**Alameda County Health Care for the Homeless Commission**  
**Meeting Minutes**  
Friday, October 21, 2016 9:00AM  
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>
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<tbody>
<tr>
<td>Lynette Lee</td>
<td>Joel Ginsberg, Program Specialist</td>
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<td>Fr. Rigo Caloca-Rivas</td>
<td>Suzanne Warner, HCH Deputy Director</td>
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<td>Betty DeForest</td>
<td>Jeffrey Seal, MD HCH Interim Medical Director</td>
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<td>Samuel Weeks</td>
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<td>Adria Walker</td>
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<td>Gay McDaniel</td>
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<td>Kathleen Clanon MD, HCH Interim Director (Ex Officio)</td>
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**Absent:**  
boona cheema  
Jean Prasher

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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 9:23am.  
• Motion to adopt agenda  
**Action Item: Approve Agenda**  
• Dr. Clanon will informally facilitate Commission meetings until the Commission elects officers by its November 2016 meeting.  
• Everyone present introduced themselves.  
• HCH staff and partners are seeking a ninth HCH Commissioner with expertise in hospital systems to round out the Commission. | Motion: DeForest, Second Caloca-Rivas, Unanimous |
| CLOSED SESSION | There was no closed session this meeting. |     |
| PUBLIC COMMENT | Public comments were invited; none were made. | Motion: DeForest, Second Walker, Yea: Walker, DeForest, Weeks, Caloca-Rivas, Abstain: McDaniel |
| CONSENT AGENDA | Motion to adopt minutes approved  
**Action Item: Approve Minutes** |     |
| BOARD ORIENTATION | • Deputy Director Suzanne Warner presented an overview of the HCH Program Tab 1.  
• Discussion of Communications of HCH Program  
• Discussion of Oakland Encampments  
• Discussion of Board Training Needs and Priorities  
  Soonest: Brown Act, Conflict of Interests  
  Other  
  • Site visits  
  • Meet as many people as possible who are doing the work  
  • Political landscape  
  • RBA framework  
  • Work plan of the Commission – focus on grant calendar, with focus on Commission role; also looking ahead 24 months, look at goals and what individual Commissioners will do, so expectations for what people do. Also want to understand the Commissioners role in terms of governance, budgets | Attachment Tab 1. |

**REGULAR AGENDA**  
**HCH Director Report**  
1. Consumer Input - no item this meeting.  
2. Board Ad Hoc Committee reports - no reports this meeting.  
3. **HCH Program report** (e.g., Program Director, QI, contracts, finance, etc.)  
   – Kathleen Clanon, MD Interim Director of HCH program provided an update on the hiring of an HCH Program Director. Mark Shotwell has been identified, interviewed and selected for position of Director, and is due to start 11/5/2016. Decision was made before inception of HCH Commission. Mr Shotwell is a services director at Bonita House,
| HCH Quality Plan | established HOST and CHOICES programs for dually diagnosed homeless.  
4. **Presentation of HCH Quality Plan**: Dr. Jeffrey Seal, interim Medical Director of the HCH Program presented HCH Quality Plan, which upon approval of HCH Commission will be presented to HRSA/BPHC. Presentation Tab2. After questions and answers, discussion, HCH Commission unanimously approved HCH Quality Plan.  
**Action Item: Approve HCH Quality Plan** |
| --- | --- |
| OTHER ITEMS | G. **OTHER ITEMS**  
1. Items for upcoming agenda  
   - Report back on public speaking / policy setting by Commission  
   - Ethics/Brown Act Training  
   - Approve director  
2. Upcoming officer election  
3. Housekeeping |
| ADJOURNMENT | Time: 10:55 a.m. |

**Motion**: Caloca-Rivas, seconded: Deforest. Unanimous

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President, HCH Commission  
Date: October 21, 2016  
David Modersbach, HCH Commission Secretary  
Date: October 21, 2016
Health Care for the Homeless Overview

- Mission: Improve the health of persons in Alameda County who are homeless or at risk of homelessness.
- 2015 stats
  - 9,289 patients served in 36,884 encounters
  - $7M budget
  - 27 FTE Alameda County staff
  - 9 contracts for patient care services ($2,122,131)
Current Initiatives:
Alameda Health System collaborations

- Homeless Coordinating Office established in 2013
- Mobile Health redesigned as County/AHS partnership

Current Initiatives:
Street Medicine Contracts

- New contracts focused on outreach and access
- Adapting successful model promoted by National Health Care for the Homeless
Current Initiatives:
Results-Based Dental Contracts

Goals:
95%-Restorative plan *reviewed with patient*
75%-Restorative plan *completed*

Current Initiatives:
TRUST Clinic—Whole Person Care

- **Integrating** services and organizations for seamless client experience
- **Housing First** philosophy and resources
Current Initiatives:
Home Stretch- Coordinated Entry for PSH

At least 4200 individuals in AC have spent a night experiencing homelessness. Data indicates that 60% have self-reported long term disabilities, 26% report serious mental illness, 30% struggle with substance abuse disorders.

- **A collaboration** between EveryOne Home, Housing Services Office, and Health Care for the Homeless
- **Housing First** philosophy
- **Coordinated entry & prioritization** system for the most vulnerable
- Employs 4 core strategies: **measure, prioritize, coordinate, & expand**

### Alameda County Housing and Health Partners

<table>
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<tr>
<th>Engagement</th>
<th>Time-limited housing and services</th>
<th>Permanent homes and ongoing supports</th>
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<tbody>
<tr>
<td>Homeless Shelters (e.g. EOCP, City Team, Sunrise Village)</td>
<td>Interim and Transitional Housing (e.g. BACS-Henry Robinson Multi-Service Center, CURA)</td>
<td>Permanent Supportive Housing (e.g. Shelter Plus Care, BHCS-MHSA Housing Programs, Main Street Village)</td>
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<tr>
<td>Hospitals (e.g. John George, Highland)</td>
<td>Respite (e.g. Lifelong Medical Respite Program, EOCP Medical Respite)</td>
<td>Health Care (e.g. TRUST Clinic, AHS clinics, CHN, BHCS Adult System of Care and Alcohol and Other Drug Services)</td>
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<td>Street Outreach (e.g. Operation Dignity, HEPPAC, BACS-Oakland Project Connect, Abode HOPE project, HCH-Mobile Health)</td>
<td>Care Management (e.g. TRUST Care-Management, AHS-Care Transitions)</td>
<td>Care Management (e.g. BHCS-Full Service Partnerships)</td>
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<td>Drop-In Centers (e.g. St. Vincent de Paul, East Oakland Recovery Center)</td>
<td>Benefits Advocacy (e.g. Social Services Agency-SSI Unit, Homeless Action Center)</td>
<td>Social Services (e.g. IHSS, Area Agency on Aging)</td>
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<td>Tenants Services (e.g. EVIC-Supplemental Rent Program, EHC: Tenant Support Program)</td>
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**Home Stretch registry** (HCAS-led registry of homeless & disabled individuals)

**Housing Resource Centers** (Hubs for housing crisis resolution including multiple partner orgs)

*In planning phase*
Alameda County Health Care for the Homeless

Quality Program and 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,
- **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 Table 1 for roles assigned to specific QC members’ positions as well as specific expertise they bring to the group.
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)
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](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>Table 2: Quality Plan Timeline 2016-17</th>
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<td><strong>Goal</strong></td>
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<tr>
<td>HCH Quality Committee Mtg</td>
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<td>Approval of Quality Program and Plan by HCH Commission</td>
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<td>Quality Report to HCH Commission</td>
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<td>Schedule complete review of HCH program data and narratives</td>
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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>Complete Quality Committee Recruitment</td>
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<td>QC complete recommendations for HCH Contract Changes related to QA/QI</td>
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<tr>
<td>QC Review/Approval of Patient Safety Protocol</td>
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<tr>
<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 A: Programmatic Chart -- Alameda County Health Care for the Homeless

- Alameda County Board of Supervisors
- Health Care Services Agency
- HCSA Medical Director
- Indigent Health and Administration
- HCH Commission (HCH Co-Applicant Board)
- Co-Applicant Agreement
- Alameda Health System Board of Trustees
- Co-Applicant Agreement
- Health Care for the Homeless
- HCH Contracted Care:
  - Street Medicine
  - Substance Use
  - Oral Health
  - TRUST Health Center
- HCH Direct Services:
  - Mobile Services & Nursing Care
  - Outreach/Enrollment
  - Behavioral Health
  - Home Stretch
- Sub-recipient Partner AHS Ambulatory Care
- Alameda Health System Homeless Coordination Office
- Mobile Care (Clinical)
- Primary Care Clinics
  - Eastmont, Highland, Hayward & Newark Wellness
- Urgent Care (Same Day Clinic at HGH)
- Homeless Substance Abuse Services Expansion (SASE)/MAT
- Health Advocates (Enabling Services)
- Substance-use Care Management (HAT)
- AHS Homeless Services Outside Scope of Project

Key:
- Scope of Project, Grant-funded
- Scope of Project, Non-grant Funded (MHSA)
- Scope of Project, Non-grant funded (AHS)
- AHS Homeless Services Outside Scope of Project

- Alameda Health System
  - AHS Care Transitions Team
  - AHS Emergency Department
  - AHS Respite Care
  - AHS HOPE Center
  - AHS JGP Psychiatric Pavilion
  - AHS Social Work Dept
  - AHS Highland Hospital
- Fairmont Skilled Nursing
- AHS San Leandro Hospital
- AHS Alameda Hospital
Results-Based Accountability™

For Communities and Programs that want to get From Talk to Action

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 most basic version of RBA (the “Turn the Curve” exercise) can be done in less than an hour, and produces ideas that can be acted on immediately. RBA is an inclusive process where diversity is an asset and everyone in the community can contribute. Like all good processes, RBA is hard work. But it is work that you control and that makes a real difference in peoples’ lives.

The RBA thinking process

We all use the thinking process behind RBA to solve problems in our every day lives. Have you ever had 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.

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 of 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.resultisleadership.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 or a count of vacant houses each month, or even a show of hands at a monthly meeting about how many people know someone who was a crime victim in the last 30 days.

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 manage 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.

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 airplanes 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?

**Baseline:** 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?**
- **Is anyone better off?**

Where has RBA worked?

RBA is being used, in whole or in part, in over 40 states and at least 8 countries. There is a growing network of people with success stories to tell. To name a few: Vermont state and local partners have turned the curve on a wide range of measures including child abuse rates, high school dropout rates and the rate of delinquents in custody. Santa Cruz County California has turned the curve on teen alcohol and drug use and other measures. Maryland, California, and other states and counties are turning the curve on measures of children ready for school. Georgia’s Family Connections Collaboratives have turned the curve on immunization rates, school attendance and many other measures. And, state and local governments, school districts, and non-profits in Arizona, Idaho, Kentucky, Minnesota and many other places have used RBA to improve the performance of their programs and services.

Even where people don’t call it RBA, this kind of thinking process has helped turn the curve on drunk driving, juvenile crime, traffic safety, and clean air and water.

Where can you get more information?

The website [www.raguide.org](http://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.

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**Fiscal Policy Studies Institute**
Santa Fe, New Mexico
[www.raguide.org](http://www.raguide.org)
[www.resultsaccountability.com](http://www.resultsaccountability.com)

**Results Leadership Group**
[www.resultsleadership.org](http://www.resultsleadership.org)
301-907-7541
## Attachment D: Alameda County Health Care for the Homeless Quality Improvement Plan
### CY2016 (Contractors)

<table>
<thead>
<tr>
<th>PERFORMANCE AREA</th>
<th>CONTRACTOR NAME</th>
<th>CONTRACT SCOPE OF WORK / OBJECTIVES</th>
<th>QUALITY IMPROVEMENT GOALS (AIMS) AND ACTIVITIES</th>
<th>QI MEASURES &amp; DOCUMENTATION</th>
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</table>
| Access: Patient Engagement | Trust Clinic | Improve access to integrated primary care & behavioral health services. Pursue additional opportunities for ongoing funding of contracted services. | **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. | **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/ 3 month timeframe – EHR /dashboards)** | **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. |
Activity 6: Work with the LifeLong Medical, Inc. Outreach department to accept volunteers.

Activity 7: “Fun Fridays” on the last Friday of each month to celebrate all patient birthdays that fall within that month.

Activity 8: Continue to monitor no show rates and continue to try out different schedule options to maximize patient access.

Activity 9: Don’t block or book too far in advance not more than 2 weeks scheduled appointments.

<table>
<thead>
<tr>
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</tr>
</thead>
<tbody>
<tr>
<td>Access: Outreach</td>
<td>OAKLAND STOMP</td>
<td>Outreach &amp; Integrated Health Care Services</td>
<td>AIM 2. Integrate process/outcome measures into CQI plan. Activity 1: Create significant involvement of all relevant staff to the QI process.</td>
<td>TBD</td>
<td>Review next quarterly report for progress to date.</td>
<td></td>
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</tbody>
</table>
|                  | Street Team Outreach Medical Program | a. 700 unduplicated clients during contract period  
|                  | Roots Community Health Center | b. >= 3,500 face-to-face encounters during contract period (n=100/month) | | | |
|                  | Medical Outreach Street Medicine Program | Street Outreach  
|                  | Tri City Health Center | Objective 1.1: Conduct outreach to at least 40 unique encampments and locations.  
|                  | (10/1/15 - 9/30/16 is first year of program implementation) | Objective 1.2: By September 30, 2017, ABODE Outreach Worker | AIM 3. Monitor and improve progress towards objectives  
|                  | | Activity 1: Include HIV test kits in medical backpacks to be used during outreach contacts  
|                  | | Activity 2: Include injection drug use/hard reduction supplies in medical backpacks to be used during outreach contacts  
|                  | | Activity 3: Continue to refine schedule detailing  
|                  | | Patient Experience survey (to be developed) to measure quality of outreach, coordination of care, and primary care services. (Need to establish baseline measure before determining a quality improvement | | | |
will provide 1,500 encounters.

**Aim 4.** Monitor and improve patient experience through regular patient surveys and other means.

**Care Provision**

<table>
<thead>
<tr>
<th>Trust Clinic</th>
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<tbody>
<tr>
<td>2. Promote health &amp; well-being through partnerships &amp; collaborations with other community-based organizations.</td>
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</table>

**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.

**Performance Area**

<table>
<thead>
<tr>
<th>Contractor Name</th>
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<tbody>
<tr>
<td><strong>Contract Scope of Work / Objectives</strong></td>
</tr>
<tr>
<td><strong>Quality Improvement Goals (Aims) and Activities</strong></td>
</tr>
<tr>
<td><strong>QI Measures &amp; Documentation</strong></td>
</tr>
<tr>
<td><strong>Results/Analysis</strong></td>
</tr>
<tr>
<td><strong>Corrective Action/Follow-up</strong></td>
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</tbody>
</table>

**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
<table>
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<tbody>
<tr>
<td></td>
<td>(Optometry Services) La Clinica de la Raza, Inc.</td>
<td>1. Provide an average of seven (7) optometry visits per month for a total of 84 visits during contract period to homeless patients.</td>
<td><strong>AIM 6.</strong> Create baseline measurement for customer experience and satisfaction of services performed.</td>
<td>Tool to be used: TBD</td>
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<td></td>
<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</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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<tr>
<td>COORDINATION OF CARE</td>
<td>Trust Clinic</td>
<td>Develop Treatment Approaches to reduce utilization of housing datafield.</td>
<td><strong>AIM 8.</strong> Improved overall mental &amp; physical health of Trust patients, as evidenced by decreased use of acute care services</td>
<td><strong>AIM 3 MEASURES:</strong> 1. 5% reduction in Trust patients using ER at least 84 visits during contract period.</td>
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<tr>
<td><strong>Activity 1</strong>: Engage patients who have &gt;2 visits/month or 10 or more visits per year to the Emergency Room.</td>
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<td>1st: Identify High Users</td>
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<td>2nd: Educate/Survey pt. with ED/PCP usage</td>
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<td>3rd: Education video ED usage</td>
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<td>4th: Reports from Notebook</td>
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<thead>
<tr>
<th><strong>Activity 2</strong>: Engage patients who have 2 or more inpatient admissions within one quarter.</th>
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<tbody>
<tr>
<td>1st: F/U appt within 5 days after d/c</td>
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<tr>
<td>2nd: Coach makes hospital visit</td>
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<tr>
<td>3rd: Provide education on medical issues that result in admission.</td>
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<thead>
<tr>
<th><strong>Activity 3</strong>: Engage patients who have one or more psychiatric admissions within a quarter.</th>
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<tbody>
<tr>
<td>1st: Connect pt. with Behavioral Health provider i.e. Psychiatric NP, LCSW</td>
</tr>
<tr>
<td>2nd: Frequent Wellness check w/Coaches</td>
</tr>
</tbody>
</table>

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**OAKLAND STOMP**
(Street Team Outreach Medical Program)

**Roots Community Health Center**

**Health Navigation and Referral Services**

- a. Supply limited lab/medication dispensing services

**Aim 9.** Improve staffing capacity to address coordination of care issues with homeless patients

**Activity 1:** Hire medical assistant to coordinate care management issues.

**Activity 2:** Work with Trust clinic staff to gain access to intensive psychiatry & case management – VSPDAT screenings.

**TBD**

Measures to be determined by Program Leadership by 10/30/16

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<table>
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<tbody>
<tr>
<td>b. Patient transportation to address urgent health needs.</td>
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<td>c. One or more external health care</td>
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</table>

**Activity 3:** Connect patients to a medical home.

- Year 1: >=40% STOMP patients connected to primary care medical home.
- Year 2-3: >=60% STOMP patients connected to primary care medical home.
<table>
<thead>
<tr>
<th>Provider</th>
<th>Activity 4: Work with ABODE staff to transport patients to clinical appointments.</th>
</tr>
</thead>
<tbody>
<tr>
<td>– physician or behavioral -- employed by AC to work w/I Street Medicine pgm.</td>
<td></td>
</tr>
<tr>
<td>d. Work, coordinate &amp; collaborate w/homeless service providers per request from HCH/HCSA to design and/or implement clinical services &amp; operations</td>
<td></td>
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</tbody>
</table>
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>
</tr>
</thead>
<tbody>
<tr>
<td>Public Hospital Redesign and Incentives in Medi-Cal (PRIME)</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>
</tr>
<tr>
<td>Whole Person Care Pilot: Alameda County Care Connect</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>
</tr>
<tr>
<td>Dental Transformation Initiative</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>
</tr>
<tr>
<td>Global Payment Program (GPP)</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</td>
</tr>
</tbody>
</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.