CEO**

**Alameda Health System Ambulatory Care Services**

**HCH Direct Services**
- Street Medicine
- Substance Use
- Oral Health
- TRUST Health Center

**Mobile Services (Clinical)**
- Primary Care (4 Clinics)
- Urgent Care (SDC)

**Homeless Substance Abuse Services Expansion (SASE)/MAT**

**Health Advocates (Enabling Services)**

**Substance-use Care Management (HAT)**

**AHS Homeless Coordination Office**

**AHS HGH Emergency Dep’t**

**AHS Highland Hospital**

**Fairmont Skilled Nursing**

**AHS San Leandro Hospital**

**AHS HCO Coordinator**

**AHS Respite Care**

**AHS HOPE Center**

**AHS JGP Psychiatric Pavilion**

**AHS Social Work Dept**

**AHS Specialty Care**

**AHS Care Transitions Team**

**KEY**
- HCH Scope of Project
- AHS / Outside of HCH Scope of Project
attachment C: overview of results-based accountability framework

what is rba?

RBA is a disciplined way of thinking and taking action that communities can use to improve the lives of children, families and the community as a whole. RBA can also be used by agencies to improve the performance of their programs. RBA can be adapted to fit the unique needs and circumstances of different communities and programs.

how does it work?

RBA starts with ends and works backward, step by step, towards means. For communities, the ends are conditions of well-being for children, families and the community as a whole. For example: “Residents with good jobs,” “Children ready for school,” or “A safe and clean neighborhood,” or even more specific conditions such as “Public spaces without graffiti,” or A place where neighbors know each other.” For programs, the ends are how customers are better off when the program works the way it should. For example: What percentage of people in the job training program get and keep good paying jobs.

how can it help?

Many people have been frustrated by past efforts that were all talk and no action. RBA is a process that gets you and your partners from talk to action quickly. It uses plain language and common sense methods that everyone can understand.

the rba thinking process

We all use the thinking process behind RBA to solve problems in our everyday lives. Have you ever had a leaking roof? You know it’s leaking when you see water dripping down. How do you go about fixing the leak? First, you think about who could help you. Then someone has to get up on the roof and figure out why it’s leaking. Next, you think about how it could be fixed. And finally you decide what you will actually do to fix it. You know it’s fixed when you stop seeing water. This sequence gets more complicated when you’re trying to fix conditions in your community, the RBA steps come from this same process.

for communities and programs that want to get from talk to action

the steps from talk to action

The community step by step process starts by bringing together a group of partners who wish to make things better. This group then uses the following thinking process:

Step 1: What are the quality of life conditions (results) we want for our community and the children and families who live here?

Step 2: What would these conditions look like if we could see, feel and experience them?

Step 3: How can we measure if these conditions exist or not (indicators)? Are the measures getting better or worse? Where are we headed if we just keep doing what we’re doing now?

Step 4: Why are these conditions getting better or worse?

Step 5: Who are the partners that have a potential role to play in doing better?

Step 6: What works to do better? What can we do that is no-cost or low-cost in addition to things that cost money?

Step 7: What do we, individually and as a group, propose to actually do?

The program step by step process starts with managers who care about the quality or their services. The managers, individually or in groups, use the following thinking process:

Step 1: Who are our customers?

Step 2: How can we measure if our customers are better off (customer results)?

Step 3: How can we measure if we’re delivering services well?

Step 4: How are we doing on the most important of these measures?

Step 5: Who are the partners that have a potential role to play in doing better?

Step 6: What works to do better, including no-cost and low-cost ideas?

Step 7: What do we propose to actually do?

Repeat the steps each time you meet. The steps can be done in any order as long as you do them all.

RBA concepts can be found in the book “Trying Hard is Not Good Enough” by Mark Friedman and the Results Accountability 101 DVD. Both can be purchased at www.resultleadership.org
Why is data important?

When you’re trying to fix a leaking roof, you really don’t need data. You can see if the roof is leaking or not. But community conditions and the way programs work are much more complicated. If we rely on just stories and anecdotes, we really don’t know if things are getting better or worse. By using common sense measures, we can be honest with ourselves about whether or not we’re making progress. If we work hard and the numbers don’t change, then something more or different is needed. We rarely have all the data we need at the beginning. But we can start with the best of what we have, and get better. And data doesn’t always have to be gathered by the experts. You can use simple, common sense methods, like community surveys with just a few questions, or a count of vacant houses each month, or even a show of hands at the monthly meeting about how many people know someone who was a crime victim in the last 30 days.

Why is common language important?

Whether it’s English, Spanish or another language, we often use words and jargon in ways that no one really understands. Pilots could never fly airplane that way. Community groups could never build playgrounds that way. We need to agree on how to use plain language so we can work together successfully. RBA asks groups to agree on what words they will use to describe a few basic ideas:

Results (or outcomes): What conditions do we want for children, families and the community as a whole?

Indicators: How could we measure these conditions?

Baselines: What does the data show about where we’ve been and where we’re headed?

What works (or strategies): What works to improve these conditions?

Turning the curve: What does success look like if we change the direction of the baseline for the better.

Performance measures: How do we know if programs are working? RBA uses three common sense performance measures:

How much did we do?

How well did we do it?

Is anyone better off?

What else do you need to get started?

RBA is one part of a larger tool kit necessary to improve the well-being of children, families and communities. Communities also need to agree on how to plan and govern their work, and may need help with community organizing and group facilitation. Agencies and programs will need to involve their employees in creating a healthy workplace. Both kinds of efforts will need to support the growth and development of new and existing leaders.

Where can you get more information?

The website www.raguide.org is an implementation guide for the RBA framework, sponsored by national, state and local foundations, including the Annie E. Casey Foundation, the Foundation Consortium for California’s Children and Youth, the Colorado Foundation, the Nebraska Children and Families Foundation, and the Finance Project. It contains answers to over 50 commonly asked questions and provides tools, formats, exercises, and links to other important resources. The website can help you decide if RBA is the right approach for your community or your organization.

Fiscal Policy Studies Institute
Santa Fe, New Mexico
www.raguide.org
www.resultaccountability.com

Results Leadership Group
www.resultsleadership.org
301-907-7541
### ACCESS: PATIENT ENGAGEMENT

**Trust Clinic**

**Performance Area:** Improve access to integrated primary care & behavioral health services.

**Contractor Scope of Work / Objectives:** Pursue additional opportunities for ongoing funding of contracted services.

**Quality Improvement Goals (Aims) and Activities**

**Aim 1.** High levels of patient engagement in care, through improved patient empowerment and access to care.

**Activity 1:** The TRUST clinic will act as a safe space by building a friendly & welcoming environment for some patients to relax, watch a movie, or drink coffee while being in a stable environment (free food and beverages — self-serve / oatmeal & instant soup available at the front desk) -- create opportunities for “health coaches” to engage patients for f/u paperwork, addressing issues, etc.

**Activity 2:** Address basic needs by providing access to the following: shower facilities, clothing, shoes, and toiletries.

**Activity 3:** Coaches will reach out to patients on their panel regularly and utilize the CHCN notebook to manage frequency of contact needed.

**Activity 4:** Computers with restricted internet access are available to patients in the waiting room.

**Activity 5:** Short educational talks presented by a health coach/ other staff member in the waiting room. Topics will include HIV, nutrition, laboratory services available at TRUST, smoking cessation, etc. Show DVDs, as well.

**QI Measures & Documentation**

- 75% of enrolled patients have had >= 1 provider visit per month within the first four months of engagement. (documented by EHR encounter data)
- 75% of patients will complete at least 2 coach visits per month for the first 4 months of enrollment at the Trust Clinic. (documented by staff notes or billing codes in EHR)
- Timely access to care using 3rd next available appointment (w/i 3 month timeframe – EHR /dashboards)

**Results/Analysis**

- Initial results indicate that tracking commitment to and completion of patient life goals is problematic. For example, many coaches report that patients feel unable to accurately articulate specific goals during the first coach encounter, which is when they had designated that goals be set. Also, limitations in the EHR software for recording patient life goals at a later point is inefficient timewise.

Based on data collected for portion of FY2015-16, the Aim 1 team adjusted two measures tracking documentation & completion of patient life goals to a different measure where they are tracking patient engagement with a health coach.
<table>
<thead>
<tr>
<th>Access: Outreach</th>
<th>Oakland STOMP (Street Team Outreach Medical Program) Roots Community Health Center</th>
<th>Outreach &amp; Integrated Health Care Services</th>
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<tbody>
<tr>
<td>Activity 6:</td>
<td>Work with the LifeLong Medical, Inc. Outreach department to accept volunteers.</td>
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<td>Activity 7:</td>
<td>“Fun Fridays” on the last Friday of each month to celebrate all patient birthdays</td>
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<td>Activity 8:</td>
<td>Continue to monitor no show rates and continue to try out different schedule options to maximize patient access.</td>
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<td>Activity 9:</td>
<td>Don’t block or book too far in advance not more than 2 weeks scheduled appointments.</td>
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<td>Activity 1:</td>
<td>Create significant involvement of all relevant staff to the QI process.</td>
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<td>AIM 2:</td>
<td>Integrate process/outcome measures into CQI plan.</td>
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<tr>
<td>Activity 1:</td>
<td>Integrate process/outcome measures into CQI plan.</td>
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<td>AIM 3:</td>
<td>Monitor and improve progress towards objectives</td>
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<td>Activity 1:</td>
<td>Include HIV test kits in medical backpacks to be used during outreach contacts</td>
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<td>Activity 2:</td>
<td>Include injection drug use/hard reduction supplies in medical backpacks to be used during outreach contacts</td>
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<td>Activity 3:</td>
<td>Continue to refine schedule detailing</td>
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<tr>
<td>AIM 4:</td>
<td>Monitor and improve patient experience through regular patient surveys</td>
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<td>AIM 4:</td>
<td>Patient Experience survey (to be developed) to measure quality of outreach, coordination of care, and primary care services.</td>
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<td>AIM 4:</td>
<td>Need to establish baseline measure before determining a quality improvement aim)</td>
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<tr>
<td>AIM 4:</td>
<td>Review next quarterly report for progress to date.</td>
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and other means.

| CARE PROVISION | Trust Clinic | 1. Assess & document functional impairments & related diagnoses.  
2. Promote health & well-being through partnerships & collaborations with other community-based organizations. | AIm 5. Achieve long term housing & health care coverage, by securing more resources for clinic patients  
Activity 1: Documentation process set up to maintain accurate log of SSA record requests & submission.  
Activity 2: Education for providers regarding proper and comprehensive documentation.  
Activity 3: Work with HealthPort to electronically send record requests weekly.  
Activity 4: Have Nextgen (EHR) staff create a check off box re: Housed, applied for housing, and declined housing referrals, on the intake form  
Activity 5: Updated survey for community partners created on Google Survey to replace previous survey tool. | 1. Timely and complete documentation of functional impairments & associated diagnoses for 90% of patients.  
(measure: pt encounter/billing form in EHR)  
2. 60% of SSDI-eligible pts have completed documentation that is submitted within 6 months. (electronic tracking log)  
3. 85% of patients will have a documented attempt or completed housing plan in EHR from housing datafield.  
4. 80% of community partners will have a high level of satisfaction with process, usefulness of & quality of services and |
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<tr>
<th>(Optometry Services) La Clinica de la Raza, Inc.</th>
<th>1. Provide an average of seven (7) optometry visits per month for a total of 84 visits during contract period to homeless patients.</th>
<th><strong>AIM 6.</strong> Create baseline measurement for customer experience and satisfaction of services performed.</th>
<th>Tool to be used: TBD</th>
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<tr>
<td>On-site Dental Care Foundation</td>
<td>1. Perform 50 clinic sessions, with 20 possible visits per session for a total of 1,000 possible visits in each year of the contracted service period. 2. Provide dental services to ~162 new clients &amp; a small number of continuing clients for each year in the contract period.</td>
<td><strong>AIM 7.</strong> Create baseline measurement for customer experience and satisfaction of services performed.</td>
<td>Tool to be used: TBD</td>
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| **COORDINATION OF CARE** | Trust Clinic | Develop Treatment Approaches to reduce utilization of emergency, inpatient, & crisis health care services. | **AIM 8.** Improved overall mental & physical health of Trust patients, as evidenced by decreased use of acute care services  
**Activity 1:** Engage patients who have >2 visits/month or 10 or more visits per year to the Emergency Room.  
1st: Identify High Users  
2nd: Educate/Survey pt. with ED/PCP usage  
3rd: Education video ED usage  
4th: Reports from Notebook  
**Activity 2:** Engage patients who have 2 or | **AIM 3 MEASURES:**  
1. 5% reduction in Trust patients using ER at least four times from previous quarter.  
2. 5% reduction in 2 or more inpatient admissions for Trust patients from previous quarter.  
3. 5% reduction in one or more psychiatric admissions for Trust |
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<th>Activity 1:</th>
<th>Health Navigation and Referral Services</th>
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<tr>
<td>1st: F/U appt within 5 days after d/c 2nd: Coach makes hospital visit 3rd: Provide education on medical issues that result in admission.</td>
<td>a. Supply limited lab/medication dispensing services</td>
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**Activity 3:** Engage patients who have one or more psychiatric admissions within a quarter

1st: Connect pt. with Behavioral Health provider i.e. Psychiatric NP, LCSW 2nd: Frequent Wellness check w/Coaches 3rd: Provide education on medical issues that result in admission.

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<th>Activity 2:</th>
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<tr>
<td>1st: Connect pt. with Behavioral Health provider i.e. Psychiatric NP, LCSW 2nd: Frequent Wellness check w/Coaches 3rd: Provide education on medical issues that result in admission.</td>
<td>Measures to be determined by Program Leadership by 10/30/16</td>
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<tr>
<th>Activity 3:</th>
<th>b. Patient transportation to address urgent health needs. c. One or more external hlth care provider – physician or behavioral – employed by AC to work w/I Street Medicine pgm. d. Work, coordinate &amp; collaborate w/homeless service providers per request from HCH/HCSA to design and/or implement clinical services &amp; operations</th>
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<tr>
<td>1st: Connect pt. with Behavioral Health provider i.e. Psychiatric NP, LCSW 2nd: Frequent Wellness check w/Coaches 3rd: Provide education on medical issues that result in admission.</td>
<td>Activity 3: Connect patients to a medical home.</td>
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<tr>
<td>1st: Connect pt. with Behavioral Health provider i.e. Psychiatric NP, LCSW 2nd: Frequent Wellness check w/Coaches 3rd: Provide education on medical issues that result in admission.</td>
<td>Activity 4: Work with ABODE staff to transport patients to clinical appointments.</td>
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**Year 1:** >=40% STOMP patients connected to primary care medical home. **Year 2-3:** =>60% STOMP patients connected to primary care medical home. **Activity 4:** Work with ABODE staff to transport patients to clinical appointments.
Attachment E:

Local Environmental Factors Affecting HCH Quality Plan Implementation

The California Medi-Cal 2020 1115 Waiver has the potential to dramatically transform the Alameda County Health Care Delivery System for Medi-Cal recipients, including homeless individuals and families. These initiatives are described in the table below. Implementation of all four components of the Waiver will require a tremendous effort on the part of core leadership and staff from all participating entities to show flexibility and creativity in building a coherent, coordinated, and quality driven health care delivery system.

### Overview of California Medi-Cal 2020 Waiver

<table>
<thead>
<tr>
<th>California Medi-Cal 2020 Waiver Initiatives</th>
<th>Project Period</th>
<th>Lead Entity</th>
<th>Description</th>
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<tr>
<td><strong>Public Hospital Redesign and Incentives in Medi-Cal (PRIME)</strong></td>
<td>2016-20</td>
<td>Alameda Health System</td>
<td>Provides financial incentives (risk-based) to public hospitals to improve quality and value of care through changed payment methodologies. The initiative includes metrics based on HEDIS measures to improve quality of care/public hospital system performance. Alameda Health System is implementing 10 projects with multiple metrics for each.</td>
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<td><strong>Whole Person Care Pilot: Alameda County Care Connect</strong></td>
<td>2016-20 (awards announced in October 2016)</td>
<td>Health Care Services Agency</td>
<td>County-based pilots to improve care for high-risk beneficiaries through the integration of the systems that provide physical health, behavioral health &amp; social services. Proposed plan from Alameda County addresses complex care coordination needs for three high priority patient groups including the homeless. There is an emphasis in prioritizing social determinants of health (e.g. housing) as an important aspect of providing holistic care to patients.</td>
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<td><strong>Dental Transformation Initiative</strong></td>
<td>2017-20 (awards announced in October 2016)</td>
<td>Health Care Services Agency</td>
<td>MediCal dental providers will receive incentive payments for meeting benchmarks in preventive services and continuity of care, targeting children’s utilization of preventive services/oral health disease management.</td>
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<tr>
<td><strong>Global Payment Program (GPP)</strong></td>
<td>2016-20</td>
<td>Alameda Health System</td>
<td>This program changes the funding (e.g. value-based mechanism to provide high value services—primary/preventive care services) for designated public hospitals to improve delivery of care to those who remain uninsured in California.</td>
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</table>

Alameda Health System (AHS), the key sub-recipient of HCH, is focused on the successful
implementation of these waiver programs, particularly PRIME and GPP for which it is the lead. HCH
wishes to support and align its quality improvement activities with AHS’ current priorities, emphasizing
those that overlap with HRSA metrics. HCH Quality Committee and AHS Ambulatory Quality Committee
members are negotiating key quality improvement activities relating to data integrity, developing a
schedule for producing homeless patient data on agreed-upon metrics, and sponsoring improvement
activities that support progress towards achieving the Triple Aim for both the homeless and the larger
Medi-Cal patient population. Leadership from both AHS and HCH will review and update the annual
sub-recipient agreement in FY2016-17, with a special emphasis on implementing practical and timely
quality assurance/quality improvement activities supporting the physical, behavioral, and social
determinants of health affecting the homeless patient population.

There are also internal HCH staffing changes that have affected the implementation timeline of the
Quality Plan. There are two key positions within HCH leadership that are currently being filled:

- **HCH Program Director**: Kathleen Clanon, MD, Medical Director for the Alameda
  County Health Care Services Agency, is serving as Interim Director of HCH during the
current county hiring process for HCH Program Director. Expected date of hire:
  December 2016.

- **HCH Medical Director**: Jeffrey Seal, MD, is interim HCH Medical Director and
  Psychiatrist.

Jennifer Martinez, MPH, HCSA Indigent Health/Health Care System Planning and Improvement, has been
brought in as the program Quality Coordinator. She will be overseeing the development and
implementation of the HCH quality management program. HCH has also hired an outside consultant to
support County staff in strengthening the quality management program. There is a strong team in place
to continue implementation, though it is always challenging to preserve momentum in the midst of
staffing changes.