



## AGENDA

**Staff Attendees:** Van Do-Reynoso, Polly Baldwin, MD, Ralph Barbosa, Dana Gamble, Melissa Gomez, Suzanne Jacobson, Michael Camacho-Craft, Jeanie Sleigh, Paola Hurtado, Elvia Lopez, Kendall Johnston, Elizabeth Simpson

<b>Board Members</b>		<p><b>Consumer Members:</b> Lee Herrington, Celia Lee, Filipino Chapelle, Richard Osbourne, Christopher Hutton, Wm Darrel Gardner, Stephen Ferrara</p> <p><b>Community Members:</b> Judy Taggart, Sylvia Barnard, Skip Szymanski, Jason Prystowsky, MD, Arianna Castellanos, Emily Casarez</p> <p><b>Non-Voting Staff Member:</b> Dr. Douglas Metz</p>	
<b>Item #</b>	<b>Time</b>	<b>Item</b>	<b>Owner</b>
<b>I.</b>	12:00-12:03	Welcome and Call to Order	Szymanski
<b>II.</b>	12:03-12:06	Review and Approve Minutes from July 24, 2019	Szymanski
<b>III.</b>	12:06-12:10	Roll Call, Sign In Sheet, and Quorum Establishment	Johnston
<b>IV.</b>	12:10-12:13	Public Comment Period	
<b>V.</b>		<b>Old Business:</b> None	
<b>VI.</b>	12:13-12:38 10 min	<p><b>New Business:</b></p> <p>1. Health Resources &amp; Services Administration (HRSA) FY 2020 Service Area Competition (SAC) Submission Process/Approval. Staff recommends that the Board review the submission process/ components and vote to approve submission of the SAC.</p>	Barbosa
	15 min	<p>2. Update on Compliance Plan. Staff recommends that the Board:</p> <p>A. Vote to approve the August 2019 Review &amp; Update to the Compliance Plan;</p> <p>B. Vote to approve the Annual Risk Reduction Plan; and</p> <p>C. Accept the CHC Compliance incident reports.</p>	Jacobson
<b>VII.</b>	12:38-1:08 5 min	<p><b>Standing Reports:</b></p> <p>1. July 2019 Financial Report: Staff recommends that the Board accept and vote to approve the Financial Report for July 2019.</p>	Jacobson
	5 min	<p>2. Policy Review Committee Report: The Policy Review Committee recommends that the Board vote to approve the policies referenced in VII.3, which were reviewed during the month of August 2019.</p>	Taggart
	5 min	<p>3. Provider Appointments: Staff recommends that the Board vote to approve the Provider Appointments referenced in VII.4.</p>	Baldwin
	10 min	<p>4. Quality Measures Report: For Board review; no action necessary.</p>	Gomez
	5 min	<p>5. Executive Director's Report: For Board review; no action necessary.</p>	Metz
<b>VIII.</b>	1:08-1:12	<b>Member Announcements</b>	
<b>IX.</b>	1:12	<b>Adjournment</b>	

MEETING DATE: August 28, 2019

AGENDA ITEM NO: VI.1

**HEALTH CENTER BOARD  
PUBLIC HEALTH DEPARTMENT**

Date: August 7, 2019

To: Health Care Center Board

From: Ralph Barbosa

Subject: Health Resources and Services Administrations (HRSA) FY 2020 Service Area Competition (SAC) Submission Process and Approval

**RECOMMENDATION:**

That the Board:

Review the submission process/components and approve the submission of the SAC.

**DISCUSSION/BRIEF SUMMARY OF ITEM:**

Each year HRSA requires a report on the progress toward the goals that pertain to the Health Center and Health Care for the Homeless Programs funding. The SAC is the competitive submission for the Project Period (the Health Center is completing the 3rd year in the current Project Period.) The program's fiscal year runs from March 1 – February 28/29 of each year granted and the Project Period when awarded by HRSA will begin March 1, 2020 and up to February 28, 2023. The submission is a two-step application process with the first submission due in Grants.gov by August 26, 2019 and due in HRSA Electronic Handbook (EHB) on September 25, 2019.

MEETING DATE: 08/28/2019

AGENDA ITEM NO.: VI.2

**HEALTH CENTER BOARD  
PUBLIC HEALTH DEPARTMENT**

Date: 08/20/2019

To: Health Center Board

From: Suzanne Jacobson

Subject: Compliance Program Update

**RECOMMENDATION:**

That the Board: Approve the August 2019 review and Update to the Compliance Plan;  
Approve the Annual Risk Reduction Plan; and accept the CHC Compliance incident reports.

**DISCUSSION/BRIEF SUMMARY OF ITEM:**

Compliance Program Update from FY 2018-19.



# SANTA BARBARA COUNTY PUBLIC HEALTH DEPARTMENT COMPLIANCE PLAN

Draft: August 2019

Last update September 26, 2018

**SANTA BARBARA COUNTY PUBLIC HEALTH DEPARTMENT COMPLIANCE  
PLAN  
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# SANTA BARBARA COUNTY PUBLIC HEALTH DEPARTMENT

## COMPLIANCE PLAN

### I. Introduction

#### A. Overview

Santa Barbara County Public Health Department (PHD) has adopted a Compliance Program that reflects its commitment to provide high quality of care and effective risk management. PHD is committed to preventing, detecting, and correcting any improper or unethical conduct or conduct that does not conform to federal and state law, payer program requirements and PHD's business practices. This Plan describes PHD's Compliance Program. The Program applies to: (1) medical necessity/quality of care and its associated documentation; (2) billings; (3) payments; (4) governance; (5) mandatory reporting; (6) credentialing; and (7) other risk areas that are identified by PHD.

PHD's Compliance Program applies to all "Compliance Partners". All Compliance Partners are expected to read, understand and comply with this Plan (including the Code of Conduct contained herein). In addition, all Compliance Partners are expected to report any conduct that they believe violates this Plan, PHD's policies, or applicable laws and regulations to their supervisor, PHD's Compliance Officer, or the Compliance Hotline.

Identity theft through illegal access to proprietary databases is occurring at levels and scopes never before encountered. An effective Compliance Program such as this one can substantially reduce potential liability for PHD and its Compliance Partners as well as protecting our client's protected health and identifying information.

Federal and state government agencies have intensified their efforts to audit, investigate and prosecute Medicare and Medicaid fraud, waste, and abuse. Civil and criminal audits and investigations of the health care and human services industry are occurring at an unprecedented rate, resulting in large fines and criminal convictions. Even if the outcome of an audit or investigation is positive, a lengthy audit or investigation can be extremely intrusive and disrupt PHD's ability to provide care and services.

#### **Definitions:**

**Adverse event or incident:** An undesired outcome or occurrence, not expected within the normal course of care or treatment, disease process, condition of the patient, or delivery of services.

**Conflict of Interest:** for this Plan is defined as a situation in which financial or

other personal considerations have the potential to compromise or bias professional judgment and objectivity.

**Compliance Partners:** are (1) individuals employed by PHD; (2) individuals, contractors, clients, volunteers, and other entities providing services and supplies to PHD; and/or (3) members of the Health Center (HC) Board

**Claims management:** Activities undertaken by the risk manager to exert control over potential or filed claims against the organization and/or its providers. These activities include;

- identifying potential claims early,
- notifying the organization's liability insurance carrier and/or defense counsel of potential claims and lawsuits,
- evaluating liability and associated costs,
- identifying and mitigating potential damages,
- assisting with the defense of claims by scheduling individuals for deposition,
- providing documents or answers to written interrogatories,
- implementing alternate dispute-resolution tactics, and
- investigating adverse events or incidents.

**Federally Qualified Health Center (FQHC):** An FQHC is a system of primary care as defined in the Public Health Services Act as administered by the Federal government Health Resources and Services Administration (HRSA). PHD, through its Health Care Centers, Homeless Program and Ryan White Program are grantees and is defined as a Community Health Center as a FQHC.

**Harm:** A deleterious outcome for a patient, staff member, practice or organization.

**Harm Reduction:** A systematic process to evaluate policies and operations to eliminate or minimize harm.

**Health Center Board:** The Health Center Board is an advisory board that together with the County Board of Supervisors provides oversight for all PHD FQHC activities.

**Loss control/loss reduction:** The minimization of the severity of losses through methods such as claims investigation and administration, early identification and management of events, and minimization of potential loss of reputation.

**Loss prevention:** The minimization of the likelihood (probability) of a loss through risk assessment and identification; staff and volunteer education, credentialing, and development; policy and procedure implementation, review, and revision; preventive maintenance; quality/performance review and improvement; root-cause analysis; and others.

**Near miss:** Through either chance or through timely intervention, an event or situation that could have resulted in an accident, injury, or illness but did not, (e.g., a procedure almost performed on the wrong patient due to lapse in verification of patient identification but caught at the last minute by chance). Near misses are opportunities for learning and afford the chance to develop

preventive strategies and actions. Near misses receive the same level of scrutiny as adverse events that result in actual injury.

**Patient Safety Goals:** National Patient Safety Goals (NPSGs) for ambulatory care are established by the Joint Commission. The purpose of NPSGs is to improve patient safety by focusing on problems in healthcare safety and how to solve them. Goals include:

- Identify patients correctly.
- Use medicines safely by labeling them appropriately and taking precautions with anticoagulants.
- Review patient medications; communicate and educate about current medication regimens.
- Prevent infections.

**Potentially compensable event (PCE):** An unusual occurrence or serious injury for which there is neither an active claim nor institution of formal legal action but that, in the organization's judgment, is reportable to the party (or parties) providing the medical malpractice insurance. Examples include a fall with injuries, delay or failure in diagnosing a patient's condition, an adverse reaction to treatment, significant complaints from a patient or family regarding care or treatment, and an attorney request for medical records.

**Red Flag:** A term used to describe a condition or set of conditions that warrant additional attention and review such as unusually diagnostic laboratory test results for a patient, evidence of potential fraud, waste and abuse, etc.

**Risk analysis:** Determination of the causes, potential probability or potential harm of an identified risk and alternatives for dealing with the risk.

**Risk assessment:** Activities undertaken in order to identify potential risks and unsafe conditions inherent in the organization or within targeted systems or processes.

**Risk avoidance:** Avoidance of engaging in practices or of hazards that expose the organization to liability.

**Risk control:** Treatment of risk using methods aimed at eliminating or lowering the probability of an adverse event.

**Risk financing:** Analysis of the cost associated with quantifying risk and funding for it.

**Risk identification:** The process used to identify situations, policies, or practices that could result in the risk of patient harm and/or financial loss. Sources of information include proactive risk assessments, closed claims data, adverse event reports, past accreditation or licensing surveys, medical records, clinical and risk management research, walk-through inspections, safety and quality improvement committee reports, insurance company claim reports, risk analysis methods such as failure mode and effects analysis and systems analysis, and informal communication with healthcare providers.

**Risk management:** Clinical and administrative activities undertaken to identify, evaluate, prevent, and control the risk of injury to patients, staff, visitors, volunteers, and others and to reduce the risk of loss to the organization itself. Activities include the process of making and carrying out

decisions that will prevent or minimize clinical, business, and operational risks.

**Root-cause analysis:** A process for identifying the basic or causal factor(s) that underlie the occurrence of an adverse event.

**Unsafe and/or hazardous condition:** Any set of circumstances (exclusive of a patient's own disease process or condition) that significantly increases the likelihood of a serious adverse outcome for a patient or of a loss due to an accident or injury to a visitor, employee, volunteer, or other individual.

## **B. Program Elements**

PHD's Compliance Program consists of eight elements.

- (1) Written compliance policies and procedures that describe PHD's Compliance Program, including a Risk Management Plan and the Code of Conduct contained herein;
- (2) Appointment of a Compliance Officer who is responsible for the day-to-day operation of the Compliance Program and a Compliance Committee to assist the Compliance Officer;
- (3) Training and education of all affected Compliance Partners on the Compliance Program;
- (4) Mechanisms to report compliance concerns;
- (5) Disciplinary policies to encourage good faith participation in the Compliance Program;
- (6) System for identifying compliance risk areas, including monitoring and auditing;
- (7) System for responding to, investigating, and correcting compliance problems; and
- (8) A policy of non-intimidation and non-retaliation for good faith participation in the Program.

PHD's development and implementation of these eight elements will require the full cooperation and participation of all Compliance Partners. Such cooperation and participation will insure that PHD maintains a high level of honest and ethical behavior in the delivery of its services.

## II. Code of Conduct

It is PHD's policy that all Compliance Partners will comply with laws, regulations, and ethical standards applicable to their duties. The following standards of conduct apply to all Compliance Partners. The PHD does not condone unethical business dealings, such as illegal acts, indirect contributions, rebates, kickbacks and bribery.

- A. This Code of Conduct contained herein applies to all: (1) individuals employed by PHD; (2) individuals and entities providing services and supplies to PHD; and (3) members of the PHD Health Center Board. **General Employee Conduct:**

**Honesty and Lawful Conduct:** Compliance Partners must be honest and truthful in all of their dealings. Compliance Partners must avoid doing anything that is, or might be, against the law.

**Respect for Individuals Served:** Compliance Partners must fully respect the rights of the individuals served including their right to privacy, respect, dignified existence, self-determination, participation in their own care and treatment, freedom of choice, ability to voice grievances, and reasonable accommodation of individual needs. The PHD expects its employees to conduct themselves in a businesslike and professional manner. Drinking, gambling, fighting, swearing, illegal drug usage and similar unprofessional activities are strictly prohibited while on the job.

**Non-Discrimination:** Compliance Partners shall not discriminate based on sex, gender, race, sexual preference, religion, creed, military status, national origin, marital status, disability, status as a victim of domestic violence, or source of payment or sponsorship. Employees must not engage in harassment, use inappropriate language, post or access inappropriate materials in their work area.

**Business Information:** Compliance Partners may not disclose or release any confidential information relating to PHD's operations, pending or contemplated business transactions, and confidential information without proper authorization. All confidential information is to be used for the benefit of PHD and the individuals it serves, and is not to be used for the personal benefit of Compliance Partners, their families, or friends. Employees uncertain about the application or interpretation of any legal requirements should refer the matter to their supervisor, who should seek consultation with the Deputy Director who may seek legal advice.

- B. Conflicts of Interest:

We must always exercise our best skill, care and judgment for the benefit of the

County and our clients. We must refrain from being influenced by personal considerations of any kind in the performance of our duties. Failure to adhere to this Policy may be considered a breach of the person's obligation to the County, and may result in disciplinary action.

The County has established Conflict of Interest controls in its procurement procedures (see [Santa Barbara County Online Purchasing Manual](#)).

Furthermore, the County has established an annual process whereby decision makers in the County that have authority to grant or withhold public benefits such as licenses, permit, contract awards, etc. are required to complete and submit an annual declaration (Form 700 Conflict of Interest Statement) of all private holdings. These declarations are reviewed for any potential conflict of interests by the County Administration. These decision-makers within the Public Health Department must examine their own and their immediate family's activities, and promptly report the existence of any enterprises in which they or their immediate family has an "interest," and/or which the person knows is engaged, or is reasonably likely to engage, in transactions with the County. A person's immediate family includes his or her spouse, siblings, children, in-law of any of them, and parents. (redundant). A person is deemed to have an "interest" in an enterprise when he or she, or a member of his or her immediate family, has some relationship with the enterprise that could be viewed as possibly compromising the personnel's loyalty to the County or its client's interests. Such a relationship includes being employed by, having a contractual relationship with, being a member, owner, director, or officer of, or having a financial interest in an enterprise from which the County (Public Health) purchases, leases, negotiates, or otherwise does business with.

Whenever a conflict of interest or even a possible conflict of interest exists, that conflict must be fully disclosed per the Policy, and the personnel involved must refrain from participating in the consideration or determination of the matter.

PHD's Health Center Board members may have conflicts of interest associated with their oversight of FQHC operations and their professional or personal activities, holdings, interests, etc. The must abide by the Health Center Bylaws and the [Health Center Board Conflict of Interest Policy](#).

Conflicts can be complicated. Please consult the Compliance Officer for guidance.

**C. Relationships with Patients/Clients and Suppliers:**

Employees should not invest in or acquire a financial interest in any business for which PHD has a contractual relationship or that provides

goods or services to PHD.

In all matters relevant to customers, suppliers, government authorities, the public and others in the PHD, employees must make every effort to achieve complete, accurate, and timely communications - responding promptly and courteously to proper requests for information and to all complaints. Employees should document compliments and complaints in the PHD data base.

**D. Gifts, Entertainment, and Favors:**

Employees must not accept entertainment, gifts, or personal favors that could, in any way, influence, or appear to influence, business decisions in favor of any person with which the PHD has business dealings. Similarly, employees must not accept preferential treatment offered because of their positions with the PHD. Please review the [County Acceptance of Gifts, Personal Policy](#) and the [PHD Policy on Acceptance of Gifts and Donations](#).

**E. Kickbacks and Secret Commissions:**

Employees may not receive payment or compensation except as authorized under County policy. The PHD strictly prohibits the acceptance of kickbacks and secret commissions from suppliers or others. Please review the [County's Online Procurement Manual](#) for specifics on avoidance of such conflict of interest.

**F. Public Health Department Funds and Other Assets:**

Employees who have access to PHD funds in any form must follow the prescribed procedures for cash handling as detailed in the PHD's policies and procedures. The PHD maintains strict standards to prevent fraud and dishonesty. If employees become aware of any evidence of fraud and dishonesty, they should immediately advise their supervisor or the Compliance Officer. Please review the [PHD Cash Handling Guidelines Policy](#).

When an employee's position requires spending PHD funds or incurring any reimbursable personal expenses, that individual must follow all appropriate PHD policies such as the PHD [Training and Travel Expenses Reimbursement policy](#), etc.

If PHD incurs any loss or theft of County property or assets, these must be reported to the Auditor-Controller in alignment with their [Reporting Loss or Theft Policy](#). These reports should be coordinated through the PHD Chief Financial Officer.

### **G. Records and Associated Communication:**

The PHD's records must accurately reflect all clinical and business transactions and these records must be posted, updated and or stored in a timely manner. The employees responsible for accounting and recordkeeping must fully disclose and record assets, liabilities, or both, and must exercise diligence in enforcing these requirements.

Compliance Partners must not create false records or communications (see County Reporting Loss or Theft Policy above) including,

- False clinical documentation, false expense, attendance, production, financial, or similar reports and statements
- False advertising, deceptive marketing practices, or other misleading representations

### **H. Dealing With Those Outside The Public Health Department:**

Employees must not use PHD identification, stationery, supplies, and equipment for personal or political matters. When communicating publicly on matters that involve PHD business, employees should not speak for the department on any topic, unless given approval in accordance with PHD's current policies.

When dealing with anyone outside the PHD, including public officials, employees must take care not to compromise the integrity or damage the reputation of the department or any individual, business, or government body.

Employees should direct the media inquiries and other questions from individuals from the community to the PHD's Public Information Officer (PIO).

### **I. Privacy and Confidentiality:**

Employees must comply with the [Confidentiality of Information](#) agreement signed upon hire. Records must be handled in a confidential manner. When handling financial and personal information about customers or others with whom the PHD has dealings, observe the following principles:

- Collect, use, and retain only the personal information necessary for the PHD's business. Whenever possible, obtain any relevant information directly from the person concerned. Use only reputable and reliable sources to supplement this information.
- Retain information only for as long as necessary or as required by law. Protect the physical security of this information.
- Limit internal access to personal information to those with a legitimate business reason for seeking that information. Use only personal

information for the purposes for which it was originally obtained. Obtain the consent of the person concerned before externally disclosing any personal information, unless legal process or contractual obligation provides otherwise.

- Follow the PHD's policies on Health Insurance Portability and Accountability Act (HIPAA) and the Health Information Technology, Economic and Clinical Health (HITECH) act requirements.

### III. Compliance Standards

#### A. Medical Necessity and Quality of Care and Services

**Delivery of Care and Services:** Individuals served by PHD will be afforded the care and service levels necessary to attain or maintain the highest possible quality of care within available resources to improve or maintain their health and well-being. Clinical staff will be trained to evaluate and provide appropriate services and are encouraged to seek guidance, when necessary, from the Supervising Physician, Medical Director, management or other senior staff members.

**Ability to Provide:** PHD will refer individuals and their families to appropriate providers when it cannot provide for the individual's needs.

**Medical Necessity:** Medical care and services shall be based on medical need and professionally recognized standards of care.

**Appropriate Treatment:** PHD shall provide appropriate and sufficient treatment and services to address individual clinical conditions in accordance with their plans of care and professional standards of practice. Employees shall be informed of and protect and preserve the basic rights of Individuals served by PHD. Employees must interact with individuals in an honest and ethical manner. Employees shall provide services respectful to an Individual's cultural, religious, or ethnic background.

**Quality Improvement:** PHD shall have processes to measure and improve the quality of its care, services and the safety of patients. PHD's quality assurance program and improvement processes shall be coordinated with its Compliance Program.

**Accountability:** Employees shall be responsible for being knowledgeable, balancing individual needs, allowable benefits, and limited resources in carrying out services, supervision, and case management.

**Survey Performance:** PHD will regularly survey its clients for input on quality

and service levels. Current and past surveys shall be reviewed in order to identify specific risk areas and where appropriate, incorporate corrective action into the program's policies, procedures, training and monitoring.

## **B. Billing For Services**

**Verification of Coverage:** The Office Professional staff is responsible for verifying insurance coverage and benefits at every client office visit. Employees shall maintain familiarity with current policies that describe the programs and insurance products which are appropriate and acceptable for the Health Care Centers. Employees should understand the requirements of the Indigent Care Program (ICP) and Tobacco Settlement funding since the PHD administers them and resources are limited.

**Accurate and Truthful Claims and Reports:** Claims submitted for payment must be accurate, truthful, and reflect only those services and supplies which were ordered and provided. Expense reports, cost reports, reimbursement requests, and financial statements must be prepared accurately and adequate documentation must exist to support information provided in the report. No individual shall willfully or purposefully misrepresent any financial reports or reimbursement requests. Non-allowable costs must be appropriately identified and removed and related party transactions must be treated consistent with applicable laws and regulations.

**Coding:** Coding of services by all staff, including Physicians, Health Care Practitioners (HCPs), PHNs, RNs, LVNs, RDs, Health Educators, Medical Assistants (MAs) and Office Professionals (OPs), shall accurately reflect the services rendered (see [PHD Coding and Billing Compliance Plan](#)).

**Adequate Documentation:** Billing of services and supplies must be based on accurate documentation to support the services and supplies, and in accordance with applicable laws and regulations and third party payor requirements. Documentation of services must be completed by employees at the time of service or as soon thereafter as practical in accordance with existing policies and procedures.

**Ordered Services:** Medically necessary services that are ordered, provided, documented, and billed must be appropriate to the quantity and type of service provided.

**Inadequate or Substandard Care or Services:** Claims shall not be knowingly submitted for payment for inadequate or substandard care or services.

**Excluded Providers:** Claims for services or supplies furnished by an individual or entity that has been excluded from participation in a federal or state health care program shall not knowingly be submitted for payment.

**Record Retention:** Records that demonstrate the right to receive payment, including medical records, will be retained in accordance with California State regulations, the [PHD Medical Record Retention Policy](#), and Medicare/Medi-Cal record retention policies.

### C. Payment

**Credit Balances:** A “credit balance” is typically the result of an excess or improper payment from billing or claims processing errors. If a department or program knows that it has received payments for which it was not entitled from a governmental or private payor or a recipient, the payments will be refunded to the appropriate payor or recipient.

**Payment of Items or Gifts:** Employees should not give anything of value, including bribes, kickbacks, or payoffs, to any government representative, fiscal intermediary, carrier, contractor, vendor, or any other person in a position to benefit PHD (see previous reference in Section II Code of Conduct, B Conflict of Interest).

**Exception for Nominal Value:** Employees may provide or receive ordinary and reasonable business entertainment and gifts of nominal value, if those gifts are not given for the purpose of influencing the business behavior of the recipient. Employees are expected to be in compliance with all applicable County policies as specified in the PHD Policy for on Acceptance of Gifts and Donations and the PHD’s Conflict of Interest Policy (See Section II B).

### D. Professional Practices

**Behavior of Employees:** Employees shall model appropriate and acceptable behavior to the individuals served and shall maintain professional boundaries with individuals served, both in and out of the office.

**Prohibited Activities:** Employees shall not engage in any activity that constitutes abuse or neglect and shall refrain from working under the influence of alcohol, illegal substances, or prescription/non-prescription medications which may impair their functionality or in conflict with the directions of their medical provider or while appearing impaired (significant odor, impaired speech or judgment). Employees are not allowed to possess a firearm of any type at

any PHD location or satellite site. Employees are prohibited from the illegal sale of drugs (prescription or otherwise), alcohol, or other illegal substances to any Individual receiving services from PHD.

**Abusive Practices:** Employees shall not intentionally prescribe or administer improper medications or have any intentional physical contact with or engage in psychological abuse of an Individual that causes or has the potential to cause harm. Employees must also refrain from any activity that could constitute sexual harassment and may not engage in sexual contact or allow or encourage sexual contact with any patient/client receiving services from PHD. New employees are required to review and acknowledge the [County Anti-Harassment Policy](#).

#### E. Governance

**Board Oversight:** The PHD Director and HC Board shall approve the Compliance Program and ensure that they receive appropriate information and updates in a timely manner. The PHD HC Board has a duty to make reasonable inquiry when presented with facts or circumstances of a material nature (i.e. indications of financial improprieties, self-dealing, or fraud) or a major governmental investigation.

**Conflict of Interest:** In accordance with the PHDs [Conflict of Interest](#) Policy identified in Section II B, any actual or potential conflict of interest for HC Board members or employees must be disclosed to ensure that the integrity of PHD's operations is not compromised. Employees must disclose to the Compliance Officer any financial interest that they or a member of their family have in any entity that does business with PHD.

#### F. Mandatory Reporting

**Abuse, Neglect, Mistreatment:** Individuals receiving services from PHD will be free from abuse, neglect and mistreatment from any Compliance Partners. Any allegations of abuse, neglect or mistreatment must be immediately reported to the appropriate supervisor and other officials as required by law and investigated in accordance with applicable policies, rules, and regulations. New employees are required to review and acknowledge the review of the PHDs policies for reporting [Elder and Dependent Adult Abuse](#) and [Child Abuse and Statutory Rape Reporting](#) Policies.

#### G. Credentialing

**Background Checks:** As specified in the PHD [Credentialing and Privileging](#)

Policy, PHD and/or its contracted Credentialing Verification Organization will screen prospective Compliance Partners against websites which provide information on excluded individuals and entities, criminal backgrounds, and professional licensure and certification. Screening is done monthly (or more frequently if mandated by another 3<sup>rd</sup> party payer) to ensure such individuals and entities have not been excluded, convicted of a disqualifying criminal offense, or had their licensure or certification suspended, revoked or terminated since the initial screening.

**Physicians:** For physicians and other healthcare practitioners, PHD shall consult the National Practitioner Data Bank: and verify the individual's license.

**Other Compliance Partners:** For applicable Compliance Partners and contractors, PHD shall consult the Office of Inspector General's Exclusion Database for Individuals and Entities; the General Services' System for Award Management Exclusion List and the California Medi-Cal Suspended and Ineligible Provider List. In addition, contractors are required to perform their own routine exclusion list monitoring for themselves, their staff and any subcontractors to ensure adherence to the PHD Compliance Plan.

**Employee, Member, and Contractor Certifications:** PHD shall require potential Compliance Partners to certify that they have not been convicted of an offense that would preclude employment, PHD HC Board membership, or a contractual relationship with PHD and that they have not been excluded from participation in any federal or state health care program.

#### H. Business Practices

**Improper and Illegal Means:** PHD will forego any business transaction or opportunity that can only be obtained by improper and illegal means, and will not make any unethical or illegal payments to anyone to induce the use of PHD's services.

**Business Records:** Business records must be accurate and truthful, with no material omissions. PHD's assets and liabilities must be accounted for properly in compliance with all tax and financial reporting requirements.

**Computer Resources and Internet Use:** Compliance Partners who use PHD computer hardware and information systems assume the responsibility for using these resources in an appropriate manner and in accordance with Santa Barbara County's Acceptable (Computer) Use Policy. PHD owns all information communicated or stored via computer.

**Purchasing:** Purchasing decisions must be made with the purpose of obtaining

the highest quality product or service for PHD at the most reasonable price and in compliance with County policy (see [County Procurement Manual](#)). No purchasing decision may be made based on considerations from which employees, or their family member or friend, will benefit.

**Grants:** Individuals associated with grants shall conduct their activity in accordance with grant approval guidelines and documentation must be maintained by grant coordinators/administrators.

**Marketing and Referrals:** Employees must refrain from improper or high pressure individual solicitation or marketing. Employees must be truthful in the representations they make in marketing PHD's services, and never agree to offer anything of value in return for referrals.

**Relationships with Other Providers:** Contracts, leases, and other financial relationships with hospitals, physicians, hospices, other medical providers and suppliers who have a referral relationship with PHD will be based on the fair market value of the services or items being provided or exchanged, and not on the basis of the volume or value of referrals of Medicare or Medicaid business between the parties. Free or discounted services or items will not be accepted or provided in return for referrals.

#### I. Scope and Application of Standards to Compliance Partners

**Responsibility of Compliance Partners:** Compliance Partners are expected to be familiar with and comply with all federal and state laws, regulations, and rules that govern their activities. Compliance Partners are also expected to adhere to this Compliance Plan Program and any applicable departmental and other compliance policies and procedures.

**Departmental Executives, Managers and Supervisors:** Departmental Executives, managers and supervisors have the responsibility to help create and maintain a work environment in which ethical concerns can be raised and openly discussed. They are also responsible to ensure that the employees they supervise understand the importance of the Compliance Plan.

**Departmental Compliance Policies and Procedures:** In addition to the Compliance Plan many of the programs have specific compliance policies and procedures. These additional policies and procedures are an integral part of the Compliance Program and are designed to complement the standards set forth in this Plan.

#### IV. Compliance Officer

- A. **Authority and Duties:** PHD's Compliance Officer has been appointed to run the day-to-day operations of the Compliance Program and is responsible for receiving, investigating, and responding to all reports, complaints, and questions.

The Compliance Officer shall:

- Develop and implement policies, procedures, and practices; integrate these compliance policies with current County policies.
  - Develop and coordinate educational and training programs and materials;
  - Conduct and facilitate internal audits to evaluate compliance and assess internal controls;
  - Investigate compliance inquiries and Compliance hotline complaints and if appropriate develop corrective action plans;
  - Ensure that screening prospective Compliance Partners is in accordance with this Plan;
  - Ensure that physicians, independent contractors, suppliers, and other agents who furnish medical, nursing, or other healthcare or personal care services to PHD are aware of the Program's requirements;
  - Disseminate information on PHD's Compliance Program to independent contractors of PHD;
  - Review and modify the Plan including the Code of Conduct, and the Compliance Program, to reflect the evolving nature of applicable laws and regulations and the priorities of PHD;
  - Assist management in review of PHD's contracts for compliance with applicable laws and regulations and qualified status of contractors;
  - Coordinate and oversee the: (1) compliance initiatives of PHD's programs; and (2) audits and investigations conducted by government agencies;
  - Maintain documentation of the following: internal and external audit and investigation results, logs of hotline calls and their resolution, corrective action plans, due diligence efforts with regard to business transactions, records of compliance training, and modification and distribution of policies and procedures; and
  - Coordinate with Risk Management and the PHD Quality Improvement committees to obtain data from incident reports and patient satisfaction survey results
- B. **Distribution Responsibility:** The Compliance Officer shall develop a system that distributes the responsibilities described in this Plan. Compliance concerns are to be reported to PHD's Compliance Officer. Depending on the findings, issues will be brought to the attention of PHD's Director, the Compliance Committee, and the PHD HC Board.

C. **Reporting:** The Compliance Officer shall report semi-annually to the PHD Director and the HC Board.

V. **Compliance Committee:**

A. **Appointment and Authority:** The PHD Director or designee shall appoint a Committee to assist in the implementation of the Compliance Program. The Committee shall include the Compliance Officer and members of the department, representing different programs, (i.e.: clinical, finance, coding, information technology, and operations.)

B. **Authority and Duties:** The scope of the Committee's authority and duties shall be determined by the PHD Director and the HC Board and modified as the Compliance Program is evaluated. The Committee's primary duties are:

- Identification of specific risks areas,
- Assessing existing policies and procedures that address these risk areas and modifying them as needed,
- Working with programs to develop or modify standards of conduct, and policies and procedures to promote compliance with legal and ethical requirements,
- Developing and evaluating appropriate strategies to promote compliance with the Compliance Program and detection of any potential violations,
- Evaluation and approval of Compliance Program initiatives, processes and documentation, and
- Receiving, reviewing, and recommending appropriate responses to reports of actual or potential non-compliance with applicable laws, regulations,
- Enforcing the Code of Conduct, and policies and procedures in coordination with the Compliance Officer and with the assistance of counsel as necessary.

C. **Meetings:** The Compliance Committee shall meet at least quarterly.

VI. **Compliance Training and Education**

A. **Applicability:** Employees shall participate in training and education on the Compliance Program, including the Code of Conduct and the PHD Risk Management Plan. Training programs should include sessions summarizing fraud and abuse laws and federal health care program and private payor requirements

B. **Frequency:** Such mandatory training shall occur periodically and shall

be made a part of the orientation for all new employees and HC Board members.

- C. **Targeted Training:** In addition to general compliance training and education, face to face training and targeted compliance training that is tailored to particular individuals, programs and identified risk areas may be offered. Such training is mandatory.
- D. **Records of Training:** The Compliance Officer shall ensure that records are maintained, including copies of training materials, the types of training program offered, dates offered, and the individuals in attendance for a period of ten (10) years from the date of training.
- E. **Periodic Review of Training:** The Compliance Committee shall periodically monitor, evaluate and assess the effectiveness of PHD's training and education programs and shall revise such programs as necessary.
- F. **Distribution of Compliance Information:** In addition to periodic training the Compliance Officer will distribute relevant new compliance information to affected Compliance Partners. Such information may include fraud alerts, advisory opinions, newsletters, bulletins and email alerts.
- G. **Distribution and Certification of Plan:** This Compliance Plan will be made accessible to Compliance Partners in whatever format is deemed appropriate, including posting on the PHD's Intranet and Website. Compliance Partners will be required to examine the Compliance Plan and certify their examination within sixty (60) days of receipt of the Plan. New Compliance Partners must certify their receipt and examination of the Plan within sixty (60) days after their commencement date. Subsequent to the initial certification, each employee or member shall annually repeat the procedure of examining and certifying the contents of the Plan. The certifications will be distributed by, and returned to, the Compliance Officer or delegate.

## VII. Reporting Compliance Issues

- A. **Required Reporting:** If any employee believes that fraud, waste, abuse or other improper conduct has occurred, **the individual is strongly encouraged to report such information internally** (see [PHD Fraud Waste and Abuse Health Care Center Policy](#) and the reporting of [Coding Fraud Waste and Abuse Reporting Policy](#)). Individuals who report such conduct in good faith shall not be retaliated against or intimidated for making such a report. PHD shall maintain the confidentiality of reports to the extent feasible and permitted by law. An individual may report a concern:

- Confidentially to their Supervisor, Manager, Deputy Director or the Compliance Officer. The Compliance Officer can be reached at (805) 681-5173 or via email at [dan.reid@sbcphd.org](mailto:dan.reid@sbcphd.org).
- Confidentially or Anonymously through the PHD's Compliance Reporting Hotline. The number is: (844)-351-0659.
- Confidentially or Anonymously through the PHD's Compliance Reporting Fax number: (805) 681-5200.
- Confidentially or Anonymously in writing through the PHD Compliance Reporting Email box ([phdcompliance@reporting@sbcphd.org](mailto:phdcompliance@reporting@sbcphd.org)).

While PHD requires such individuals to report fraud, waste, abuse or other improper conduct to PHD, certain laws provide that individuals may also bring their concerns directly to the government. Compliance Partners and contractors may also contact the Office of Inspector General hotline at 1-800-HHS-TIPS (1-800-447-8477).

- B. Confidentiality:** Any individual who reports a compliance concern in good faith will have the right to do so anonymously. The information provided by the individual will be treated as confidential and privileged to the extent feasible and permitted by applicable laws. However, individuals who report compliance concerns are encouraged to identify themselves when making such reports so that an investigation can be conducted with a full factual background and without any delay.
- C. Non-Retaliation and Non-Intimidation** Any individual who reports a compliance concern in good faith will be protected against retaliation and intimidation.

In such an instance, retaliation is itself a violation of the Code of Conduct and unlawful. However, if the individual who reports the compliance issue has participated in a violation of law, the Code of Conduct or a PHD policy, PHD retains the right to take appropriate disciplinary action.

## **VIII. Responding to Compliance Problems.**

- A. Investigation of Reports** Upon receiving a credible report of suspected or actual fraud, waste, abuse or other improper conduct or upon the identification of a potential or actual compliance problem in the course of self-evaluation and audits, the Compliance Officer will investigate such report or problem through internal compliance processes, and involve County Counsel, auditors, or other experts to assist in an investigation, as appropriate and necessary. PHD requires that all Compliance Partners fully cooperate in any such investigations. The investigative file should contain documentation of the alleged violation, a description of the investigative process, copies of

interview notes and key documents, a log of the witnesses interviewed, documents reviewed, the results of the investigation, and any disciplinary and/or corrective action plan.

- B. Corrective Action:** After appropriate investigation, if the Compliance Officer determines that there has been an occurrence(s) of fraud, waste, abuse, improper conduct or violation(s) of the Code of Conduct, Compliance Program, PHD's policies and procedures, and any applicable laws or regulations, the Compliance Officer shall institute corrective action. Any problems identified shall be corrected promptly and thoroughly, and procedures, policies, and systems shall be implemented as necessary to reduce the potential for reoccurrence. Such action may include: additional training for Compliance Partners, modification or improvement of PHD's business practices; and modification or improvement of the Compliance Program itself to better ensure continuing compliance with applicable federal and state laws and regulations; disclosure to appropriate government agencies and/or third party payers; and repayment of funds that were improperly paid.
- C. Disciplinary Action** After appropriate investigation, if the Compliance Officer determines that there has been an occurrence(s) of fraud, waste, abuse, improper conduct or violation(s) of the Code of Conduct, Compliance Program, PHD's policies and procedures, and any applicable laws or regulations, the Compliance Officer will report - findings to PHD Administration and work with County Human Resources or the County Purchasing Division to impose sanctions against those individuals involved. Sanctions shall be imposed against any Compliance Partners for: (1) failing to report suspected problems; (2) participating in non-compliant behavior; and (3) encouraging, directing, facilitating or permitting non-compliant behavior. Sanctions shall be imposed subject to the due process requirements of any applicable employment contracts, civil service rules, organizational bylaws, or contracts or agreements. Sanctions shall be fairly and consistently applied and enforced in accordance with any written standards of disciplinary action.
- Employee sanctions can range from an oral warning to, in the most extreme cases, termination.
  - HC Board Member sanctions can range from written admonition to, in the most extreme cases, removal from the HC Board.
  - Contractor sanctions shall range from written admonition, financial penalties, and in the most extreme cases, termination of the contractor's relationship with PHD.
  - In some instances, as per current County policies as a local government entity, investigation results may be released to law enforcement for potential criminal prosecutions.

## IX. Risk Management Plan

- A. Patient Safety and Risk Management Program Purpose:** The Risk Management Plan is designed to support the mission and vision of the Public Health Department (PHD) as it pertains to clinical risk patient, visitor, volunteer, and employee safety and potential business, operational, and property risks.
- B. Guiding Principles:** The Risk Management Plan is an overarching, conceptual framework that guides the development of a program for risk management and patient safety initiatives.

The Patient Safety and Risk Management Program supports the PHD's philosophy that patient safety and risk management is everyone's responsibility. Teamwork and participation among managers, providers, volunteers, and staff are essential for an efficient and effective patient safety and risk management program.

PHD supports the establishment of a culture that emphasizes implementing evidence-based best practices, learning from error analysis, and providing constructive feedback. Unsafe conditions and hazards should be readily and proactively identified, medical or patient care errors will be reported and analyzed, mistakes are openly discussed, and suggestions for systemic improvements are welcomed. Individuals are held accountable for compliance with patient safety and risk management practices.

The PHD's Risk Management Plan stimulates the development, review, and revision of the organization's practices and protocols in light of identified risks and chosen loss prevention and reduction strategies. Principles of the Plan provide the foundation for developing key policies and procedures for day-to-day risk management activities, including:

- Provider and staff education, competency validation, and credentialing requirements
- Claims management
- Confidentiality and release of information
- Event investigation, root-cause analysis, and follow-up
- Complaint resolution
- Reporting and management of adverse events
- Trend analysis of events

- C. Governing Body Leadership:** The success of the Patient Safety and Risk Management Program requires top-level commitment and support. The Santa Barbara County Board of Supervisors and Health Center(HC) board authorize

the formal program and adoption of this Plan through a resolution documented in board meeting minutes.

The HC Board is committed to promoting the safety of patients, visitors, employees, volunteers, and other individuals involved in organizational operations. The Patient Safety and Risk Management Program is designed to reduce system-related errors and potentially unsafe conditions by implementing continuous improvement strategies to support an organizational culture of safety. The HC Board empowers the organizational leadership with the responsibility for implementing performance improvement and risk management strategies.

**D. Program Goals and Objectives:** The Patient Safety and Risk Management Program goals and objectives are to:

- Continuously improve patient safety and minimize and/or prevent the occurrence of errors, events, and system breakdowns leading to harm to patients, staff, volunteers, visitors through proactive risk management and patient safety activities.
- Minimize adverse effects of errors, events, and system breakdowns.
- Minimize losses to the organization by proactively identifying, analyzing, preventing, and controlling potential clinical, business, and operational risks.
- Facilitate regulatory and legal compliance, (e.g., HRSA).
- Protect human and intangible resources (e.g., reputation).

**F. Scope and Functions of the Risk Management Program:** The PHD's Patient Safety and Risk Management Program is designed to interface with all programs and services throughout the organization.

**1. Functional Interfaces:**

Functional interfaces with the patient safety and risk management program include the following: Provider documentation and appropriateness of medical care

- Buildings and grounds
- Claims management
- Regulatory compliance
- Credentialing of providers
- Disaster preparation and management
- Employee health
- Event/incident/accident reporting and investigation

- Finance/billing
- Human resources
- Infection control
- Information technology
- Legal and contracts
- Marketing/advertising/public relations
- Nutritional services
- Patient and family education
- Patient satisfaction
- Pharmaceuticals and therapeutics
- Product/materials management
- Quality/performance assessment and improvement
- Safety and security
- Social service programs
- Staff education
- Volunteers

## **2. Patient Safety and Risk Management Program Functions:**

Risk management functional responsibilities include:

- a) Developing systems for and overseeing the reporting of adverse events, near misses, and potentially unsafe conditions. Reporting responsibilities may include internal reporting as well as external reporting to regulatory, governmental, or voluntary agencies. This includes the development and implementation of event-reporting policies and procedures.
- b) Ensuring the collection and analysis of data to monitor the performance of processes that involve risk or that may result in serious adverse events (e.g., preventive screening, diagnostic testing, medication use processes, perinatal care). Proactive risk assessment can include the use of failure mode and effects analysis, system analysis, and other tools.
- c) Overseeing the data collection and processing, information analysis, and generation of statistical trend reports for the identification and monitoring of adverse events, claims, finances, and effectiveness of the risk management program.

This system may utilize and include, but is not limited to, the following:

- Attorney requests for medical records, x-rays, laboratory reports
- Committee reports and minutes
- Criteria-based outcome studies

- Event, incident, or near miss reports
  - Medical record reviews
  - Monitoring systems based on objective criteria
  - Notice letters, lawsuits
  - Nursing reports
  - Patient complaints & surveys
  - Provider input
  - Root-cause analyses of sentinel events
- d) Analyzing data collected on adverse events, near misses, and potentially unsafe conditions; providing feedback to providers and staff; and using this data to facilitate systems improvements to reduce the probability of occurrence of future related events. Root-cause analysis and systems analysis can be used to identify causes and contributing factors in the occurrence of such events.
- e) Ensuring compliance with data collection and reporting requirements of governmental, regulatory, and accrediting agencies.
- f) Facilitating and ensuring the implementation of patient safety initiatives such as improved tracking systems for preventive screenings and diagnostic tests, medication safety systems, and prevention programs.
- g) Facilitating and ensuring provider and staff participation in educational programs on patient safety and risk management.
- h) Facilitating a culture of safety in the organization that embodies an atmosphere of mutual trust in which all providers and staff members can talk freely about safety problems and potential solutions without fear of retribution. This ordinarily involves performing safety culture surveys and assessments and modeling appropriate behavior and program support by administration and executives.
- i) Proactively advising the organization on strategies to reduce unsafe situations and improve the overall environmental safety of patients, visitors, staff, and volunteers.
- j) Reducing the probability of events that may result in losses to the physical plant and equipment (e.g., biomedical equipment maintenance, fire prevention, etc.).
- k) Preventing and minimizing the risk of liability to the organization, and protecting the financial, human, and other tangible and intangible assets of the organization.

- l) Decreasing the likelihood of claims and lawsuits by developing a patient and family communication and education plan. This includes communicating and disclosing errors and events that occur in the course of patient care with a plan to manage any adverse effects or complications.
- m) Decreasing the likelihood of lawsuits through effective claims management, and investigating and assisting in claim resolution to minimize financial exposure in coordination with the liability insurer and its representatives.
- n) Reporting claims to the County's Risk Manager in accordance with policy
- o) Supporting quality assessment and improvement programs throughout the organization.
- p) Implementing programs that fulfill regulatory, legal, and accreditation requirements.
- q) Establishing an ongoing patient safety/risk management committee composed of representatives from key clinical and administrative departments and services.
- r) Monitoring the effectiveness and performance of risk management and patient safety actions. Performance monitoring data may include:
  - Claims and claim trends
  - Culture of safety surveys
  - Event trending data
  - Ongoing risk assessment information
  - Patient survey results
  - Quality performance data
  - Research data
- s) Completing insurance and deeming applications.
- t) Developing and monitoring effective handoff processes (such as Patient Centered Medical Home models) for continuity of patient care.

**G. Administrative and Committee Structure and Mechanisms for Coordination:**

The Patient Safety and Risk Management Program is administered through the Compliance Officer, who reports to the Deputy Director. The Compliance

Officer interfaces with administration, staff, medical providers, and other professionals and has the authority to cross operational lines in order to meet the goals of the program. The Compliance Officer chairs the Compliance Committee. The committee meets regularly and includes representatives from key clinical and administration areas. The composition of the Compliance Committee is designed to facilitate the sharing of risk management knowledge and practices across multiple disciplines and to optimize the use of key findings from risk management activities in making recommendations to reduce the overall likelihood of adverse events and improve patient safety. The Committee's activities are an integral part of a patient safety and quality improvement and evaluation system.

Documentation of the designation of the Compliance Officer is contained in the Patient Safety and Risk Management Plan. The Compliance Officer is responsible for overseeing day-to-day monitoring of patient safety and risk management activities and for investigating and reporting to the County's Risk Manager actual or potential clinical, operational, or business claims or lawsuits arising out of the organization, according to County policy. The Compliance Officer serves as the primary contact between the organization and other external parties on all matters relative to risk identification, prevention, and control, as well as risk retention and risk transfer. The risk manager oversees the reporting of events to external organizations, per regulations and contracts, and communicates analysis and feedback of reported risk management and patient safety information to the organization for action.

- H. **Monitoring and Continuous Improvement:** The Patient Safety/Risk Management Committee reviews risk management activities regularly. The Compliance Officer reports activities and outcomes (e.g., claims activity, risk and safety assessment results, event report summaries and trends) regularly to the governing board. This report informs the governing board of efforts made to identify and reduce risks and the success of these activities and communicates outstanding issues that need input and/or support for action or resolution. Data reporting may include event trends, claims analysis, frequency and severity data, credentialing activity, relevant provider and staff education, and risk management/patient safety activities. In accordance with the organization's policies and protocols, recommendations from the Patient Safety/Risk Management Committee are submitted as needed to the HC Board.
  
- I. **Confidentiality:** Documents and records that are part of the patient safety and risk management process shall be privileged and confidential to the extent provided by state and federal law. Confidentiality protections can include attorney client privilege, attorney work product, and peer review protections.

X. **Monitoring and Auditing**

- A. **System for Identifying Risks:** The Compliance Committee shall develop a system for routine identification and evaluation of compliance risk areas. Such a monitoring and auditing system shall include the Risk Management Plan (see **Section IX** above and also referred to as the Annual Risk Reduction Work Plan), performance of regular, periodic compliance audits by internal or external auditors and designated Compliance Partners. Such audits will include reviews of PHD's business and billing practices, including pre-billing audits, and measures to identify, anticipate, and respond to quality of care risk areas. In addition, such System shall include a periodic review of the Compliance Program to determine whether the elements of the Program have been satisfied and the effectiveness of the Program has been determined or evaluated.

PHD shall have an annual financial audit and a single audit conducted by the County Auditor/Controller and/or an independent Certified Public Accountant Firm to examine, on a test basis, evidence supporting the proper handling and reporting of amounts and disclosures relating to the financial activity of PHD. PHD shall also conduct annual reviews of business and contractual agreements and relationships as well as billing practices to reasonably ensure that all activities are in compliance with its Code of Conduct, standards, and procedures. PHD shall also maintain a disclosure listing of all individuals associated with PHD who have identified outside party interests that represent potential conflicts of interest. Results of audits related to the FQHC operations and the Public Health Department will be shared with the Health Center Board on an annual basis.

The Compliance Officer and/or Committee shall establish and implement standard operating procedures for conducting internal reviews. These procedures shall establish specific schedules for the frequency of each type of review activity. Sampling shall be conducted in a manner consistent with generally accepted statistical standards. The results of such reviews shall be documented on a standardized form and retained for a minimum of ten years.

- B. **Corrective Action Plans:** The Compliance Officer and/or Committee shall receive and review the results of such reviews, develop a corrective action plan to remedy any deficiencies identified in the results, and provide the corrective action plan to those individuals who will be charged with the responsibility of implementing it. If periodic review and monitoring activities identify substantial deviation from acceptable norms, the Compliance Officer, Committee, and HC Board shall take prompt steps to address such deviations. Where additional investigation of such deviations is appropriate, the Compliance Officer, in consultation with the Committee, shall retain the

services of such independent advisors as shall be necessary to address such deviations.

- C. Government Inquiries.** If contacted by a government (i.e.: Medicare, Medicaid, Federal Bureau of Investigation (FBI), Office of Inspector General (OIG), Health Resources Services Administration (HRSA)) official, employees are required to obtain the official's identification and immediately inform their supervisor and the Compliance Officer of the contact. While employees may voluntarily speak with such officials, they are strongly encouraged that before they speak to such officials, they first contact their supervisor and the Compliance Officer.

Employees may not respond to a request to disclose PHD's documents without first obtaining approval from their supervisor, HIPAA Privacy Officer, and/or Compliance Officer.

## **XI. Laws Regarding the Prevention of Fraud, Waste and Abuse.**

### **A. Federal Laws**

**Federal False Claims Act:** Any employee who submits a claim to the federal government that is false is subject to civil penalties of \$5000-\$10,000 per false claim.

**Administrative Remedies for False Claims and Statements:** If a person submits a claim that the employee knows is false, contains false information or omits material information, the employee may be subject to a \$5,000-\$10,000 penalty per claim and triple damages (see [Federal False Claims Act](#)).

**Federal Anti-Kickback Law:** Employees may not knowingly offer, pay, solicit, or receive remuneration in exchange for referring, furnishing, purchasing, leasing or ordering a service or item paid for by Medicare, Medicaid, or other federal health care program. Criminal or civil penalties include repayment of damages, fines, imprisonment, and exclusion from participation in federal health care programs.

### **B. State Laws**

California has the following similar laws: these include the California False Claims Act, False Statements Law, Anti-Kickback Law, Self-Referral Prohibition Law, Health Care and Insurance Fraud Penal Law. Individuals may be entitled to bring an action under the State False Claims Act, and share in a percentage of any recovery. However, if the action has no merit and is for the purpose of harassing PHD, the individual may have to pay PHD for its legal fees and costs.

## **C. Whistleblower Protections**

**Federal Whistleblower Protection:** An employee who is discharged, demoted, suspended, threatened, harassed, or discriminated against because of their lawful acts conducted in furtherance of a False Claims Act action may bring an action against the employer. However, if the employee's action has no basis in law or fact or is primarily for harassment of the employer, the employee may have to pay the employer its fees and costs.

**California State Whistleblower Protection:** Compliance Partners who, in good faith, report a false claim are protected against discharge, demotion, suspension, threats, harassment, and other discrimination by their employer. Remedies include reinstatement, double back pay plus interest, and litigation costs and attorneys' fees.

*\*These are summaries of very complex laws. The Compliance Officer can provide you with more information about these laws, or their application to any situation you may encounter. These laws all serve the important function of protecting the Federal and State health care programs from fraud, waste, and abuse and allow those funds to protect the beneficiaries of these programs. PHD supports the goals of these laws and requires all Compliance Partners, to comply with these laws as part of our mission of providing services to individuals.*

## **XII. Program Evaluation**

The Compliance Officer will oversee an annual review of the PHD Compliance Program, which may include the following:

- Randomly survey staff as to their knowledge and understanding of the Program.
- Will make a report to the PHD Director and the HC Board annually on the activities and the effectiveness of the Program.
- Examine employee certifications of compliance and filing with the applicable government regulatory agency, if necessary.
- Coordinate with PHD Supervisors and Managers to evaluate adherence to the employee elements of the Compliance Program and Code of Conduct for PHD employees through the existing annual employee performance review (EPR) and the annual individual performance plan (IDP) evaluation processes.

## **XIII. Summary**

PHD is proud of its reputation for consistently providing high quality care, practicing the values of professionalism, integrity and trust. Select this [link](#) to review the Public Health Department Mission, Vision and Values.

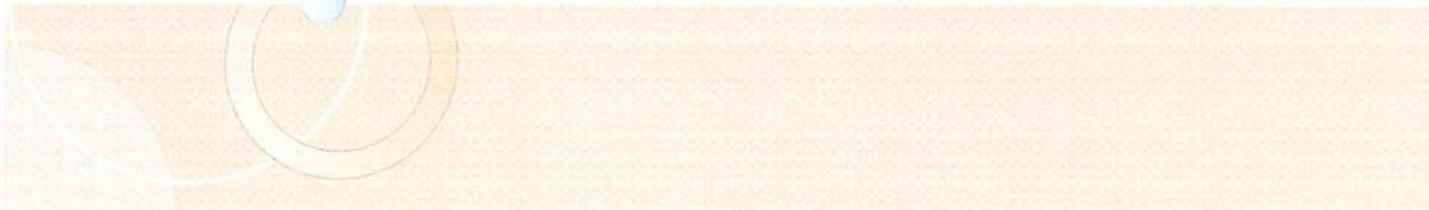
The signatures below represent an acceptance of the Compliance Program and the Code of Conduct.

PHD Director Approval: \_\_\_\_\_

Date: \_\_\_\_\_

HC Board Approval \_\_\_\_\_

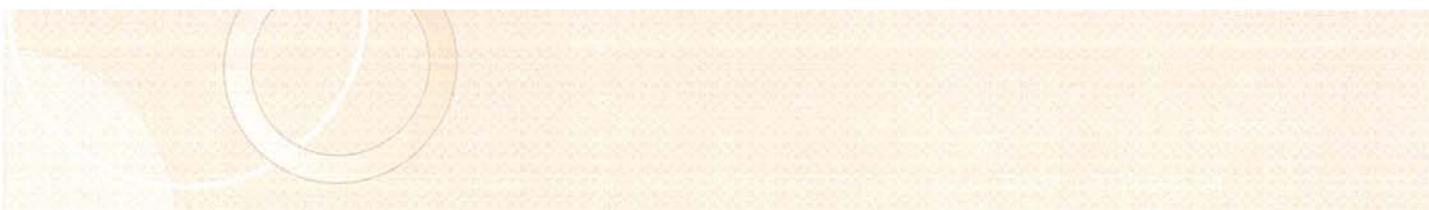
Date: \_\_\_\_\_



# Compliance Program Update

Santa Barbara County Public Health Department  
Health Center Board

August 28, 2019



# Compliance Program Background

- Is a requirement of our HRSA grant
- Is a requirement for Medicare billing
- Reports to the Health Center Board
- Provides semi-annual updates on activities.
- Dan Reid was our Compliance Officer until his retirement in March of 2019

# Compliance Program Currently

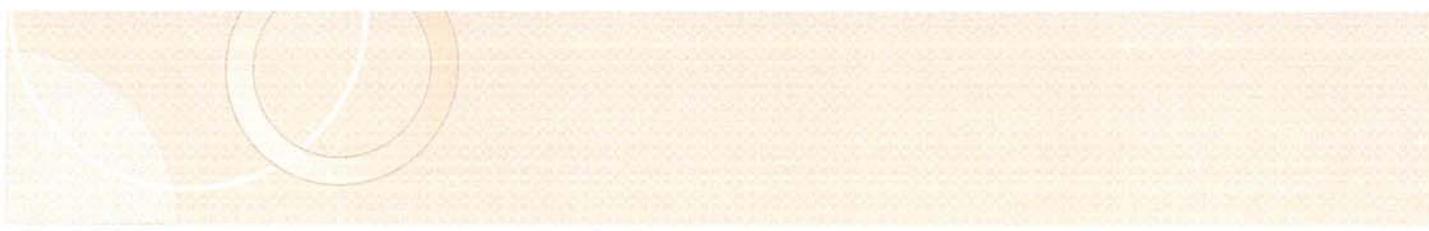
- Suzanne Jacobson is Interim Compliance Officer
- Janine Neal is the IT Security Officer
- June English is the Privacy Officer
- Janice Payment is the Billing Compliance Officer
- We also have an *Interdisciplinary Compliance Team* made up of individuals across our programs who meet quarterly.

## Duties of Compliance Team

- *Ensure the integrity of the Department's billing, invoicing, systems, and data.*
- **Through:**
  - Annual training
    - HIPAA Privacy/Security/Cybersecurity
  - Investigations of Reported Incidents
    - Keeping track in ComplyTrack software
    - Reporting to Officials, if necessary
    - Anonymous hotline/email/etc
  - Risk Reduction Work Plan

## Report & Update: July 2018 to June 2019

- Annual Review/Approval of Compliance Plan
  - No changes from Prior Year Plan
  - Requires HC Board Chair Signature
- Annual Review/Approval of Risk Reduction Work Plan
  - Updated with Compliance Team Input
  - Specific focus areas for FY 2019-20
- Periodic Review of Incidents
  - Health Center Board Report from Comply Track System



## Recommendation

- Approve the August 2019 review and update to the *Compliance Plan*
  - *Board Chair to sign*
- Approve the *Annual Risk Reduction Work Plan* for FY 2019-20
- Accept the *CHC Compliance Incidents Board Report* for FY 2018-19.

MEETING DATE: 08/28/2019

AGENDA ITEM NO.: VII.1

**HEALTH CENTER BOARD  
PUBLIC HEALTH DEPARTMENT**

Date: 08/20/2019

To: Health Center Board

From: Suzanne Jacobson

Subject: Financial Report for July 2019

**RECOMMENDATION:**

That the Board: Accept and approve the Financial Report for July 2019

**DISCUSSION/BRIEF SUMMARY OF ITEM:**

Financial Report and Narrative for period ended 07/31/2019.

**Santa Barbara County Public Health Department**

**Community Health Center Board**

*Financial Statement Narrative for **July, 2019***

*Includes variances over \$100K, either YTD or MTD*

<u><b>Financial Results:</b></u>	<u><b>Year to Date</b></u>	<u><b>July</b></u>
Revenues:	\$4,060,967	\$4,060,967
Expenditures:	<u>\$4,275,552</u>	<u>\$4,275,552</u>
Net Surplus/(Deficit):	<u>(\$214,585)</u>	<u>(\$214,585)</u>

<u><b>Revenue Highlights:</b></u>	<u><b>Year to Date Variance (82.9%)</b></u>	<u><b>July Variance (82.9%)</b></u>
<b>Over (Under) Budget</b>		
Medicaid/Medicare:	(\$446,660)	(\$446,660)
Local/State Funds:	(\$276,064)	(\$276,064)
Federal 330 grant:	(\$175,000)	(\$175,000)

<u><b>Expenditure Highlights:</b></u>	<u><b>Year to Date Variance (87.3%)</b></u>	<u><b>July Variance (87.3%)</b></u>
<b>Over (Under) Budget</b>		
Personnel/Benefits:	\$112,747	\$112,747
Pharmaceuticals:	(\$178,470)	(\$178,470)
Physician Fees:	(\$178,536)	(\$178,536)
Other Office Expenses:	(\$109,073)	(\$109,073)

**Financial Results Discussion**

Our Community Health Center financial results for July 2019 reflect a negative *month to date* and *year to date* net financial impact of **(\$214,585)**.

Overall, our revenues are at 82.9% of budget and our expenditures are at 87.3% of budget. There are a few reasons for this:

- July is a month with 31 days and our monthly budget is 1/12 of the total year (about 30 days), so Salaries and Benefits appear high against the budgeted amount.
- This is the first month of the new fiscal year and the State tends to be slow paying patient claims after the end of their fiscal year, which is also June.
- This is the first month of the new fiscal year and most of our July invoices (contract physician fees, pharmaceuticals) have not been received.

### **Revenue Highlights:**

*We have negative variances for the following:*

- Medicaid and Medicare Revenue – Below budget and will be improving in the coming months as the State catches up with claims payment.
- Local/State Funds – Below budget so far, but still very early in the year, we hope to improve our Medi-Cal revenues to use less of our local funds.
- Federal 330 Grant Funds – Under budget because the federal drawdowns are generally made quarterly.

### **Expenditure Highlights:**

*We have positive variances for the following:*

- Pharmaceuticals – Under budget, although we anticipate expenditures to increase and there is a lag in receiving invoices.
- Physician Fees – Under budget due to the timing of invoices from physicians. These generally are delayed and track approximately one month behind the services performed.

*And a negative variance for:*

- Salaries and Benefits – Over budget due to the fact that July had 31 days and no holidays. The annual budget is divided equally by 12, so there are lower budgeted dollars (about 30 days worth) than actual expenses for months with 31 days and more budgeted dollars with months with fewer working days, like February. It should all even out by the end of the fiscal year.

Santa Barbara County Public Health Department Health Care Centers  
 Financial Monthly Report for CHC/HCH Grant H80CS00046  
 For the Month of July 2019 - Fiscal Year 2019-20

	FY 19-20 ADOPTED BUDGET	FY 19-20 As of 7-31-19 BUDGET	FY 19-20 As of 7-31-19 YTD ACTUALS	FY 19-20 July YTD Variance	FY 19-20 YTD % of Budget	ONE MONTH ADJUSTED BUDGET	FY 19-20 July ACTUALS	FY 19-20 July Variance	FY 19-20 July % of Budget
<b>REVENUES</b>									
<b>PROGRAM INCOME</b>									
Medicaid	\$ (39,270,200)	\$ (3,272,517)	\$ (2,765,871)	\$ 506,645	85%	\$ (3,272,517)	\$ (2,765,871)	\$ 506,645	85%
Medicare	(5,478,400)	(456,533)	(516,518)	(59,985)	113%	(456,533)	(516,518)	(59,985)	113%
Self-pay (includes HAP)	(1,772,100)	(147,675)	(197,995)	(50,320)	134%	(147,675)	(197,995)	(50,320)	134%
<b>LOCAL AND STATE FUNDS</b>									
State/Local Funds-TSAC/GF	(9,387,616)	(782,301)	(506,237)	276,064	65%	(782,301)	(506,237)	276,064	65%
<b>FEDERAL 330 GRANT</b>	(2,100,000)	(175,000)	-	175,000	0%	(175,000)	-	175,000	0%
<b>OTHER FEDERAL FUNDING</b>									
ADAP	(766,000)	(63,833)	(74,345)	(10,512)	116%	(63,833)	(74,345)	(10,512)	116%
<b>TOTAL REVENUE</b>	<b>\$ (58,774,316)</b>	<b>\$ (4,897,860)</b>	<b>\$ (4,060,967)</b>	<b>\$ 836,892</b>	<b>82.9%</b>	<b>\$ (4,897,860)</b>	<b>\$ (4,060,967)</b>	<b>\$ 836,892</b>	<b>82.9%</b>
<b>EXPENDITURES</b>									
<b>PERSONNEL</b>	\$ 22,208,800	\$ 1,850,733	\$ 2,040,965	\$ 190,232	110%	\$ 1,850,733	\$ 2,040,965	\$ 190,232	110%
FRINGE BENEFITS	14,195,500	1,182,958	1,105,473	(77,485)	93%	1,182,958	1,105,473	(77,485)	93%
<b>TOTAL PERSONNEL</b>	<b>36,404,300</b>	<b>3,033,692</b>	<b>3,146,438</b>	<b>112,747</b>	<b>104%</b>	<b>3,033,692</b>	<b>3,146,438</b>	<b>112,748</b>	<b>104%</b>
<b>TRAVEL</b>									
PHD Carpool	62,200	5,183	5,335	152	103%	5,183	5,335	152	103%
Transportation - Local Mileage	26,100	2,175	2,161	(14)	99%	2,175	2,161	(14)	99%
Training and Travel	88,500	7,375	705	(6,670)	10%	7,375	705	(6,670)	10%
<b>TOTAL TRAVEL</b>	<b>176,800</b>	<b>14,733</b>	<b>8,200</b>	<b>(6,533)</b>	<b>56%</b>	<b>14,733</b>	<b>8,200</b>	<b>(6,533)</b>	<b>56%</b>
<b>SUPPLIES</b>									
Medical Supplies	630,400	52,533	52,664	131	100%	52,533	52,664	131	100%
Office Supplies	168,000	14,000	14,153	153	101%	14,000	14,153	153	101%
Pharmaceuticals	6,724,000	560,333	381,864	(178,470)	68%	560,333	381,864	(178,470)	68%
Bus Tokens	20,000	1,667	-	(1,667)	0%	1,667	-	(1,667)	0%
<b>TOTAL SUPPLIES</b>	<b>7,542,400</b>	<b>628,533</b>	<b>448,681</b>	<b>(179,853)</b>	<b>71%</b>	<b>628,533</b>	<b>448,681</b>	<b>(179,853)</b>	<b>71%</b>
<b>CONTRACTUAL</b>									
Janitorial Services	303,500	25,292	8,595	(16,697)	34%	25,292	8,595	(16,697)	34%
Physician Fees	2,080,900	173,408	(5,127)	(178,536)	-3%	173,408	(5,127)	(178,536)	-3%
Professional Services	816,000	68,000	(11,034)	(79,034)	-16%	68,000	(11,034)	(79,034)	-16%
<b>TOTAL CONTRACTUAL</b>	<b>3,200,400</b>	<b>266,700</b>	<b>(7,566)</b>	<b>(274,266)</b>	<b>-3%</b>	<b>266,700</b>	<b>(7,566)</b>	<b>(274,266)</b>	<b>-3%</b>
<b>OTHER</b>									
Building Maintenance	35,200	2,933	-	(2,933)	0%	2,933	-	(2,933)	0%
Communications	287,600	23,967	22,221	(1,746)	93%	23,967	22,221	(1,746)	93%
Data Processing	912,100	76,008	-	(76,008)	0%	76,008	-	(76,008)	0%
Liability Insurance	361,800	30,150	30,117	(33)	100%	30,150	30,117	(33)	0%
Malpractice Insurance	452,600	37,717	41,767	4,050	111%	37,717	41,767	4,050	0%

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Other Clinical Expenditures	268,500	22,375	21,261	(1,114)	95%	22,375	21,261	(1,114)	95%
Other Office Expenditures	1,309,700	109,142	24,834	(84,308)	23%	109,142	24,834	(84,308)	23%
Public Health Lab Services	90,000	7,500	(100)	(7,600)	-1%	7,500	(100)	(7,600)	-1%
Rents & Leases	141,600	11,800	9,292	(2,508)	79%	11,800	9,292	(2,508)	79%
Services County Provided	146,200	12,183	-	(12,183)	0%	12,183	-	(12,183)	0%
Utilities	404,200	33,683	18,214	(15,469)	54%	33,683	18,214	(15,469)	54%
<b>TOTAL OTHER</b>	<b>4,409,500</b>	<b>367,458</b>	<b>167,605</b>	<b>(199,853)</b>	<b>46%</b>	<b>367,458</b>	<b>167,605</b>	<b>(199,853)</b>	<b>46%</b>
<b>TOTAL DIRECT COSTS</b>	<b>\$ 51,733,400</b>	<b>\$ 4,311,117</b>	<b>\$ 3,763,359</b>	<b>\$ (547,758)</b>	<b>87.3%</b>	<b>\$ 4,311,117</b>	<b>\$ 3,763,359</b>	<b>\$ (547,757)</b>	<b>87.3%</b>
<b>INDIRECT COST (13.61% OF TADC)</b>	<b>7,040,916</b>	<b>586,743</b>	<b>512,193</b>	<b>(74,550)</b>	<b>87.3%</b>	<b>586,742.98</b>	<b>512,193</b>	<b>(74,550)</b>	<b>87.3%</b>
<b>TOTAL BUDGET</b>	<b>\$ 58,774,316</b>	<b>\$ 4,897,860</b>	<b>\$ 4,275,552</b>	<b>\$ (622,308)</b>	<b>87.3%</b>	<b>\$ 4,897,860</b>	<b>\$ 4,275,552</b>	<b>\$ (622,307)</b>	<b>87.3%</b>
<b>Net Surplus/ Deficit</b>	<b>\$ (0)</b>	<b>\$ (0)</b>	<b>\$ 214,585</b>	<b>\$ 214,585</b>		<b>\$ (0)</b>	<b>\$ 214,585</b>	<b>\$ 214,585</b>	

**HEALTH CENTER BOARD  
PUBLIC HEALTH DEPARTMENT**

Date: August 21<sup>st</sup> 2019

To: Health Center Board

From: Policy Review Committee

Subject: Policy Recommendations

**RECOMMENDATION:**

That the Board approve the policies referenced below as reviewed and approved by the Policy Review Committee.

**DISCUSSION:**

The Policy Review Committee recommends the Board vote to approve the following policies reviewed during the month of August 2019.

<b><u>POLICY NO.</u></b>	<b><u>TITLE</u></b>
1. 01-C-143	Workers Compensation in Santa Barbara County Health Care Centers
2. 05-C-269	Health Center Schedules Alteration/Modification
3. 13-C-582	Evidence Based Guidelines
4. 97-C-048	Child Abuse and Statutory Rape Reporting
5. 99-C-131	Grievance Procedure for CenCal Health
6. 14-C-596	HIV Universal Testing and HIV Pregnancy Screening
7. 19-C-645	Auditing-Provider, Program and Requirement Internal Auditing
8. 04-C-206	Walk-In Clinics at Health Care Centers
9. 13-C-585	24/7 Access to Clinical Advice

<p>Santa Barbara County  <b>PUBLIC Health</b>    DEPARTMENT</p>	<p>Number: 01-C-143</p>
<p>Prepared By: Douglas Metz, MPH, DPM, Deputy Director PCFH; Polly Baldwin, MD, Medical Director; Dana Gamble, Assistant Deputy Director</p>	<p>Effective Date: 08/28/2019</p>
<p>Authorized By: Douglas Metz, MPH, DPM, Deputy Director PCFH</p>	<p>Original Date: 1/1/2001</p>
<p><b>TITLE: Workers Compensation in Santa Barbara Healthcare Centers</b></p>	

**POLICY**

The Public Health Department (PHD) is not a Provider for Workers Compensation cases. Patients should be referred to an approved workers compensation clinic or designated medical facility for their care and PHD Providers should not complete a Doctor's 1st report.

**PURPOSE**

To describe the policy and procedure for processing patients who present to the PCFH clinics with a workers compensation injury.

<p>Santa Barbara County  <b>PUBLIC Health</b>    DEPARTMENT</p>	<p><b>Number: 05-C-269</b></p>
<p><b>Prepared By: Health Center Administrators</b></p>	<p><b>Effective Date: 08/28/2019</b></p> <p><b>Original Date: 1/16/2008</b></p>
<p><b>Authorized By: Dr. Douglas Metz, MPH, DPM,  Deputy Director PCFH</b></p>	<p><b>Next Review Date: 08/28/2020</b></p>
<p><b>TITLE: Health Center Schedules Alteration/Modification</b></p> <div style="border: 1px solid black; padding: 5px; margin-top: 10px;"> <input checked="" type="checkbox"/> Approved by Santa Barbara Health Center Board on 9/26/18 (See Board Meeting minutes) </div>	

**POLICY**

Management of Health Care Center provider schedules is key to ensuring appropriate access for patients seeking care. It is the policy of the Santa Barbara County Public Health Department to manage its schedules to optimize access to health care services with the goal to meet the needs of the community and the budget goals of the department. Only a Health Care Center Administrator or designee may approve changes in the health center provider schedules.

**PURPOSE**

The purpose of this policy is to ensure that health center schedules provide reasonable access to needed health care. This policy supports the "Broken and Follow Up Appointment Scheduling Policy" and the Average Number of Days to Schedule an IM or Family Medicine Appointment Recurring Performance Measures.

<p>Santa Barbara County  <b>PUBLIC Health</b>    DEPARTMENT</p>	<p><b>Number: 13-C-582</b></p>
<p><b>Prepared By: Polly Baldwin, MD, Medical Director</b></p>	<p><b>Effective Date: 08/28/2019</b>  <b>Original Date: 02/12/2012</b></p>
<p><b>Authorized By: Polly Baldwin, MD, Medical Director</b></p>	<p><b>Next Review Date: 08/28/2020</b></p>
<p><b>TITLE: Evidence Based Guidelines</b></p>	

**POLICY**

It is the policy of the Santa Barbara County Public Health Department (SBCPHD) to follow evidence-based guidelines for the medical management of their patients.

**PURPOSE**

To document the source of the evidence based guidelines used by the providers in the SBCPHD. Clinical protocols and guidelines are developed to guide clinician decision making about appropriate health care for specific clinical circumstances. The use of these clinical practice guidelines helps reduce practitioner variation in diagnosis and treatment.

Certain medical conditions, such as diabetes, have a high prevalence in our patient population. For these very prevalent disorders we provide guidelines to our clinicians to support appropriate treatment. The selection of clinical protocols and/or practice guidelines is based on relevance to the SBCPHD patient population

<p>Santa Barbara County  <b>PUBLIC Health</b>    DEPARTMENT</p>	<p><b>Number: 97-C-048</b></p>
<p><b>Prepared By: Margaret Dodds, Supervising MD,  Franklin/Carpinteria HCCs</b></p>	<p><b>Effective Date: 8/28/2019</b></p> <p><b>Original Date: 1/1997</b></p>
<p><b>Authorized By: Douglas Metz, MPH, DPM, Deputy  Director PCFH, Polly Baldwin, MD, Medical  Director</b></p>	<p><b>Next Review Date: 8/28/2020</b></p>
<p><b>TITLE: Child Abuse and Statutory Rape Reporting</b></p>	

**POLICY**

Public Health Department clinics shall comply with California Penal Code Sections 261.5, 288 and 11164-11167.5. These laws require any Health Practitioner or other mandated reporter who, in his/her professional capacity or within the scope of his/her employment, has knowledge of or observes a child whom the mandated reporter knows or reasonably suspects has been the victim of child abuse, neglect, sexual abuse or statutory rape must make a report to the local child protective services agency.

**PURPOSE**

Santa Barbara County Public Health Department values the safety and well-being of children. This policy is to insure compliance with child abuse reporting laws. A mandated reporter who fails to report under this law is guilty of a misdemeanor punishable by up to six months confinement in the county jail, a fine of \$1,000 or both.

<p>Santa Barbara County</p>  <p><b>PUBLIC Health</b> DEPARTMENT</p>	<p><b>Number: 99-C-131</b></p>
<p><b>Prepared By: Douglas Metz, MPH, DPM, Deputy Director PCFH</b></p>	<p><b>Effective Date: 08/28/2019</b></p> <p><b>Original Date: 4/1/2005</b></p>
<p><b>Authorized By: Douglas Metz, MPH, DPM, Deputy Director PCFH</b></p>	<p><b>Next Review Date: 08/28/2020</b></p>
<p><b>TITLE: Grievance Procedure for CenCal Health</b></p>	

**POLICY**

All Public Health Department Clinics will comply with the CenCal Member Grievance Procedure.

**PURPOSE**

To provide CenCal Members a process by which they can file a complaint or appeal with CenCal.

 <p>Santa Barbara County <b>PUBLIC Health</b> DEPARTMENT</p>	<p><b>Number: 14-C-596</b></p>
<p><b>Prepared By: Lynn Fitzgibbons, MD</b></p>	<p><b>Effective Date: 08/28/2019</b></p> <p><b>Original Date: 09/17/2014</b></p>
<p><b>Authorized By: Polly Baldwin, MD, Medical Director</b></p>	<p><b>Next Review Date: 08/28/2020</b></p>
<p><b>TITLE: HIV Universal Testing and HIV Pregnancy Screening</b></p>	

**POLICY**

Screening and testing for human immunodeficiency virus (HIV) infection is an important aspect of comprehensive clinical and public health services.

**PURPOSE**

The Santa Barbara County Public Health Department recommends HIV testing according to the Center for Disease Control and Prevention (CDC) guidelines,

For patients in all health-care settings:

- HIV screening is recommended for patients in all health-care settings after the patient is notified that testing will be performed unless the patient declines (opt-out screening).
- Persons at high risk for HIV infection should be screened for HIV at least annually.
- Separate written consent for HIV testing should not be required; general consent for medical care should be considered sufficient to encompass consent for HIV testing.
- Prevention counseling should not be required with HIV diagnostic testing or as part of HIV screening programs in health-care settings.

For pregnant women:

- HIV screening should be included in the routine panel of prenatal screening tests for all pregnant women.
- HIV screening is recommended after the patient is notified that testing will be performed unless the patient declines (opt-out screening).
- Separate written consent for HIV testing should not be required; general consent for medical care should be considered sufficient to encompass consent for HIV testing.
- Repeat screening in the third trimester is recommended in certain jurisdictions with elevated rates of HIV infection among pregnant women.

<p>Santa Barbara County  <b>PUBLIC Health</b>    DEPARTMENT</p>	<p><b>Number: 19-C-645</b></p>
<p><b>Prepared By: Janice J Payment, CPC, Health Care Program Coordinator</b></p>	<p><b>Effective Date: 08/28/2019</b></p> <p><b>Original Date: 08/28/2019</b></p>
<p><b>Authorized By: Suzanne Jacobson, CPA, Chief Financial Officer</b></p>	<p><b>Next Review Date: 08/28/2020</b></p>
<p><b>TITLE: Auditing – Provider, Program and Requirement Internal Auditing</b></p>	

**POLICY**

It is the policy of The County of Santa Barbara, Public Health Department that all clinical staff providing services must document and bill their services in compliance with all Federal, State and Local guidelines. It is our policy to perform internal auditing and motoring of clinical documentation supporting coding and billing rendered by both employed and contracted clinical staff, that provide and bill for services in our Health Care Centers and Homeless Shelters.

**PURPOSE**

The Office of Inspector General (OIG) has issued compliance guidance for healthcare providers which emphasizes the importance of self-audits to ensure that medical records and billing comply with applicable coding, billing and documentation requirements. The purpose of this policy is to outline The Public Health Department’s policy and procedures for the auditing and monitoring of clinical documentation, coding and billing of clinical services.

<p>Santa Barbara County  <b>PUBLIC Health</b>    DEPARTMENT</p>	<p><b>Number: 04-C-206</b></p>
<p><b>Prepared By: Paola Hurtado, SBHCC HCA</b></p>	<p><b>Effective Date: 8/28/2019</b></p> <p><b>Original Date: 5/16/2019</b></p>
<p><b>Authorized By: Dr. Douglas Metz, Deputy Director, PCFH; Dr. Polly Baldwin, MD Medical Director</b></p>	<p><b>Next Review Date: 8/28/2020</b></p>
<p><b>TITLE: Walk-In Clinics at Health Care Centers</b></p>	

**POLICY**

It is the policy of the Public Health Department Health Care Centers to offer same day, urgent and walk in appointments for their patients whenever possible

**PURPOSE**

To serve the needs of patients who have an urgent medical problem and cannot wait for a future appointment with their Primary Care Physician.

<p>Santa Barbara County  <b>PUBLIC Health</b>    DEPARTMENT</p>	<p><b>Number: 13-C-585</b></p>
<p><b>Prepared By: Janette Avina, R.N., and Melissa Gomez, R.N., Performance Improvement Coordinators.</b></p>	<p><b>Effective Date: 9/25/2019</b></p>
<p><b>Authorized By: Polly Baldwin MD, Medical Director</b></p>	<p><b>Original Date: 4/1/2013</b></p>
<p><b>TITLE: 24/7 Access to Clinical Advice</b></p>	<p><b>Next Review Date: 9/25/2020</b></p>
<p><input checked="" type="checkbox"/> Approved by Santa Barbara Health Center Board on 9/26/18 (See Board Meeting minutes)</p>	

**POLICY**

The Santa Barbara County Public Health Department (PHD) will provide a timely response to patients calling in or messaging for clinical advice both during and after office hours.

**PURPOSE**

- To establish guidelines for the Center response during and after business hours
- To establish processes for recording and communicating responses to the care team
- To provide access to patients for acute issues that cannot wait until regular business hours

MEETING DATE: 8/28/19

AGENDA ITEM NO.: VII.3

**HEALTH CENTER BOARD  
PUBLIC HEALTH DEPARTMENT**

Date: August 20, 2019  
To: Health Center Board  
From: Dr. Polly Baldwin  
Subject: Approval of Provider Appointments

**RECOMMENDATION:**

That the Board: Vote to approve the initial appointment of

- Keith Dillon, MD OBGYN-Santa Maria Health Care Center



**DISCUSSION/BRIEF SUMMARY OF ITEM:**

Provider has been approved by Board Delegate.

MEETING DATE: August 28, 2019

AGENDA ITEM NO.: VII.4

**HEALTH CENTER BOARD  
PUBLIC HEALTH DEPARTMENT**

Date: 8/28/19

To: HC BOARD

From: Melissa Gomez

Subject: Quality Update-2019 monthly quality improvement measures update (July data)

**RECOMMENDATION:** For HC Board review.

**DISCUSSION:**

This is the monthly review of the quality measures selected by the medical quality team for the annual performance improvement plan.

# Monthly Medical Quality Update performance improvement measures 2019

Melissa Gomez RN CCM 8/2019

SBCPHD



*Quality Improvement*



# Measures for Improvement 2019

- Diabetes Control
- Asthma with appropriate medication
- Hypertension
- Depression screening and intervention
- Breast cancer screening(Mammography)
- Patient satisfaction with wait time(in clinic)-  
crossroads quarterly report

Performance Measure 2019 EPIC(07/31/18 to 07/31/19)	Patients		Percentage	Homeless		Percentage Homeless	Goal	HRSA 2017 National
	Total			Total				
Hga1c 9 or less	2022		68.50%	92		57.86%	73.00%	67.05%
	2952			159				
Asthma- persistent asthma and on controller medication	324		84.38%	15		79.95%	85.00%	86.62%
	384			19				
Hypertension- Blood Pressure controlled with last BP less than 140/90	2886		57.75%	128		39.63%	70.00%	62.71%
	4997			323				
Depression Screening with intervention if screening is positive	6091		39.89%	455		52.42%	25%(internal goal 60%)	66.15%
	15269			868				
Mammography -women 50-74 q2 years(EPIC FY1819 Q4 7/1/18-6/30/19)	1703		55.74%	40		25.00%	59%	58.0%
	3055			160				

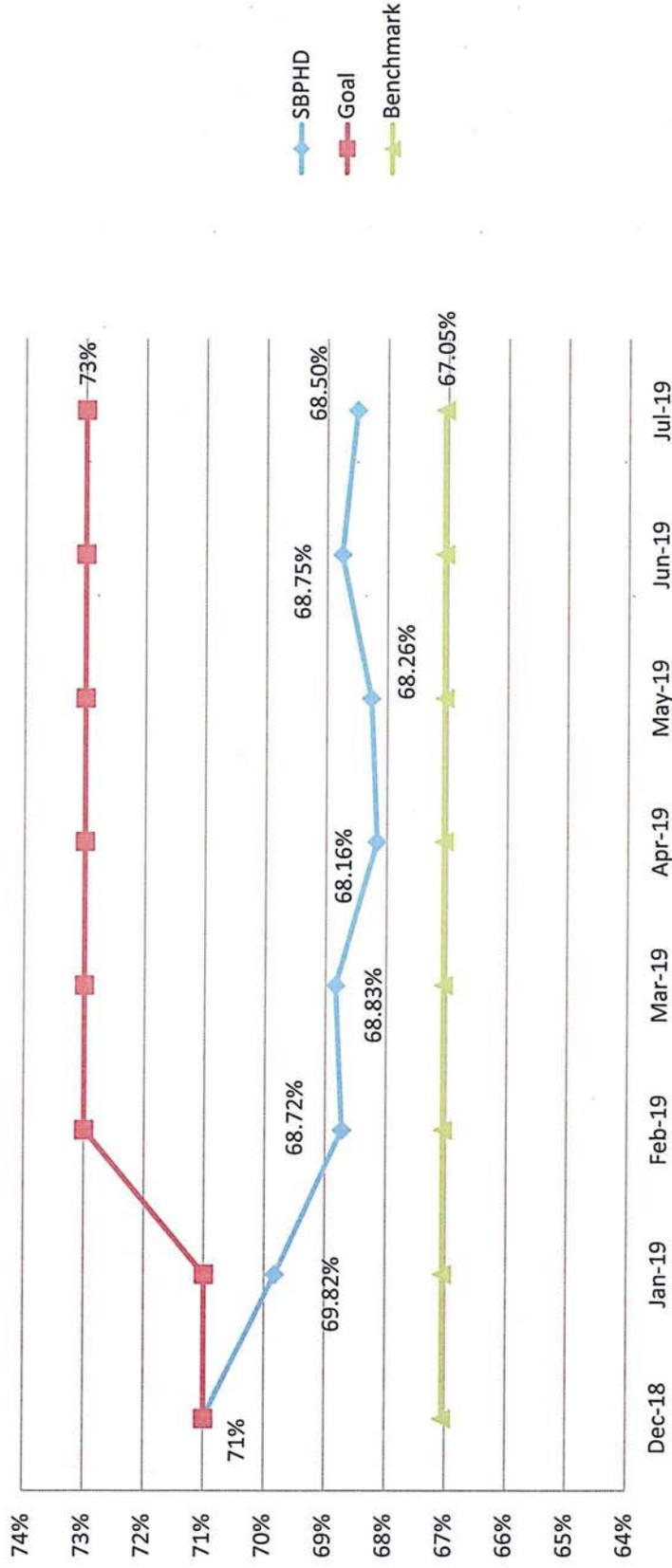
SBCPHID



Quality Improvement

Diabetes control has remained fairly stagnant, The DM group education visits have begun happening at FHCC. Both FHCC and CHCC have begun working on identification of patients who might benefit from increased care management, DM education and DM clinic visits. The HCC compliance is above the benchmark and we will continue to work towards increased compliance.

### Diabetes A1c control

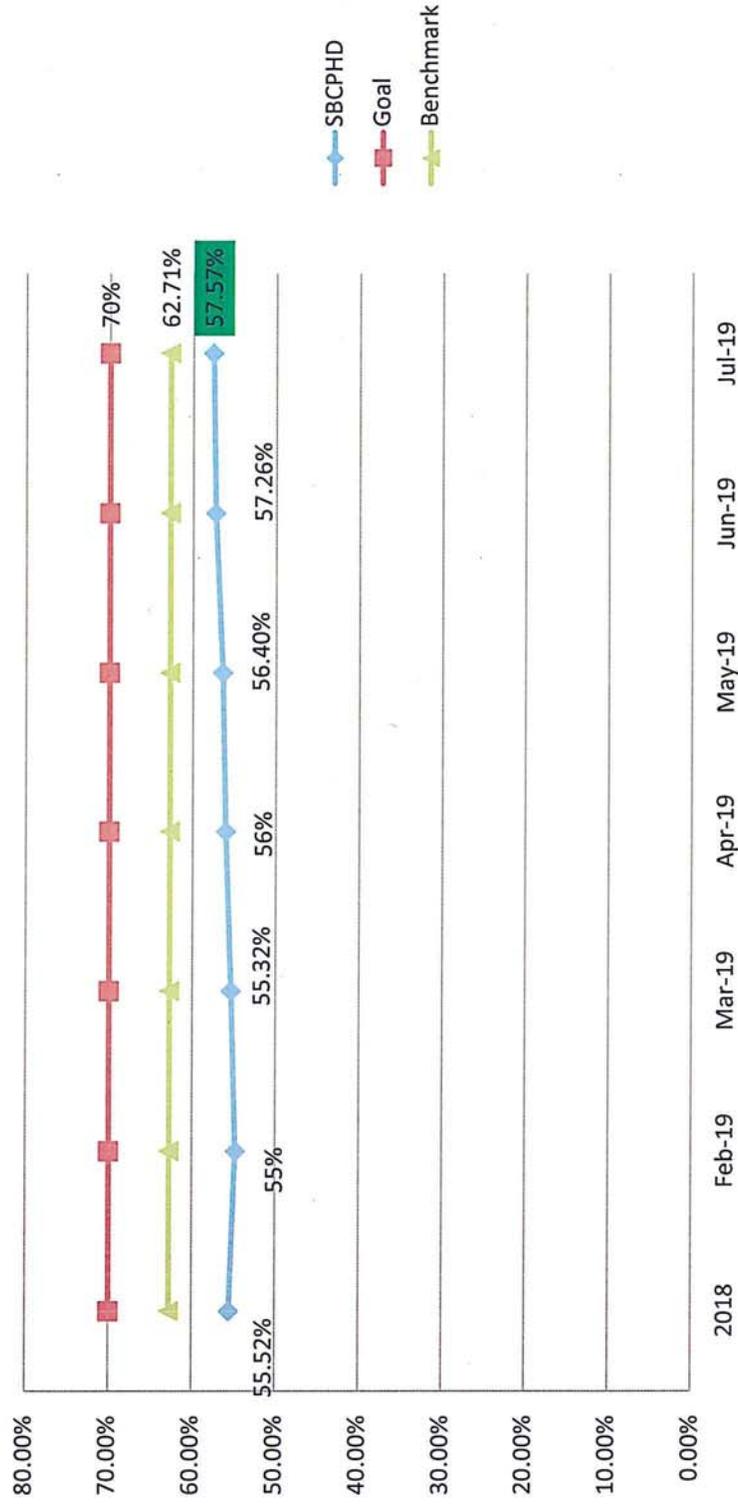


We have seen over a 5% improvement in this measure since the start of the year- 2.5% in just the past month! As the EHR staff and the providers continue to work on improved asthma action plans and training on diagnosis codes we should see ongoing improvement.



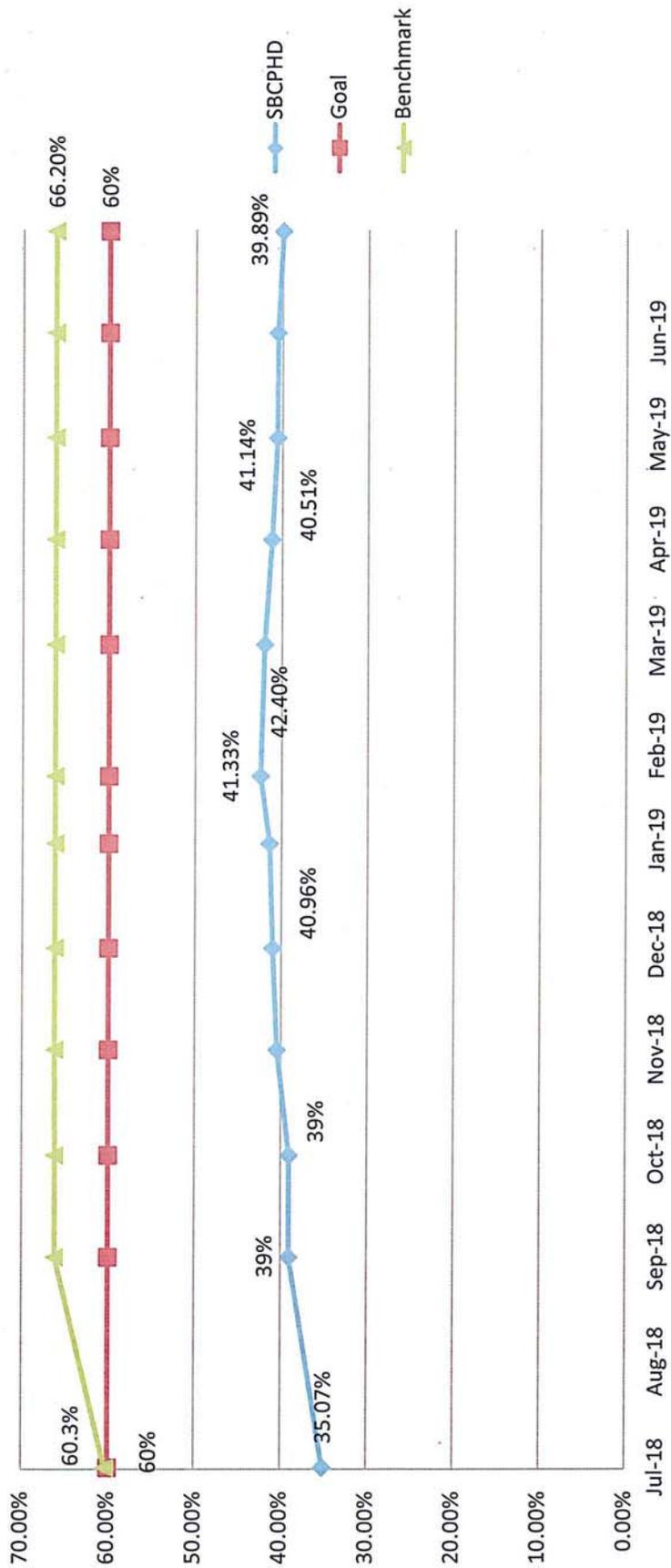
There has been a 2% improvement from the start of the year

## Hypertension

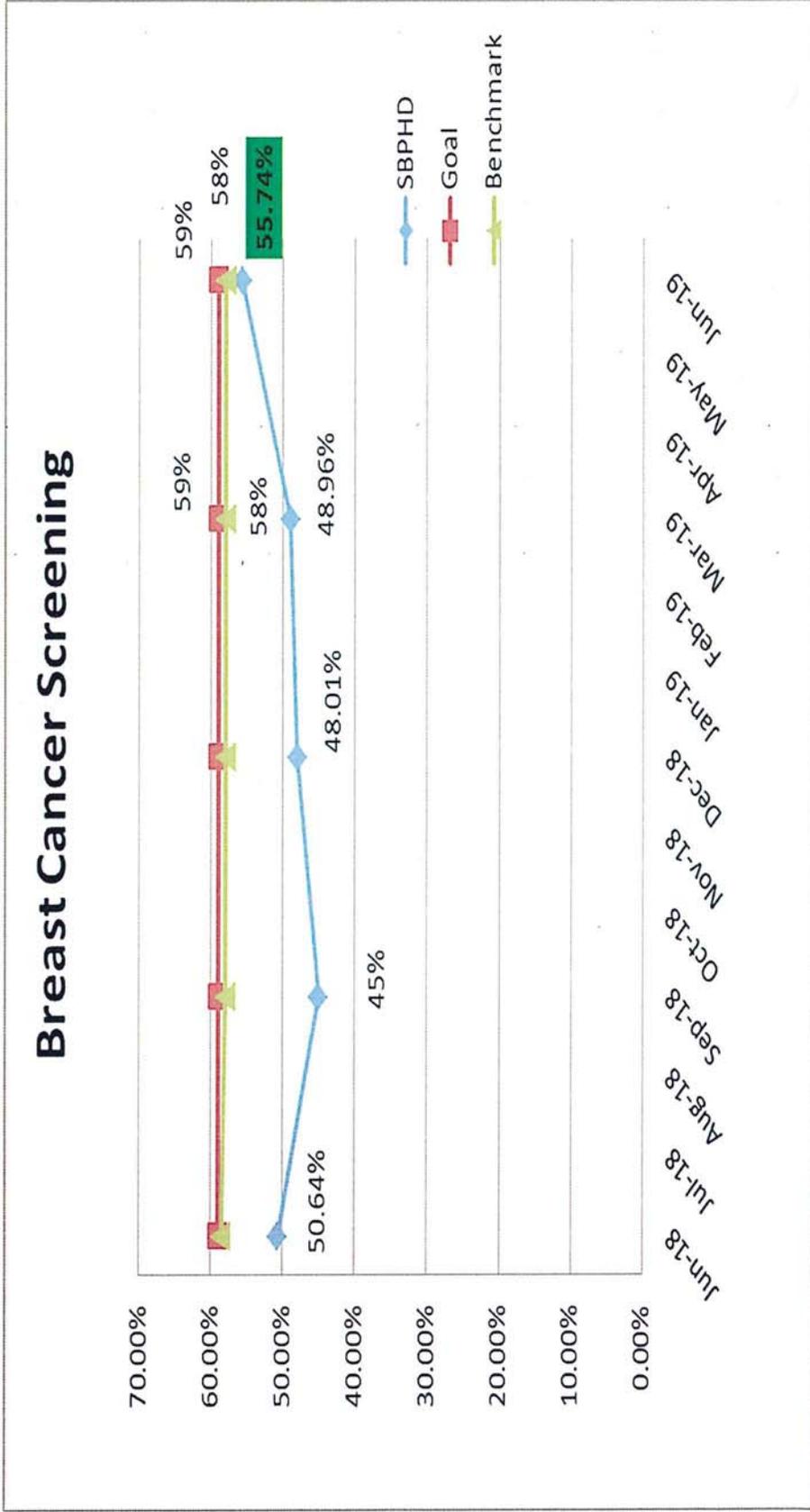


Even as several HCC's have been working specifically on this measure and have seen HUGE improvements, as a whole, this measure has remained stagnant this year. These results have been reviewed at MPC with providers, and with HCC staff. All have been reminded that all eligible patients should have screening completed, not just those with a PCP visit.

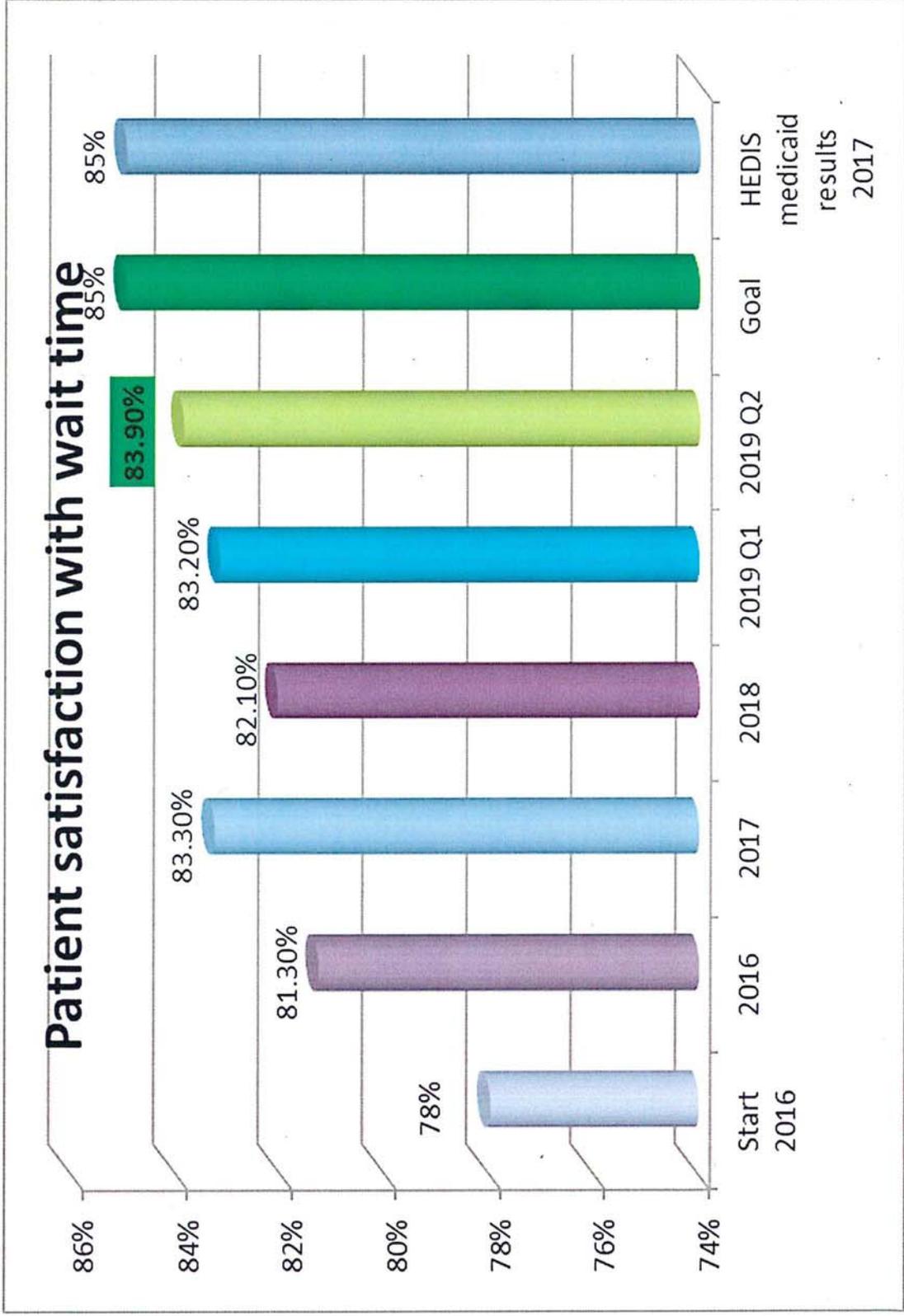
### Depression Screening and intervention



SBHCC and FHCC have been focused on this measure and we have seen an over 7% improvement so far this year! This will continue to be a focus and we anticipate ongoing improvement!



# Patient satisfaction with wait time





# Plan

- Increased care management at FHCC and CHCC of patients with A1c greater than 9%
- Ongoing QI work on Mammography compliance
- Review of workflow for depression screening and intervention
- Continued Care team work on Asthma action plans.

MEETING DATE: 08/28/2019

AGENDA ITEM NO.: VII.5

**HEALTH CENTER BOARD  
PUBLIC HEALTH DEPARTMENT**

Date: 08/28/2019

To: Health Center Board

From: Douglas Metz

Subject: Executive Director's Standing Report

**RECOMMENDATION:**

No action required – Submitted as Executive Director's monthly report to the Board.

**DISCUSSION/BRIEF SUMMARY OF ITEM:**

N/A

**Date:** Wednesday, August 28, 2019  
**To:** Health Center Board of Directors  
**From:** Dr. Douglas Metz, Executive Director, Health Centers  
**RE:** E.D. Report

Focus Area	Monthly Highlights
<b>Health Center Operations</b>	
<ul style="list-style-type: none"> <li>● <b>HRSA Relations</b> (Ralph Barbosa, Dana Gamble)</li> </ul>	<ul style="list-style-type: none"> <li>▪ Next HRSA requirement will be the SAC grant continuation application in September, 2019</li> <li>▪ SAC Planning Meeting / Preparations</li> <li>▪ IBHSS Supplemental Funding Received! \$167K ongoing additional funding for BH staff use</li> <li>▪ UDS Planning Meetings (2018 review, 2019 preparations)</li> </ul>
<ul style="list-style-type: none"> <li>● <b>Santa Barbara</b> (Paola Hurtado)</li> </ul>	<ul style="list-style-type: none"> <li>▪ SBHCC Leadership Team developed new process for Santa Barbara Cottage Hospital Follow-up appointment calls</li> <li>▪ Began monthly training for Front Office Team with a focus on customer service, Change Management &amp; Conflict Resolution etc.</li> <li>▪ Facilitated HIPAA Privacy annual training at All-Staff meeting</li> <li>▪ Planning for expanded Franklin NHCW Event</li> </ul>
<ul style="list-style-type: none"> <li>● <b>Franklin</b> (Elvia Lopez)</li> </ul>	
<ul style="list-style-type: none"> <li>● <b>Carpinteria</b> (Interim: Elvia Lopez)</li> </ul>	<ul style="list-style-type: none"> <li>▪ Carp HCA Daniel Denhalter resigned position as of 8/8</li> <li>▪ Recruitment began for new Carp HCA month of August</li> <li>▪ Elvia Lopez to serve as Interim HCA at Carp until new hire – Dana, Dr. Metz, Paola to help out by spending 1 day a week at Carp until permanent replacement found</li> </ul>
<ul style="list-style-type: none"> <li>● <b>Santa Maria</b> (Michael Camacho-Craft)</li> </ul>	<ul style="list-style-type: none"> <li>▪ Initiated EyePACS Implementation Planning</li> <li>▪ Reviewed Quarterly Patient Satisfaction at All Staff meeting</li> <li>▪ Established Outreach with residents of Good Sam’s SAFE program</li> <li>▪ Continued Efficiency Discussion with All Staff</li> </ul>
<ul style="list-style-type: none"> <li>● <b>Lompoc</b> (Jeanie Sleight)</li> </ul>	<ul style="list-style-type: none"> <li>▪ HCA met with IAPC Project Team to develop requested Pilot Program</li> <li>▪ Hosted the new CEO and Chief of Medical Staff of Lompoc Valley Medical Center for Partnership Meeting and tour of LHCC</li> <li>▪ Held a Farewell Pot Luck for Dr. Annette Ndagano, Pediatrician – began recruitment for her replacement</li> </ul>
<ul style="list-style-type: none"> <li>● <b>Healthcare for the Homeless</b> (Ralph Barbosa)</li> </ul>	<ul style="list-style-type: none"> <li>▪ Homeless Death Review Team Meetings and Data Collection continue</li> </ul>
<ul style="list-style-type: none"> <li>● <b>Pharmacy</b> (Carol Millage)</li> </ul>	<ul style="list-style-type: none"> <li>▪ Started the training and implementation process on the new law for USP 800 for pharmacy staff. USP 800 relates to the handling of hazardous drugs in health settings</li> <li>▪ New IVR first stage of implementation. IVR is a phone software system that interfaces with the pharmacy software for patient requested refills and a phone tree</li> </ul>
<ul style="list-style-type: none"> <li>● <b>Clinical Lab</b> (Linda Weisman)</li> </ul>	<ul style="list-style-type: none"> <li>▪ Linda Weisman began medical leave 4-6 weeks; trained Dana, Joy and Helen how to keep the Lab running in her absence in August and September</li> </ul>

<ul style="list-style-type: none"> <li>• <b>Health Information Management / HIPAA / Data Security</b> (Dana Gamble, June English, Laura Lui)</li> </ul>	<p><b>Privacy</b></p> <ul style="list-style-type: none"> <li>▪ County-wide Privacy Meeting on 7/25</li> <li>▪ Data Sharing Committee meetings to review proposals (multiple)</li> <li>▪ Complytrack updates of ongoing investigations</li> <li>▪ Notification to BA Cottage Privacy regarding various faxes/emails of unknown patients that had been sent to SBHCC in error. Also sent attestations of confidentiality from all of our staff who had viewed the documents. They are investigating.</li> </ul> <p><b>Training</b></p> <ul style="list-style-type: none"> <li>▪ 2019 Training for HIPAA and Compliance - Launch trainings and begin sending reminders to supervisors with lists of trained employees</li> </ul>
<ul style="list-style-type: none"> <li>• <b>PCMH</b> (Karla Quintana, Melissa Gomez, Polly Baldwin, Doug Metz)</li> </ul>	<ul style="list-style-type: none"> <li>▪ Nothing new to report</li> </ul>
<ul style="list-style-type: none"> <li>• <b>Customer Service</b> (Health Center Administrators)</li> </ul>	<ul style="list-style-type: none"> <li>▪ Nothing new to report</li> </ul>

**PATIENT VOLUME REPORT\***

July 2019

Site	"Billable" Visits This Month	Visits Last Month	Unique Patients This Month	Unique Patients Last Month	Notes
Carpinteria HCC	581	550	454	436	July = 22 clinic days 26 visits / day
Franklin HCC	1,126	889	869	731	51 visits / day
Franklin Elementary School Clinic (1 evening/wk)	0	0	0	0	(School is out)
Santa Barbara HCC	2,200	2,101	1,515	1,502	100 visits / day
Lompoc HCC	3,040	2,552	2,254	1,962	138 visits / day
Santa Maria HCC	2,372	2,150	1,504	1,374	108 visits / day
Homeless Shelters (3 sites combined)	139	149	113	110	
Outside Sites: PHN Home Visits, Hospital, Deliveries, SNF, etc.)	134	112	127	111	
<b>TOTALS</b>	<b>9,592</b>	<b>8,503</b>	<b>6,836</b>	<b>6,226</b>	Note: July pt. visits/day = 436, a 3% increase over last month, but well short of the monthly target of 509 by 14%
% difference of pts/day from previous month	3% Increase of daily pts over last month				

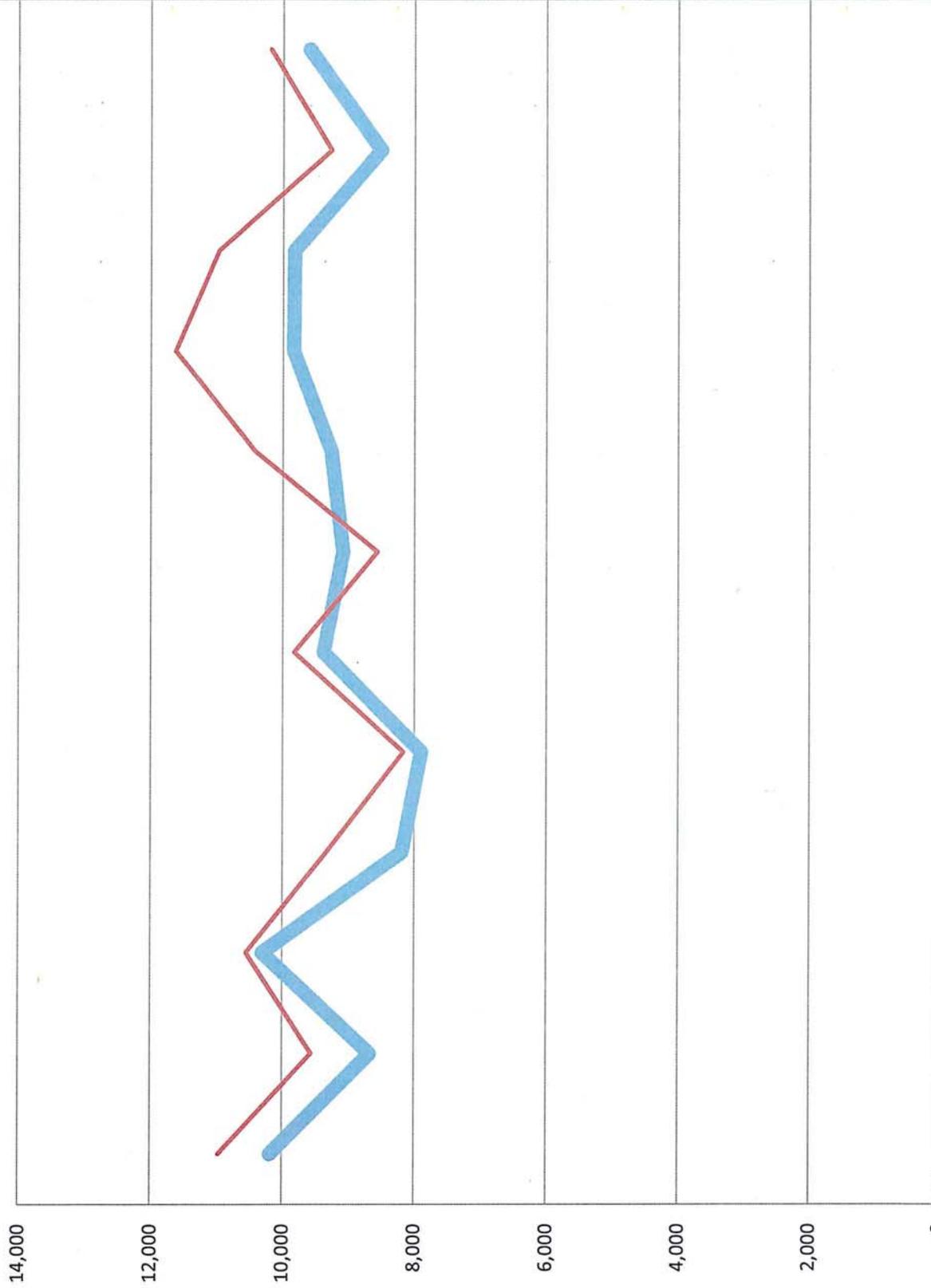
\*Preliminary reporting from the new system – monthly data not fully verified and may differ from 10-15% from actual numbers

**CLINIC OPERATIONAL MEASURES REPORT (ACROSS ALL SITES)\***

Metric	Current Benchmark	Actual This Month	Last month	Notes
Pt visits / Clinical FTE	16 overall visits / 1.0 clinical FTE	Epic Reporting System not yet available		Epic Reporting System not yet available
% of unfilled appointment slots	<10%, not counting purposely unfilled "day-of" open access slots)			Epic Reporting System not yet available
No show rates	<15%	Avg. across all sites = 17%	Avg. across all sites = 16%	
"Third Next Available" (TNAA) Appointment	< 14 days	~17 days (average across all sites)	~17 days (average across all sites)	These reports are not yet verifiable from Epic
Clinic Waiting Time (Cycle Time: registration to provider visit)	< 45 min.	*	*	These metrics will be automated in Epic; not yet reliable enough to be reportable

\*Some metrics reports are still being written for the new system

# Patient Visit Trending Over 12 Months



	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul
Visits-actual	10,182	8,668	10,299	8,184	7,891	9,379	9,080	9,262	9,836	9,824	8,503	9,592
TARGETS	10,967	9,562	10,551	9,336	8,171	9,829	8,561	10,418	11,623	10,969	9,265	10,186