Parkland

HOMES
Agenda

Agenda for the ***Board of Managers HOMES*** meeting of the Dallas County Hospital District is scheduled for ***Wednesday, October 26, 2022 at 12:30 PM*** at 5200 Harry Hines Blvd (WISH Building) Dallas, TX 75235, Conference Room 02-175. (If assistance is needed in locating the room, please see the Administration receptionist on the 4th floor, 04-131.) A quorum will be physically present at the location of the meeting. Videoconferencing access is also possible via Webex. That application is available at https://www.webex.com/downloads.html. Teleconferencing access is possible by calling +1-415-655-0001. Both virtual access forms require inputting (meeting number: 2624 503 3731; meeting password: 1234) to join the meeting. The ***Board of Managers HOMES*** reserves the right to exercise discretion and may convene in Executive Session as permitted by Texas Government Code §§551.071 (consultation with attorney), 551.072 (deliberations regarding real estate), 551.074 (personnel matters), 551.076 (deliberations regarding security devices or security audits), 551.078 and/or 551.0785 (deliberations by medical committee or by governmental body that administers a public insurance, health or retirement plan regarding individuals' medical or psychiatric records), 551.085 (deliberation by governing board of certain providers of health care services), 551.087 (deliberation regarding economic development negotiations), 551.088 (deliberation regarding test item); Texas Government Code §418.183 (deliberation of information under §§418.175 – 418.182 for purposes of disaster management or disaster planning); Texas Health & Safety Code §161.032 (medical committee or medical peer review committee records, information or reports; and/or medical committee or medical peer review committee proceedings under Tex. Health & Safety Code Chapter 161 and/or Tex. Occ. Code Chapters 151 and 160); and/or as otherwise authorized by law on any item listed below. The ***Board of Managers HOMES*** may consider any of the agenda items in open or executive session and may continue the meeting as necessary to accomplish the business at the time and place designated by the Chair to reconvene.

		PAGE	TIME (MIN)	PRESENTER(S)
I.	**Declare a Quorum Present/Call to Order/Mission Statement** ***Advance Wellness | Relieve Suffering | Develop and Educate*** **I CARE** **I**ntegrity **C**ompassion and Collaboration **A**ccountability **R**espect **E**quity **Public Comments Regarding Agenda Items** *See public comment registration information and rules at* *https://www.parklandhospital.com/board-of-managers*			Chair
II.	**Consent Agenda**			
A.	Approve Minutes 2022-09-28 HOMES	2	1	Chair
B.	Approve Minutes 2022-10-10 HOMES Advisory Board	6		
III.	**Reports Requiring Deliberation(s) or Approval(s)**			
A.	Operations Update	12	2	Kyla Rankin
B.	Management and Finance Update	14	2	
C.	Governance Update	15	2	
D.	Quality Improvement Update	16		
E.	HRSA Compliance Manual Requirements: The Big 20	24	3	
F.	HRSA Compliance Manual Requirements - Chapter 10: Quality Improvement Assurance Plan	28	3	
G.	Approve Homeless Outreach Medical Services (HOMES) QAPI	31	1	
H.	Approve HOMES Billing and Collections	40	1	
IV.	**Action Items**			
A.	Board May Take Action on Any Agenda Item(s) Above			Chair
V.	**Adjourn**			
A.	Closing Remarks			
B.	Call to Adjourn			

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Approve Minutes 2022-09-28 HOMES

Parkland

MINUTES

Dallas County Hospital District Board of Managers

HOMES
September 28, 2022

Minutes of the Board of Managers HOMES meeting of the Dallas County Hospital District, held Wednesday, September 28, 2022, scheduled for 12:30 p.m. in the WISH Building Conference Room (02-175) at Parkland Health and via WebEx. These minutes do not constitute a certified agenda from the meeting.

I. Attendance and Call to Order

Chair Marjorie Petty, JD, noted that a quorum was physically present and called the meeting to order at 12:50 p.m.

Board Member attendees included: Chair Marjorie Petty, JD; Eric G. Bing, MD, PhD; Todd Furniss, JD; Ramon Miguez, PE; Farida Minner, RN; and Elizabeth Palacios, MD. Board member Lisa Sutter attended via Webex.

Board members Reina Gonzalez, JD; John Proctor; Don O'Bannon, Esq; and Jeff Tillotson, JD; were not present.

Staff Present (via Webex and in-person) included:

Donna Richardson, EVP & Chief Nursing Executive (in-person)
Edmundo Castañeda, EVP & Chief Operating Officer (in-person)
Forrest Stovall, Governance Program Manager (in-person)
Fred Cerise, President & Chief Executive Officer
Kyla Rankin, HOMES Project Director (in-person)
Pamela Bryant, SVP & Chief Supply Chain Officer
Rick Humphrey, EVP & Chief Financial Officer
Roberto de la Cruz, EVP & Chief Clinical Officer (in-person)
Saul Cordero, VP & Chief Governance Officer (in-person)
Steven Roth, EVP & Chief Legal Officer (in-person)
Vic Summers, SVP & Chief Audit Officer

Other Attendees:
Paula Dobbs-Wiggins, Former Board of Managers Member
Remigio Acevedo Obregon, Sr. ICU RN

II. Mission Statement

Chair began the meeting by stating the mission statement:
Advance Wellness | Relieve Suffering | Develop and Educate

III. Public Comments Regarding Agenda Items

No members of the public registered for comments regarding the agenda items.

IV. Conflicts of Interest

After review of the agenda, the Chair noted zero conflicts of interest for Board Members present.

V. Consent Agenda

A. Approve Minutes 2022-08-24 HOMES

Ramon Miguez, PE, motioned for the approval of the Consent Agenda. Elizabeth Palacios, MD, seconded the motion. The motion passed unanimously.

VI. Reports Requiring Deliberation(s) or Approval(s)

The Board received information for the following updates presented by HOMES Project Director Kyla Rankin.

A. Operations Update

Kyla Rankin first reported on HOMES' staffing. HOMES has 6.5 FTEs currently posted. One driver accepted an offer and, as an update to the slides, one dental assistant accepted an offer. HOMES is providing COVID-19 and Monkeypox vaccines and will continue vaccine campaigns with existing community partners moving into the fall.

Kyla provided an update on new site partners. The Deflection Center is operational and has seen less than ten patients as of the meeting. There are monthly meetings with the deflection center team to discuss increasing volume. Catholic Charities-St. Jude clinic operations will begin in October rotating between their two permanent supportive housing sites.

HOMES is relocating its mobile medical units & mobile operations to a new site. Clinic operations will close briefly for the move. A new sprinter unit is also expected to arrive in the next month. Lastly, one of the new mobile units was recently in an accident. The mobile unit was drivable and damage appears to be mostly cosmetic, but the mobile unit is currently in the automotive shop being serviced. No staff were harmed in the accident and the driver was not at fault.

The Board asked questions and received additional information related to the Operations Update. The Board also asked questions and received additional information related to the mobile unit accident.

B. Management and Finance Update

Kyla Rankin shared that HOMES has seen 5,892 patients this year, which is 61% of the goal. She does not expect to meet the unduplicated patient goal. Kyla expects overtime to decrease with the recent addition of a new driver and dental assistant.

The Board asked questions and received additional information as to whether HOMES will offer flu vaccines in addition to COVID-19 & Monkeypox vaccines.

C. Governance Update

The next HOMES Advisory Board is Monday, October 10, 2022. The meeting will be held in-person and virtually. Kyla has assessed membership by contacting current

members via telephone. If members were not present at the August Advisory board meeting, Kyla also informed them of proposed bylaws amendments via telephone. Kyla will begin actively recruiting for new Advisory Board members to increase input and participation on the board.

D. HRSA Compliance Manual Requirements: The Big 20
Kyla Rankin reviewed The Big 20 manual.

E. HRSA Compliance Manual Requirements: Chapter 11: Key Management Staff
Kyla Rankin reviewed Chapter 12: Key Management Staff. She reported on the HRSA requirements and how HOMES demonstrates compliance with the HRSA requirements. Kyla reviewed the key personnel positions and the overall organizational chart of HOMES.

VII. Adjourn

With no further business to discuss, Chair Marjorie Petty, JD, adjourned the meeting at 12:59 p.m.

SO RECORDED:

Marjorie D. Petty, JD	Steve Roth, JD, MPH
Chair	Assistant Secretary

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Approve Minutes 2022-10-10 HOMES Advisory Board

HOMES ADVISORY BOARD
MEETING MINUTES

Date: 10/10/2022 **Time:** 1200 **Location:** Webex

Facilitators: Kyla Rankin

Attendees							
X	Kyla Rankin	x	Benita Grant				Saul Cordero
	Sara Galvez	X	Forrest Stovall		Latisha Blair		Guadalupe Ramirez
	Dolores Diaz		W.R. Cunningham		Pink Elke	X	Donna Persaud
x	Farida Miner	x	Margie Roberts (virtual)		Moyinoluwa Ajibade	x	Elfrieda Cole (virtual)
	Dennis Thomas	X	Wanda Wonzer		Marjorie Petty		Trudy Hernandez
Guests							
x	Michael Gilot	x	Queen Jeffery (virtual)				

	Agenda Item/ Presenter	Discussion	Action items
	Approval of August Minutes	- Minutes were approved by Wonda Wonzer and second by Farida Miner	
	Introductions	- Introduction of 2 guests-Michael Gilot and Queen Jeffery	
	Staffing	- Kyla discussed the 5.5 open positions and noted that 3 new staff are set to onboard.	
	Operations	- COVID/Monkeypox – we have given 5,301 doses of COVID. Monkey pox cases have slowed down. Ms. Wonzer asked if there is a certain type of people that get monkey pox and Dr. Persaud explained the criteria to her. Dr. Persaud also explained about how the smallpox vaccine that was given in the 50's and the monkey pox vaccine now both leave an ulcer on your skin. - Flu vaccine campaign has started, HOMES is collaborating with shelters, vaccine drives will be held, and the vaccine will be available at all sites. - Our dental mobile unit is currently running one day per week after being out of service due to lack of staffing. - EPIC Wisdom is set to go live on December 4th. The implementation process includes multiple weekly meetings. - We have been partnering with Housing Forward (formerly MDHA) to see patients at encampment decommissions. Housing Forward brings patients to the mobile clinics as part of their journey to housing. - Dallas County Deflection center is open, the volume has been lower than expected. We provide primary care two days and Deflection Center is open seven days a week (8:30AM – 9PM). The goal is with increased law enforcement education, the volume will increase - This week we will be moving out of our current shed location on Harry Hines and into our new temporary location on Butler. To complete the move, HOMES services will be closed on Thursday afternoon and resume on Monday afternoon.	

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HOMES ADVISORY BOARD
MEETING MINUTES

Date: 10/10/2022 **Time:** 1200 **Location:** Webex

Facilitators: Kyla Rankin

		- HOMES new sprinter vehicle will be delivered soon. This unit will typically be operated by two staff. It will most likely be a nurse and registration staff or it could be behavioral health staff. The goal is to increase our presence in street medicine. - We have started two new sites. One of the locations is in Grand Prairie where they have been requesting our services for a while. We have asked the Grand Prairie Health Center for some space. Using the Grand Prairie space, we can provide telehealth to patients in that area. The other site is St. Jude, operated by Catholic Charities. They have 2 permanent supportive housing sites; we will alternate locations each week. Behavioral health will also provide onsite services. St. Jude is very excited about the partnership.	
	Quality	- We are at 67% of our goal of unduplicated patients. We are ahead of where we were last year. HRSA is not going to penalize for not meeting our unduplicated goal. However, we need to continue to think of ways to move closer to the goal. - We had three safety posts. Two of them were two staff members tripping on rolling stools and fell. The third one was a person sleeping in his car at 4811 Harry Hines. Staff was worried if person was okay. Person was woken up and drove away. - One of the Environment of Care issues was the dust. - We implemented our new process at The Bridge to get more patient satisfaction surveys. September's data will not be accurate, an EVS staff accidentally threw away surveys that had been collected that were on an employee's desk. A safety post was placed for this incident.	
	HRSA Update	- ARPA grant expires March 2023. - Pathways Forward has kicked off and we are seeing patients at Salvation Army. - We have purchased a sprinter, 12 passenger van and a mobile unit. - EPIC wisdom is still work in progress and plans to go live in December 2022.	
	Advisory Board Bylaws	- Kyla had two proposed bylaw amendments. The first one is for Regular and Special Meetings and add that the December meeting will be a Joint Advisory Board meeting of all Parkland health centers. The second one is for Absence of Meetings. A member with three consecutive unexcused absences from regular scheduled Advisory Board meeting shall be deemed to have resigned. We will continue to have zoom meetings so that board members can easily attend. A motion was made to amend the bylaws. Ms. Miner motioned first and then Ms. Wonzer seconded the motion.	
	HOMES UBC	- UBC presented the idea of having an Employee of the Quarter. The first winner, Michelle Ukairo, RN was awarded at our September staff meeting. The votes were compiled via staff survey.	
	Next Meeting	- Our next meeting will be the COPC Joint Advisory Board on December 22, 2022. We will provide additional details closer to the meeting date.	

HOMES ADVISORY BOARD
MEETING MINUTES

Date: 10/10/2022 **Time:** 1200 **Location:** Webex

Facilitators: Kyla Rankin

	Miscellaneous	- Ms. Wonzer asked how long we will be at Butler location. Kyla responded March 2023. - Mr. Gilot asked if we could provide more information on the surveys like how many surveys were from 24 Hour club. Kyla said we can start providing that data. Mirna will also send a copy of the patient satisfaction survey to board as requested by Ms. Wonzer.	Copy of survey sent to advisory board members via email

The minutes, records and improvement activities operate under HB 4495b and the Texas Health & Safety Code, Sec. 161.031 & 161.032 affording protection from disclosure or discovery. Records of these committees are not public and are not subject to court subpoena. Records may be made available to persons who have a right to review the records and who are required to keep the information confidential.

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Homeless Outreach Medical Services Program Monthly Update Report – October 2022

Kyla Rankin, Project Director

Agenda

- Operational Updates
- Management and Finance
- Governance
- Quality Improvement/Assurance
- HRSA Compliance Manual Requirements: The Big 20
- Policy Approval
  - Quality Assessment and Performance Improvement
  - Billing and collections

Staffing

- Accepted
  - 1.0 FTE Dental Assistant
  - 1.0 FTE RN
- Posted
  - 1.0 FTE Driver
  - 1.0 FTE Dental Assistant
  - 1.0 FTE Peer Recovery Navigator
  - 1.0 FTE MPA
  - 0.5 FTE Business Intelligence Specialist (ARPA)
  - 1.0 FTE Social Work (ARPA)

Operations

- COVID/Monkeypox
  - vaccine and testing available
- Flu Outreach
- Sites
  - Grand Prairie-virtual visits
  - St. Jude
- Mobile Medical Units (MMUs)
  - Shed move

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Management & Finances – September 2022

Unduplicated	GY to Date	Annual Goal	% to Goal	% Year Complete
Patients	6529	9,675	67%	75%

FY	Month				Year to Date			
Metrics	Actual	Budget	Variance	% Var	Actual	Budget	Variance	% Var
Visits	3496	1755	1741	99.2%	37,264	25,302	11,962	47.3%
Expenses	$649,131	$602,752	($46,379)	-7.7%	$6,704,359	$7,365,080	$660,721	9.0%
Charges	$2,580,413	$864,886	$1,715,527	198.4%	$27,984,341	$12,469,138	$15,515,204	124.4%
Revenue	$11,994				$145,007			
Commercial	$0				$2023			
Medicaid	$7340				$98,454			
Medicare	$4654				$44,530			
FTE	58.46				56.40			
FTE - OT	1.38	0.71	(.67)	-93.8%	1.35	1.16	(0.19)	-16.6%

- HRSA recommendation is claims billed in less than 30 days.
- HRSA grant year: January 1, 2022 to December 31, 2022

Governance

- Advisory Board Meeting
  - Monday, October 10, 2022
  - 4 Advisory Board Members in attendance
  - 2 visitors
  - Next meeting: December 2022-Joint Population Health-date TBD

Quality Improvement / Assurance

- 3rd Quarter 2022 QA/QI data

COPC Metric Balance Score Cards Patient Care & Safety Audits

Measures	July 2022	Aug 2022	Sep 2022	Goal
Staff Safety Post	3	3	4	Information Only
Complaints	0	0	0	Information Only
Grievances	0	0	0	Information Only
2 Pt ID Error	100%	100%	100%	100.0%
Specimen Labeling	100%	100%	100%	100.0%
Hand Hygiene	100%	100%	100%	100.0%
Medication Reconciliation	97.6%	98%	98%	90.0%
Environment of Care	98%	89%	97.2%	Information Only
Patient Messages (1-5-7)	95.8%	94.2%	83.9%	90.0%

Clinical Quality Metrics

18 HRSA Metrics- National Quality Standards
YTD 2022 Summary Performance

8 measures above goal

- Most are same as waiver
- Includes pregnancy tracking; Low Birth Weight

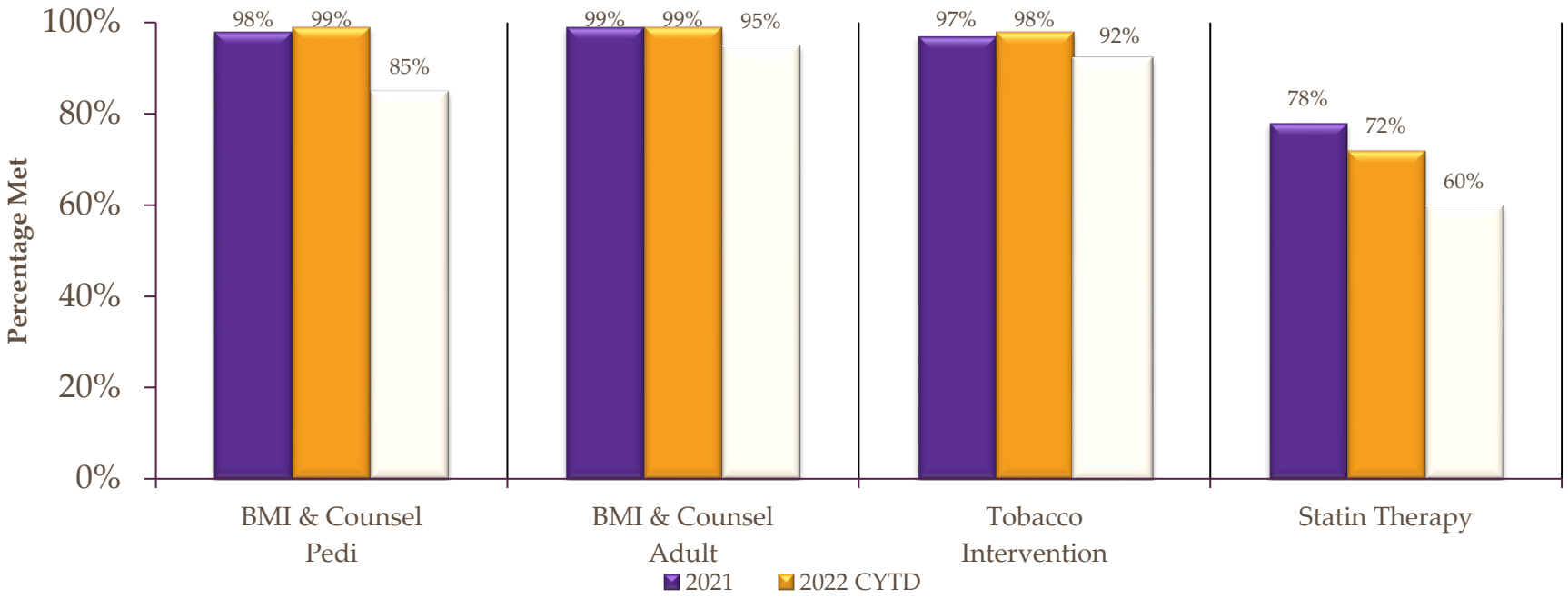
4 measures YOY improvement, without goal established

- Breast cancer screen, HIV testing, Dental Sealants, Depression Remission at 12 months

6 measures need improvement

- Use of Aspirin or Antiplatelet
- Depression Remission at 12 months (new measure, no goal, documentation opportunities)
- Depression: Screening & Follow-up (Planning PI project with HOMES Clinical Psychologist Dr. Fisher, documentation opportunities)
- Hypertension Control 50% vs Target 55% (Approved Hypertension Chart review)
- Pregnancy tracking; prenatal care 1st trimester
- Childhood Immunization Status

HRSA Quality Measures at or above Goal 1 of 2 YTD – September 30, 2022



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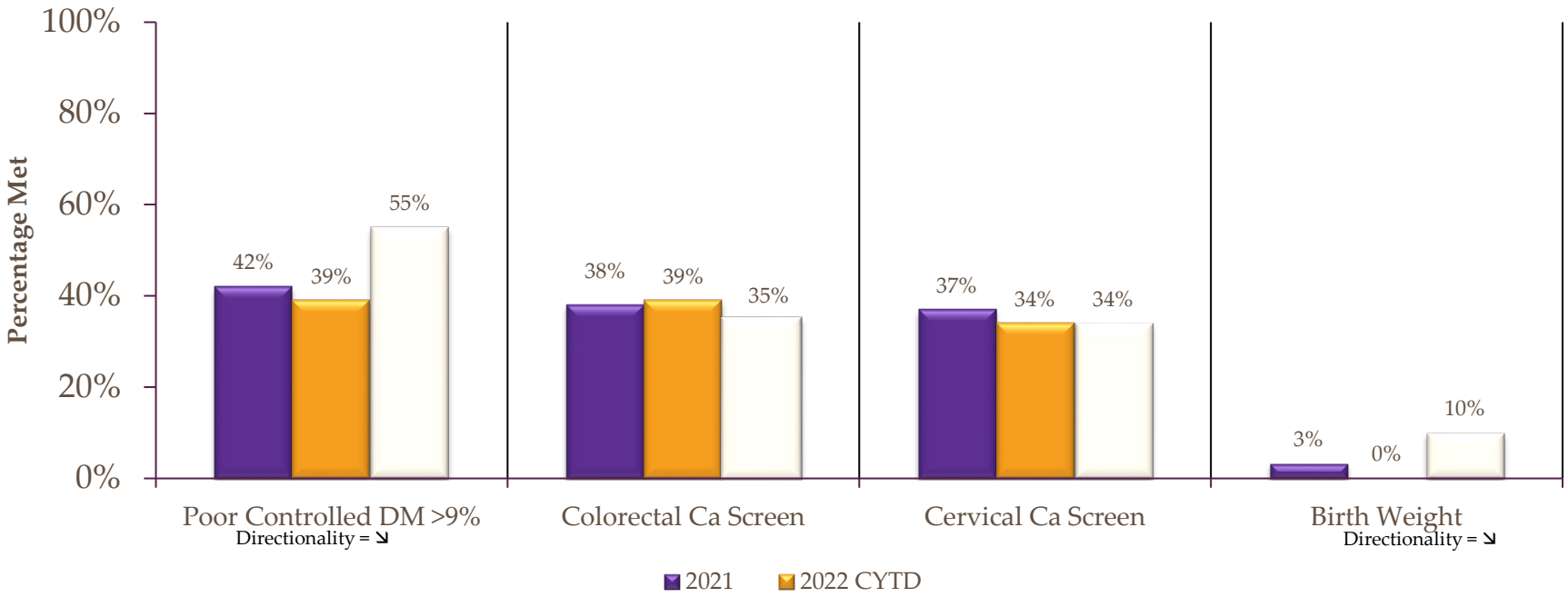
HRSA Quality Measures at or above Goal 2 of 2
YTD – September 30, 2022



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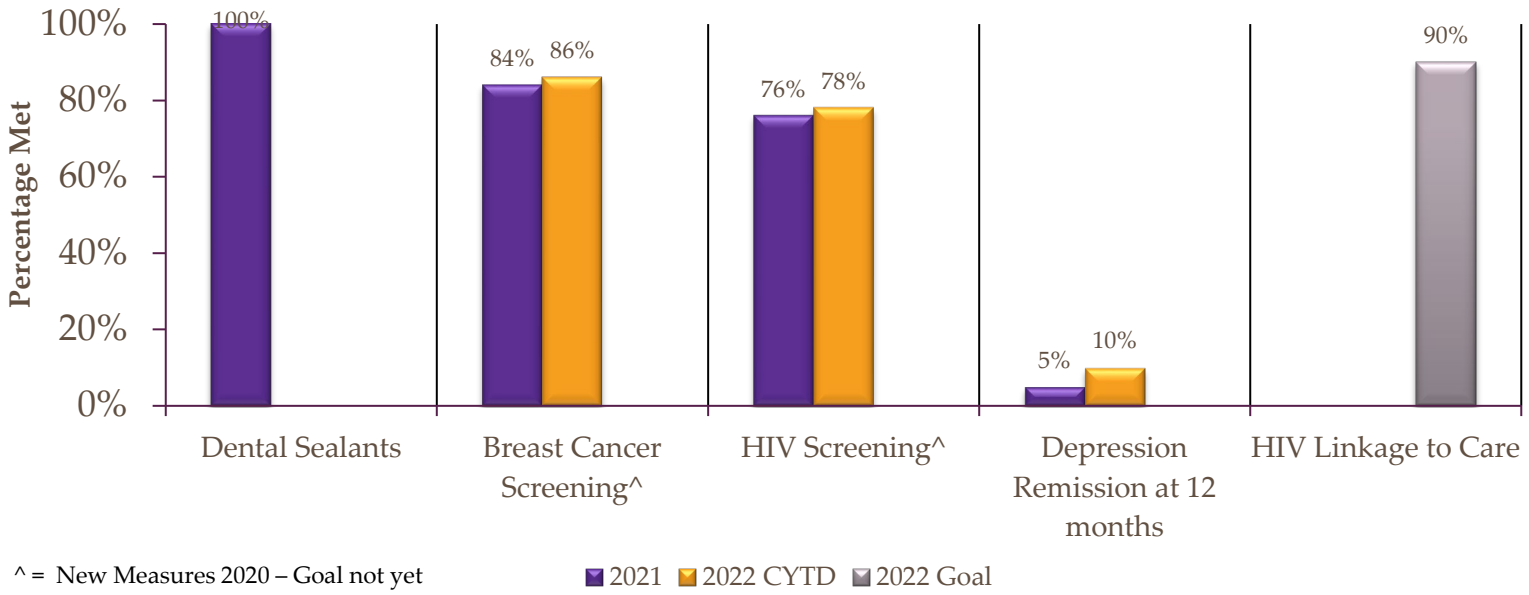
HRSA Quality Measures/ YOY Improvement
YTD – September, 30, 2022



Dental Sealants: No Qualifying Patients YTD
HIV Linkage to care: No Qualifying Patients YTD
HIV Screening: Percentage of patients aged 15-65 at the start of the measurement period who were between 15-65 years old when tested for HIV

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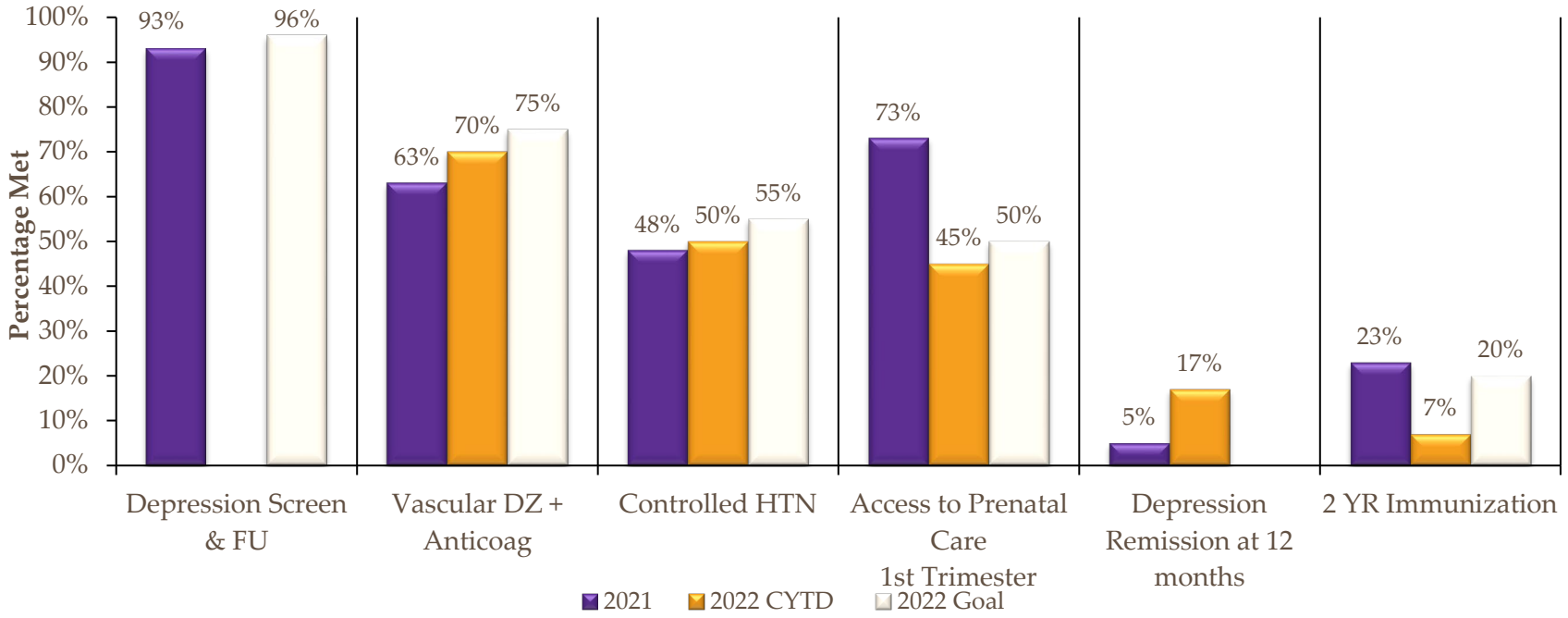
HRSA Quality Measures Needing Improvement
YTD – September 30, 2022



Depression Screening and Follow up:
YTD report in production

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HOMES AWARDED 4 NATIONAL QUALITY RECOGNITION BADGES FROM HRSA!

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The Big 20

The HRSA Compliance Manual has 21 chapters which cover 19 requirements in the four (4) areas:

1. Need
2. Services
3. Management & Finance
4. Governance
5. Annual training was added as a 20th requirement

Developed a calendar to review each chapter with the Board of Managers.

HRSA Health Center Program Compliance Requirements Summary for Board of Managers

HRSA Requirement	Description	Board Month
1. **Needs Assessment (Ch. 3)**	Demonstrates and documents the needs of its target population, updating its service area, when appropriate. Community Needs Assessment	September Every 3 years (2019)
2. **Required & Additional Services (Ch. 4)**	Provides all required primary, preventive, enabling health services and additional health services as appropriate and necessary, either directly or through established written arrangements and referrals.	May
3. **Staffing (Ch. 5)**	Maintains a core staff as necessary to carry out all required health services either directly or through arrangements and referrals. Staff must be appropriately licensed, credentialed, and privileged.	June
4. **Accessible Hours of Operation / Locations (Ch. 6)**	Provides services at times and locations that assure accessibility and meet the needs of the population.	May
5. **Coverage for Medical Emergencies During & After Hours (Ch. 7)**	Provides professional coverage for medical emergencies during regularly scheduled hours and when the center is closed.	April
6. **Hospital Admitting Privileges & Continuum of Care (Ch. 8)**	Physicians have admitting privileges at one or more referral hospitals, or other such arrangement to ensure continuity of care. In cases where hospital arrangements (including admitting privileges and membership) are not possible, health center must firmly establish arrangements for hospitalization, discharge planning, and patient tracking.	June and update as needed

HRSA Health Center Program Compliance Requirements Summary for Board of Managers

7. Sliding Fee Discounts (Ch. 9)	A system is in place to determine eligibility for patient discounts adjusted on the basis of the patient's ability to pay. • This system must provide a full discount to individuals and families with annual incomes at or below 100% of the Federal poverty guidelines (only nominal fees may be charged) and for those with incomes between 100% and 200% of poverty, fees must be charged in accordance with a sliding discount policy based on family size and income. • No discounts may be provided to patients with incomes over 200 % of the Federal poverty guidelines. • No patient will be denied health care services due to an individual's inability to pay for such services by the health center, assuring that any fees or payments required by the center for such services will be reduced or waived.	September
8. Quality Improvement/ Assurance Plan (Ch. 10)	A Quality Improvement/Quality Assurance (QI/QA) program is in place which includes clinical services and management, and confidentiality of patient records. The QI/QA program must include: • A clinical director whose focus of responsibility is to support the quality improvement/assurance program and the provision of high quality patient care; • periodic assessment of the appropriateness of the utilization of services, quality of services provided or proposed to be provided to individuals served by the health center; assessments shall: – be conducted by physicians or by other licensed health professionals under the supervision of physicians; – be based on the systematic collection and evaluation of patient records; and – identify and document the necessity for change in the provision of services by the health center where indicated.	February May August November
9. Key Management Staff (Ch. 11)	Maintains a fully staffed team as appropriate for the size and needs of the center. Prior approval by HRSA of a change in the Project Director/Executive Director/CEO position is required.	April and update as needed
10. Contractual/Affiliation Agreements (Ch. 12)	Exercises appropriate oversight and authority over all contracted services, including assuring that any subrecipient(s) meets Health Center program requirements.	Ongoing
11. Collaborative Relationships (Ch. 14)	Makes effort to establish and maintain collaborative relationships with other health care providers, and health centers, in the service area of the center. The health center secures letter(s) of support from existing health centers in the service area or provides an explanation for why such letter(s) of support cannot be obtained.	February and ongoing
12. Financial Management and Control Policies (Ch. 15)	Maintains accounting and internal control systems appropriate to the size and complexity of the organization reflecting Generally Accepted Accounting Principles (GAAP) and separates functions appropriate to organizational size to safeguard assets and maintain financial stability. An annual independent financial audit is performed in accordance with Federal audit requirements, including submission of a corrective action plan addressing all findings, questioned costs, reportable conditions, and material weaknesses cited in the Audit Report.	February

HRSA Health Center Program Compliance Requirements Summary for Board of Managers

13. Billing and Collections (Ch. 16)	Systems in place to maximize collections and reimbursement for its costs in providing health services, including written billing, credit and collection policies and procedures.	September
14. Budget (Ch. 17)	Develops a budget that reflects the costs of operations, expenses, and revenues necessary to accomplish the service delivery plan, including the number of patients to be served.	August
15. Program Monitoring & Data Reporting Systems (Ch. 18)	Have systems in place to accurately collect and organize data for program reporting and support management decision making.	April
16. Scope of Project	Maintains its funded scope of project (sites, services, service area, target population, and providers); including any increases based on recent grant awards.	September
17. Board Authority (Ch. 19)	Governing board maintains appropriate authority to oversee the operations of the center, including: • holding monthly meetings; • approval of the health center grant application and budget; • selection/dismissal and performance evaluation of the health center CEO; • selection of services to be provided and the health center hours of operations; • measure and evaluate the organization's progress in meeting its annual and long-term programmatic and financial goals and develop future plans for the organization by engaging in strategic planning, ongoing review of the organization's mission and bylaws, evaluating patient satisfaction, and monitoring organizational assets and performance; and • establish policies for the health center.	October
18. Board Composition (Ch. 20)	Governing board is composed of individuals, a majority of whom are being served by the center and, this majority as a group represents the individuals being served by the center in terms of demographic factors such as race, ethnicity, and sex. Specifically: • Governing board has at least 9 but no more than 25 members, as appropriate for the complexity of the organization. • The remaining non-consumer members of the board shall be representative of the community in which the center's service area is located and shall be selected for their expertise in community affairs, local government, finance and banking, legal affairs, trade unions, and other commercial and industrial concerns, or social service agencies within the community. • No more than one half (50%) of the non-consumer board members may derive more than 10% of their annual income from the health care industry.	October
19. Conflict of Interest Policy (Ch. 13)	Bylaws or written corporate board approved policy include provisions that prohibit conflict of interest by board members, employees, consultants and those who furnish goods or services to the health center. No board member shall be an employee of the health center or an immediate family member of an employee. The Chief Executive may serve only as a non-voting ex-officio member of the board.	October
20. Annual Board Training	Annual training of governing board. New governing board members will be trained during board orientation.	December

For additional information on these requirements, please review:

- Health Center Program Statute: Section 330 of the Public Health Service Act (42 U.S.C. §254b)
- Program Regulations: 42 CFR Part 51c and 42 CFR Parts 56.201-56.604
- Grants Regulations: 45 CFR Part 74

HRSA Health Center Program Compliance Requirements – Chapter 10: Quality Improvement Assurance Plan

Requirements

- Ongoing quality improvement/assurance (QA/QI) system
- Focus of responsibility to support the QA/QI program
- Periodic assessment of appropriate utilization of services
- Maintain confidentiality of patient records

HRSA Health Center Program Compliance Requirements – Chapter 10: Quality Improvement Assurance Plan

Demonstrating Compliance

- Board-approved policy(ies) that establishes a QI/QA program that addresses
  - Quality and utilization of health center services
  - Patient satisfaction and patient grievance processes
  - Patient safety and adverse events
- Designated individual to oversee the QI/QA program established by board-approved policy(ies)
- Operating procedures or processes that addresses :
  - Clinical Practice Guidelines, standards of care, practice, provision of services
  - Identify, analyze address, patient safety, adverse events
  - Assessment of patient satisfaction
  - Hearing & resolving patient grievances
  - Quarterly QI\QA assessments, producing reports and sharing to support decision-making and oversight
- Maintenance of certified EHR and systems with protection and safeguarding of patient information consistent with Federal and state requirements

HRSA: HOMES Policy Updates

- Quality Assessment and Performance Improvement

  (QAPI-POP.PI.002)

  - Annual review-no updates

- HOMES Billing and Collection (SPFS01)
  - Annual review
  - Includes verbal attestation for reduced/waived payments for virtual visits

Parkland

Approve Homeless Outreach Medical Services (HOMES) QAPI

Homeless Outreach Medical Services (HOMES) QAPI	POP.PI.002	Published: XX/XX/XXXX
POPULATION HEALTH - Performance Improvement		Page 1 of 8

PURPOSE:

The Homeless Outreach Medical Services (HOMES) Program promotes the mission, vision and values of Parkland Health and Hospital System by implementing and maintaining an ongoing quality improvement/assurance (QI/QA) system that includes clinical services and clinical management and maintains the confidentiality of patient records. The HOMES Quality Assessment and Performance Improvement (QAPI) plan is aligned and integrated with the enterprise-wide QAPI (SYS PI 001-QAPI Plan).

The HOMES QAPI provides for the following:

- Organizational arrangements, including a focus of responsibility, to support the quality assurance program and the provision of high-quality patient care; and
- Periodic assessment of the appropriateness of the utilization of services and the quality of services provided or proposed to be provided to individuals served by HOMES. Assessments must:
    - Be conducted by physicians or by other licensed health professionals under the supervision of physicians;
    - Be based on the systematic collection and evaluation of patient records;
    - Assess patient satisfaction, achievement of project objectives, and include a process for hearing and resolving patient grievances; and
    - Identify and document the necessity for change in the provision of services by the center and result in the institution of such change, where indicated.

SCOPE:

All Parkland Health & Hospital System (“Parkland”) Federally Qualified Health Center (FQHC) HOMES service locations. HOMES, a Section 330(h) of the Public Service Act Health Care for the Homeless health center designation under the Health Resources and Services Administration (HRSA), serves individuals:

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- Who lack housing (without regard to whether the individual is a member of a family);
- Whose primary residence during the night is a supervised public or private facility that provides temporary living accommodations;
- Who reside in transitional housing;
- Who reside in permanent supportive housing or other housing programs that are targeted to homeless populations; and/or
- Who are children and youth at risk of homelessness, homeless veterans, and veterans at risk of homelessness.

PROCEDURE:

1. Structure and Accountability: HOMES Board of Managers

   A. HOMES is governed by the Dallas County Hospital District's Board of Managers (Board). The Board has full power and authority to oversee and provide direction regarding the affairs of HOMES. The Board sets priorities and policies for the HOMES program, assists the program in promoting its goals, and provides input and feedback to generally assist the development, implementation, and evaluation of the program.

2. HOMES Quality Leadership Committee Structure:

   A. Chair - The HOMES Medical Director will serve as Chair

   B. Co-Chair

   C. HOMES Project Director

   D. HOMES Quality Nurse

   E. HOMES Nurse Manager

3. HOMES QAPI Program

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A. The framework of the HOMES QAPI includes:

1) Adhering to current evidence-based clinical guidelines, standards of care, and standards of practice in the provision of HOMES services, as applicable;

2) Identifying, analyzing, and addressing patient safety and adverse events and implementing following up actions, as necessary;

3) Addressing patient satisfaction;

4) Hearing and resolving patient grievances;

5) Completing periodic QI/QA assessments on at least a quarterly basis to inform the modification of the provision of HOMES services, as appropriate;

6) Producing and sharing reports on the QI/QA to support decision-making and oversight by HOMES key management staff, the HOMES Advisory Board, and the Board regarding the provision of HOMES services;

7) Monthly QAPI meetings; and

8) HRSA clinical and financial measures as part of Uniform Data System (UDS) annual reporting.

B. QI/QA Assessments

1) The HOMES Medical Director conducts QI/QA assessments on at least a quarterly basis, using data systematically collected from patient records to ensure provider adherence to current evidence-based clinical guidelines, standards of care, and/or standards of practice in the provision of HOMES services. The Program identifies patient safety and adverse events, participates in investigation of these events, and develops and implements appropriate action plans when indicated.

2) Data from all quality and safety activities are reviewed and analyzed by the Medical Director, the Project Director, Nursing leadership, and HOMES Quality Nurse.

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3) Findings are discussed at monthly staff meetings, the monthly QAPI meeting, and no less than quarterly at the Board meeting.

4) HOMES Advisory Board meetings are held bi-monthly and are used to gather data on reported health needs. Feedback is analyzed from the consumer meetings and reported to HOMES Quality Leadership Committee quarterly. Focus Groups are held annually and as needed.

C. Patient Safety

1) All clinical events falling outside the usual course of care, including “near misses”, at HOMES sites are reported using Parkland’s Safety Center reporting system. (See Parkland’s Hospital QAPI policy SYS.PI.001) Examples of reported events include but are not limited to falls, medication errors, equipment failures, assaults, property theft, treatment events, and good catches/near misses. This process mirrors Parkland’s QAPI.

2) Serious safety events are reviewed immediately by the Nurse Manager and sent to the Medical Director for review. The investigation is conducted by HOMES leadership in partnership with Parkland’s Patient Safety and Risk management team. Root Cause Analysis (RCA2) may be conducted to identify system or process issues that may have contributed to the event and develop an action plan for preventing similar occurrences in the future.

3) Medical Error Reduction:

a) All medical errors are reviewed by the Medical Director and Project Director and discussed with HOMES team members. Trends in errors are reviewed by the Medical Director and Project Director and immediate efforts are made to intervene with measurable improvement indicators.

D. Quality and Utilization of HOMES Services:

1) The Medical Director and Project Director provide oversight of quality measures to evaluate the effectiveness and safety of services and quality of care. (Reference – UDS Resources)

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2) The quality measures include, but are not limited to, the UDS clinical quality measures. (Reference – UDS Resources)

3) The metrics included on the HOMES Dashboards must be geared toward measuring and improving quality outcomes.

4) The goal is meeting the quality measure benchmarks, outlined in the HRSA grant, that are reported annually in the UDS.

E. Quality Improvement Projects:

1) The Medical Director and Project Director provide oversight of the quality improvement projects, the number and scope of which shall be proportional to the scope and complexity of the services offered. HOMES uses standardized Plan, Do, Study, Act (PDSA) methodology for all quality improvement-related activities. The PDSA Model is used to ensure a consistent and thorough approach and consists of the following steps:

a) Plan— observe and assess problem, create plan for improvement;

b) Do— test intervention on a small scale;

c) Study— analyze the data and study the effect of the intervention;

d) Act—Refine based on findings, operationalize (adapt or adopt); and Cycle is repeated until desired state is achieved.

F. Prioritization:

1) The Medical Director, Project Director, and Nursing Leadership prioritize performance improvement activities that:

a) Focus on high-risk, high-volume, or problem prone areas;

b) Consider the incidence, prevalence, and severity of problems on those areas; and

c) Affect health outcomes, patient safety and quality of care.

G. Patient Satisfaction and Patient Grievances Processes

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1) Patient Satisfaction Surveys are conducted by the HOMES staff at the point of care. The results are reviewed by leadership and program staff to develop planned actions. Reports are provided at the HOMES Board of Directors, the HOMES Quality Leadership Committee, and the HOMES Advisory Board.

2) Patient Complaint and Grievance processes are followed by the system-wide policy SYS.RR.004. This policy also addresses 25 Tex. Administrative Code §133.42 (2016) (Dep't of State Health Services, Patient Rights), The Joint Commission, Patient Rights and Responsibility Standard. RI.01.07.01 (2016), , the beneficiary billing complaint related to rights and limitations provided by 42 CFR 489 and Condition of Participation 42.C.F.R § 482.13 (a)(2).

H. Infection Prevention

1) The Infection Prevention (IP) Department in collaboration with HOMES leadership oversees the implementation and sustainability of the Infection Prevention and Control Program (IP Program) throughout Parkland. The goal of the IP Program is to eliminate or reduce the risk of acquisition and transmission of healthcare acquired infections (HAI), including multi-drug resistant bacteria and infections of public health importance. The IP program is governed by the Infection Prevention and Control Committee (IPCC), a multidisciplinary medical staff committee comprised of representatives from various service lines and health system departments. The IPCC is charged with the oversight of infection control processes and policies throughout the health system. The IP Department facilitates the development of an annual IP risk assessment and work plan that informs the IP Program and is approved through the IPCC, QCPSC (Hospital Quality of Care & Patient Safety Committee) and the QBOM (Quality of Care & Patient Safety Committee of the Board of Managers).

2) IP collaborates with several areas including but not limited to nursing, medical staff, facilities, sterile processing, environmental services (EVS), occupational health and pharmacy in order to regularly and consistently evaluate the environment of care, proactively identify evolving infection-related risks, enhance adherence to existing infection control processes, promote

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antimicrobial stewardship and facilitate ongoing infection control process improvement.

I. HOMES and Vaccines

1) HOMES follows the established guidelines for ordering, storage, handling, contingency plans and administration of vaccines for clinics participating in the Texas Vaccine for Children (TVFC) Program (procedure POP.MM.001).

J. Pharmacy

1) Medication Storage: All medication within Parkland Class D pharmacies follows the appropriate guidelines for the storage of drugs and/or devices (policy PHR- CD-006).

2) Receiving of Drugs and Devices: All medication within Parkland Class D pharmacies follows the appropriate process to receive drugs/devices (policy PHR-CD-016).

3) Delivery of Drugs and Devices: All medication within Parkland Class D pharmacies follows the appropriate process on how drugs and devices are delivered (policy PHR-CD-017).

K. Confidentiality of Medical Records:

1) HOMES maintains the confidentiality of patient records, including all information as to personal facts and circumstances obtained by the HOMES staff about recipients of services. Specifically, HOMES must not divulge such information without the individual's consent except as may be required by law or as may be necessary to provide service to the individual or to provide for medical audits by the Secretary of Health and Human Services (HHS) or his/her designee with appropriate safeguards for confidentiality of patient records.

2) HOMES maintains a retrievable health record (Epic electronic health record) for each patient, the format and content of which are consistent with both Federal and state laws and requirements.

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3) HOMES has implemented systems for protecting the confidentiality of patient information and safeguarding this information against loss, destruction, or unauthorized use, consistent with Federal and state requirements.

L. Approval:

1) The HOMES QAPI Plan is reviewed and approved no less than annually by the HOMES Quality Leadership Committee and the Board. Any revisions intra-year will be presented to the HOMES Quality Leadership Committee and the Board.

DEFINITIONS:

Uniform Data System (UDS): The UDS is a core set of information appropriate for reviewing the operation and performance of health centers. The UDS annually collects a variety of information, including patient demographics, services provided, staffing, clinical indicators, utilization rates, costs, and revenues.

REFERENCES:

Health Resources & Services Administration, Health Center Program Compliance Manual; https://bphc.hrsa.gov/programrequirements/compliancemanual

Health Resources & Services Administration, Uniform Data System Resources; https://bphc.hrsa.gov/datareporting/reporting

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Parkland

Approve HOMES Billing and Collections Policy

HOMES Billing & Collection Policy	HOMESPFS01	Published: 10/8/21
PFS Accounts Receivable Manual		Page 1 of 6

PURPOSE:

The purpose of this policy is to provide clear and consistent guidelines for billing and collection operations for Parkland's HOMES program.

SCOPE:

All Parkland Health & Hospital System ("Parkland") Workforce members.

PROCEDURE:

1. Ability/Refusal to Pay

   A. No patient will be refused service based on their inability to pay due to a lack of financial means.

   B. Parkland Health & Hospital System reserves the right to limit or deny services to any patient with the documented ability to pay and the patient has refused to pay.

1. Reduced/Waived Payments
   A. Financial screening will be conducted to determine if a patient qualifies for any program including but not limited to ACA, grants, Sliding Fee Scale, Charity, or other types of funding programs.
      1) Patients will self-attest in writing to reasons for requesting reduced/waived fees. For those patients needing to provide verbal attestation (i.e. due to virtual visit), verbal attestation and reason for requesting the reduced/waived fees will be documented by staff in the patient's account. Criteria for reduced/waived fees include but are not limited to:
      2) Patients who lack housing (without regard to whether the individual is a member of a family)
      3) Patients whose primary residence during the night is a supervised public or private facility that provides temporary living accommodations
      4) Patients who reside in transitional housing
      5) Patients who reside in permanent supportive housing or other housing programs that are targeted to homeless populations

6) Patients who reside in a domestic violence shelter
7) Patients who have experienced a natural disaster

C. Those who are determined to qualify for reduced/waived fees are automatically approved for Parkland's charity program, HOMES Parkland Financial Assistance, and Parkland will waive their co-pays for primary care services. Patients who are covered by a third party insurance (Medicare, Medicaid, or private insurance) for which Parkland is required to collect co-pays and deductibles are not eligible for waived fees or reduced payments.

2. Supplies and/or Equipment Not Provided by Clinic

A. Parkland Health & Hospital System maintains contractual agreements with third party vendors to supply special items or services not provided within the FQHC setting.

B. Services provided via a written or contract/agreement will be bound to provide the same or greater discounting as would be received if Parkland Health & Hospital System were to provide the service.

3. Insurance Billing

A. All patients seen by Parkland Health & Hospital System's FQHC locations with a funding source such as private insurance, government program coverage, or any other form of third party coverage will be billed as applicable for services provided.

B. If a claim is denied due to a provider error the patient is not held liable.

4. Patient Billing

A. Patients with a funding source that have co-pay, coinsurance, or deductible obligations will be billed when the funding source has adjudicated the claim and remitted payment.

B. Patients with a valid address on file, will be billed directly and receive a statement as part of the organization's normal patient billing process.

C. Payment plans can be approved for patients indicating they may have difficulty paying their balance in a single installment.

D. Parkland Health & Hospital System is not required to accept patient-initiated payment arrangements and may refer accounts to a collection agency if the patient is unwilling to make acceptable payment arrangements, has defaulted on an established payment plan, or has not been responsive to previous collection attempts.

5. Collection Practice

A. In compliance with state and federal laws and in accordance to the provisions outlined in this FQHC Billing and Collection Policy, Parkland Health & Hospital System engages in collection activities to collection outstanding patient balances.

B. General collection activities include follow-up phone calls and statements.

C. All patient/guarantors will be sent a minimum of three (3) statements within a 120 days period starting within three (3) days of placement with the first statement being sent within 30 days of service date.

6. Accounts become eligible for outsource to Early Out Vendor 55 days after discharge date or 55 days after the residual balance is placed in the self-pay bucket and the insurance bucket balance is resolved.

A. Self-Pay; Self-Pay after Insurance, Payment Plan Default, Sliding Fee Scale, and Self-Pay discounted balances may all qualify for Early Out collection process.

7. Accounts become eligible for Bad Debt if collection efforts by the Early-Out Vendor for the patient/guarantor portion of the bill are unsuccessful, the account will be pulled from the Self Pay Vendor after 180 days from initial placement and placed with a Bad Debt Vendor.

A. All patient/guarantors will be sent at least three (3) statements within a 120 day period starting within three (3) days of placement.

B. Vendor will give the patient/guarantor a minimum of 45 days to dispute the claim or provide additional information if applicable.

C. After 45 days, from the time of placement, and no dispute is received, the Vendor will report the account delinquent to all three credit reporting agencies.

D. If after 365 days and no payment is received, the account will be pulled from the Vendor and sent to PHHS clearing agency code. The Bad Debt Vendor will remove the account from all credit reporting agencies when the account is pulled.

8. Payment Plans

A. Payment plans can be approved for patients with difficulty paying their financial responsibility in a single installment.

B. Patients can set up a payment plan for a negotiated amount to be due on a monthly basis.

C. Statements will be sent monthly as a reminder of payment amount and date due.

D. Default of a payment plan will result in the outstanding patient balance being sent to a collection agency for collection within 45 days after the default date.

10. Patient disputes:

A. Patient complaint or dispute relating to charges, services or quality of care.

B. PFS will be responsible for the researching and resolving “billing or collection” issues that occur.

C. Service or care related issues will be resolved by the operational department and resolution coordinated by Patient Relations.

D. If a patient calls regarding a service or care related issue, they will be instructed to contact Patient Relations at 469-419-0820. The person receiving the call will document in the patient accounting system that the patient has a service or care related issue and they were notified to call Patient Relations.

E. If a written notice is received concerning a service/care related complaint from the patient; the notice is to be sent to Patient Relations for handling.

EQUIPMENT:

N/A

DEFINITIONS:

Bad Debt: Financial classification for accounts in which previous collection efforts have been unsuccessful.

Financial Assistance Policy: A separate policy that describes the Sliding Fee Scale discount program which includes specific criteria patients must meet to qualify for the Sliding Fee Scale discount.

Inability to Pay: No financial means to pay for services provided based on lack of income.

Insurance: Coverage program of the insured for the expenses incurred from illness, injury, preventative health care, or injury that pays for health care services directly to a provider.

Refusal to Pay: Documented proof of a patient's ability to pay for services and the patient refuses to pay.

Self-Pay Balances after Insurance: Insurance has paid their portion and the remaining balance is the patient/guarantor's responsibility.

Self-pay Charity Discount: Dallas County and Non-Dallas County program for patients without a third party funding source that are qualified for a percentage discount from gross charges.

Uncollectible Accounts: Accounts in which all collection efforts have ceased.

Workforce member: An employee, volunteer, member of the medical staff, contractor, vendor, trainee or other person whose conduct, in the performance of work for Parkland, is under the direct control of Parkland, whether or not he or she is paid by Parkland.

REFERENCES:

N/A

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REFERENCES:

N/A

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Questions?