Alameda County Health Care for the Homeless

ALAMEDA COUNTY HEALTH CARE FOR THE HOMELESS
1404 Franklin Street, Suite 200
Oakland, CA 94612
TEL (510) 891-8950
FAX (510) 832-2139
www.achch.org

ACHCH Commission Clinical Quality Sub-Committee Meeting
October 12, 2020
10:00am-11:30am
Via Zoom
https://us02web.zoom.us/j/88431903169?pwd=b3lKQlBFR0UrLzBxYWowM29KTjVqdz09
Meeting ID: 884 3190 3169; Passcode: 178277
Dial by your location: 669 900 9128; Meeting ID: 884 3190 3169; Passcode: 178277

AGENDA

Goals of the meeting:

1. Come away with a consensus idea of what Quality means at ACHCH
2. What can the Sub-Committee specifically supply to the ACHCH staff?
   a. Guidance
   b. Skills
   c. Questions

1. Welcome and introductions (15m)
   a. Specific introductory remarks from each member:
      - What is your experience in Quality?
      - What does Quality mean to you?

2. The Data Approach: Precision vs. Accuracy vs. Information (20 min)
   a. Precision:
      i. How well are we doing at acquiring data?
      ii. Are there specific identified leaks in the pipeline?
      iii. Are there commonalities among these leaks?
   b. Accuracy:
      i. How well does the data describe the facts on the ground?
      ii. Are we overly constrained by HRSA measures?
      iii. Is there anything we want? Will the benefit outweigh the costs?
   c. Information:
      i. What does the data show about how we are serving our patients?
      ii. Can it point us to specific opportunities for improvement?

3. The Narrative Approach: Telling the story of a bad outcome. (20 min)
   a. “Morbidity & Mortality” Conference (M&M)

i. Classic style of case review, looks primarily at errors leading to excess morbidity (illness) or unexpected mortality (death). Tends to be punitive, shaming; learning by negative modeling.

b. Case Conference: Focus on what makes clinical hard
    - Is it a knowledge gap? Moving too fast?
    - What are the systems issues that contributed to the bad outcome?
    - Are they fixable?
    - Bring in experts, sometimes the patient themselves to tell their own story.

c. Can be expanded to a global inquiry for "Root Cause Analysis" (RCA)
    i. Sentinel Events: Each health care organization defines them for itself; must include a minimum set- usually major breaches resulting in death or disability
    ii. RCA conducted within 45 days of a sentinel event for JCAHO-accredited organizations

4. Why is quality so complicated at ACHCH (20 min)
    a. FQHC vs. FQHC-P
        i. HRSA quality structure built for a clinic or system to use its own data to evaluate its own care, rather than for a third party.
        ii. What is best for our homeless neighbors in Alameda County?
            1. Centralize/take ownership of quality assessment at ACHCH?
                a. We are the content experts
                b. We have the most invested in this community
            2. Allow it to reside at the contractor level and merely aggregate & report
                a. They have more flexibility and authority re: fixable issues - we can only ask them for (or make funding contingent upon) a fix
                b. Most of our contractors have to report to HRSA anyway, but don't necessarily segregate their data on homeless patients.

5. To cover at future meetings: (15 min)
    a. The RBA structure
    b. HRSA quality indicators
    c. Our specific areas in which we measure quality:
        i. AHS – subrecipient
        ii. Street Health contracts
        iii. Trust
        iv. Our own care – Our street zone, our care at Trust, shelter health (tied to AHS)
        v. Optometry
        vi. Dental
        vii. The ACHCH home office

Alameda County Health Care for the Homeless

Alameda County Health Care Services Agency

Alameda County Health Care for the Homeless Commission
Committee Report

Committee:

☐**Executive:** Oversees Commission structure organized and moving; provides strategic guidance to staff. Meets monthly.
☐**Consumer Community Advisory Board (CCAB):** Maintains a strong patient voice within ACHCH. Meets monthly.
☒**Clinical Quality:** Recommends clinical measures to the full Commission; informs medical, dental, mental health, SUD programming. Meets quarterly.
☐**Budget and Finance:** Monitors HRSA grant budget vs actuals; recommends budgetary actions to the full Commission. Meets quarterly.

Commissioner liaison to the full Commission: Michelle Schneidermann, MD	
Last meeting date: April 20, 2020	Current meeting date: October 12, 2020
Commissioners in attendance: Michelle Schneidermann, MD, Shannon Smith-Bernardin, RN PhD, Gerard Jenkins, MD	
ACHCH staff in attendance: Harrison Alter, MD; Theresa Ramirez DrPH, Luella Penserga MPH	
Absent: Sam Weeks, DDS	

1. Items discussed:

   a. Data approach: precision vs. accuracy vs information; challenges with getting data to track quality. Should ACHCH take multiple approaches – for example service areas where traditional HRSA UDS is collected (i.e., primary care patients/visits at AHS and Trust Clinic) vs data to answer questions on newer programmatic areas, e.g. street health and shelter health outreach services.

   b. Guiding principles: what clinical questions does ACHCH need answer for ourselves? For others? Additionally, what data can show ACHCH's immediate impact, helping people immediately, e.g. how many supplies were distributed?

   c. ACHCH on use of case conferences, "Morbidity & Mortality" conferences for sentinel events. Group discussed the importance of having ACHCH P&P on file to meet HRSA regulatory requirements, and more importantly something that will get used.

d. Data and quality infrastructure of ACHCH partners are geared towards Medi-Cal billing, State Medi-Cal waiver (e.g., PRIME), HRSA and other regulatory and finance demands.

2. Informational item(s) to report to the full Commission:

   a. Challenge of tracking impact across different service areas, some of which are new, e.g. Street Health.

   b. What constitutes as reportable event/sentinel event for homeless. Events where there is loss of dignity. Where there is a death, consistently ask: was it a direct consequence of services? Was there a chance where we could have intervened? Establish root cause analysis. Incident reporting/sentinel events policy and procedure (share draft next meeting).

   c. Connect with existing quality committees, e.g. AHS, CHCN. Solidify ACHCH quality agenda; consider convening the group to discuss quality care for homeless populations.

   d. Staff to look into providing space for case conferences, peer support, especially for new service areas which are still getting stabilized, i.e., street health outreach. Apply adult learning approaches; alternate times for peer exchange with didactic trainings. Some trainings could be on-demand to free up time. Acquire one-pager from Ted Aames re: conducting case studies to share with group.

   e. Staff to produce an environmental scan - Create a visual of quality work currently being done at ACHCH and to show the landscape of the quality and data work that is being done across the ACHCH network, to show where there can be impact and what is outside of the realm, e.g., HRSA measures, inflows and outflows of those data. What data is already being collected (e.g. by health plans, CHCN etc). Try to map the complex web of relationships and key data sets of interest. Help Commission understand the core datasets including an easy to digest table of current measures on which ACHCH is currently collecting data.

3. Action(s) recommended by the Committee for discussion/action by the full Commission at the next meeting:

   a. No action recommended for full Commission at this time.