Parkland

HOMES
Agenda

Agenda for the ***Board of Managers HOMES*** meeting of the Dallas County Hospital District is scheduled for ***Wednesday, December 20, 2023, 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.) 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: 2634 338 5257; 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 2023-11-15 HOMES	2	1	Chair
III.	**Reports Requiring Deliberation(s) or Approval(s)**			
A.	Operations Update	9	2	Kyla Rankin
B.	Management and Finance Update	10	2	
C.	Governance Update	11	2	
D.	HRSA Compliance Manual Requirements: The Big 20	12	2	
E.	HRSA Compliance Manual Requirements: Chapter 12: Contracts and Subawards	16	2	
F.	HRSA Annual Review	18	2	
G.	Approve Credentialing and Privileging Policy	21	1	
H.	Approve Quality Assessment and Performance Improvement (QAPI) Policy	31	1	
I.	2024 Point in Time Count	48	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			

Approve Minutes 2023-11-15 HOMES

Parkland

MINUTES

Dallas County Hospital District Board of Managers

HOMES
November 15, 2023

Minutes of the Board of Managers HOMES meeting of the Dallas County Hospital District, held Wednesday, November 15, 2023, 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 12:30 p.m.

Board Member attendees included: Chair Marjorie Petty, JD; Eric G. Bing, MD, PhD (via Webex); Byron Cryer, MD; Todd Furniss, JD; Reina Gonzalez, JD; Vincent Hall; Ramon Miguez, PE; Farida Minner, RN; Elizabeth Palacios, MD; and Lisa Sutter.

Board member John Proctor was not present.

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

Christina Mintner, SVP of Operations Population Health/HOMES
Donna Richardson, EVP & Chief Nursing Executive
Edmundo Castañeda, EVP & Chief Operating Officer
Felicia Miller, EVP & Chief Talent Officer
Forrest Stovall, Governance Program Manager
Fred Cerise, President & Chief Executive Officer
Jessica Hernandez, SVP Chief DEI Officer
Kyla Rankin, HOMES Project Director
Rick Humphrey, EVP & Chief Financial Officer
Roberto de la Cruz, EVP Chief Clinical Officer
Saul Cordero, SVP & Chief Governance & Strategy Officer
Steven Roth, EVP & Chief Legal Officer
Vic Summers, Chief Audit Executive

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 2023-10-25 HOMES

Vincent Hall motioned for the approval of the Consent Agenda. Byron Cryer, 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 Kyla Rankin, HOMES Project Director.

A. Operations Update

Kyla Rankin reported on HOMES' staffing. There is currently one nurse, one community development specialist, one dental assistant, and one family nurse practitioner position posted. Kyla indicated that the Nurse Practitioner vacancy could cause some challenges going into calendar year 2024 trying to meet the unduplicated patient goal. Three new staff members are scheduled to start in the next few weeks. HOMES provided 425 flu and COVID vaccines at 22 outreach events. HOMES also continues to work with the Virtual Care Team and Information Technology (IT) on improving connectivity for both telehealth and the mobile medical units daily operations.

The Board asked questions and received additional information related to the Operations Update.

B. Management and Finance Update

HOMES has seen 7,486 unduplicated patients to date. The annual goal is 9,675. Expenses remain over budget which is driven by a new shuttle purchase as well as pharmacy expenses. Kyla stated the shuttle purchase will come from ARPA money and those funds will be drawn down from the grant and reimbursed to the HOMES cost center.

The Board asked questions and received additional information related to the Management and Finance Update.

C. Governance Update

The HOMES Advisory Board will not meet in December. The Advisory Board members are invited to attend the annual Joint Community Advisory Board Meeting on Friday, December 1st.

D. HRSA Compliance Manual Requirements: The Big 20

Kyla Rankin reviewed The Big 20 manual.

E. HRSA Compliance Manual Requirements - Chapter 16: Billings and Collections

Kyla Rankin reviewed Chapter 16: Billings and Collections. She reported on the HRSA requirements and how HOMES demonstrates compliance with the HRSA requirements.

F. Approve Billing and Collection Policy
Kyla Rankin presented the Billing and Collection Policy to the Board for approval. She reviewed the proposed changes.

Todd Furniss, JD, motioned for the approval of the Billing and Collection Policy. Vincent Hall seconded the motion. The motion passed unanimously.

G. HRSA Recognition
Kyla Rankin informed the Board of three national quality awards HOMES received from HRSA:

- Health Center Quality Leader
- Access Enhancer
- Health Disparities Reducer

VII. Executive Session

At 12:40 p.m., the Board went into Executive Session as permitted by the closed meeting exceptions specified on the agenda.

A. Performance Appraisal of HOMES Project Director: Kyla Rankin

Members of management in executive session attendance included:

Christina Mintner, Edmundo Castañeda, Fred Cerise, and Kyla Rankin

Chair adjourned Executive Session and moved into Open Session at 12:54 p.m.

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

A. Approve Performance Appraisal of HOMES Project Director: Kyla Rankin

Vincent Hall motioned for the approval of Performance Appraisal of HOMES Project Director: Kyla Rankin. Ramon Miguez, PE, seconded the motion. The motion passed unanimously.

IX. Adjourn

With no further business to discuss, Chair Marjorie Petty, JD, adjourned the meeting at 12:56 p.m.

SO RECORDED:

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

Parkland

Homeless Outreach Medical Services Program Monthly Update Report – December 2023

Kyla Rankin, Project Director

Agenda

- Operational Updates
  - Operations
  - Management and Finance
- Governance
- The Big 20
  - Chapter 12: Contracts & Subawards
- HRSA Annual Review
- Policy Approval
- 2024 Point In Time count

Operational Updates

Staffing

- 1.0 FTE Community Development Specialist
- 1.0 FTE FNP
- 1.0 FTE Dental Assistant
- 1.0 FTE MPA-Supervisor

Highlights

- World AIDS day outreach
- 2024 Healthcare for the Homeless presentation

Management & Finances – November

Unduplicated	GY to Date	Annual Goal	% to Goal	% Year Complete
Patients	8038	9665	83%	92%

FY	Month				Year to Date			
Metrics	Actual	Budget	Variance	% Var	Actual	Budget	Variance	% Var
Visits	3370	3400	(30)	-0.9%	7344	7138	206	2.9%
Expenses	$609,625	$669,358	59,733	8.9%	$1,407,799	$1,367,858	($39,941)	-2.9%
Charges	$2,479,644	$2,434,725	$246,446	1.8%	$4,773,936	$5,111,798	($337,803)	-6.6%
Revenue	$50,570				$117,071			
Commercial	$881				$2326			
Medicaid	$29,648				$71,127			
Medicare	$20,041				$43,618			
FTE	62.21				62.21			
FTE - OT	1.91	1.04	(0.87)	-83.1%	1.78	1.06	(0.73)	-68.9%

- HRSA recommendation is claims billed in less than 30 days.
- HRSA grant year: January 1, 2023 to December 31, 2023

Governance

- Joint Community Advisory Board Holiday Luncheon
- Next HOMES Advisory Board Meeting:
  - February 12, 2024
  - Hybrid option available

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

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.	August
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.	August
4. Accessible Hours of Operation / Locations (Ch. 6)	Provides services at times and locations that assure accessibility and meet the needs of the population.	August
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.	March
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.	August 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.	Annually to align with Federal Poverty Guidelines
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.	Quarterly Metric Review: February or approval of annual UDS report August November December QAPI Policy: October
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.	September 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.	October and 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.	March 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.	July

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.	November
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.	HRSA approval
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.	March
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.	Award notification & update as needed
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.	December
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.	December
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.	December
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 12: Contractual Affiliation Agreements

Requirements

- Procedures for purchasing and procurement
- Annual audits and management letters
- Include contracts which include the HRSA scope of service

Demonstrating Compliance

- Purchasing Practice and Procedure Manual
- Contracts
- Financial records
- Statistical records

HRSA Health Center Program Compliance Requirements – Chapter 12 Contracts & Subawards

- **Cenikor Foundation**
- Residential Treatment for Mental Health & Substance Abuse
- Base Term: 10/1/2019 to 9/30/2021; not to exceed $72,000
- Current Term: 10/1/2023 to 4/30/2024
- Provide monthly data on patient demographics, CPT & ICD-10 codes, & success rate
- Data included in annual report to HRSA
- FY22: 87 encounters
- FY23: 65 encounters

HRSA Health Center Program Compliance Requirements – Annual Review

- Receive federal award funds under the Health Center Program authorized by section 330 of the Public Health Service Act
- 330(h): Health Care for the Homeless Program Federally Qualified Health Center
- Compliance Manual is foundation for HRSA's eligibility & compliance-related determinations & review process for program
- Compliance Manual includes 21 chapters which cover 19 requirements in the four (4) areas:
  - Need
  - Services
  - Management & Finance
  - Governance
- Link to HRSA Compliance Manual: HRSA Compliance Manual

HRSA Health Center Program Compliance Requirements – Annual Review

- Amount Requested Annually for 1/1/2024 to 12/31/2026: $3,618,019
  - Supplemental Awards
    - Bridge Funding $85,000
    - Primary Care HIV Prevention (PCHP) $57,114
- Reporting & Application
  - Annual reporting: Due February 15 each year
  - Reporting requirements of supplemental funding awards or HRSA requirements
  - Continuing Competitive Grant: Every 3 years with a CHNA; September 15*
  - Federal Finance Report: April 30; Grants Management
  - Non-competing Continuation (NCC): Annual progress report
- Operational Site Visit: 14 to 18 months into new project period (Spring 2025)
  - All elements of compliance manual will be assessed
  - Chart review
  - Interviews

Policy Approval

HOMES Credentialing and Privileging

Updates to include

- Minor formatting changes
- Language changes for clarity and to align with actual operational practice

HOMES Quality Assessment and Performance Improvement (QAPI)

- Minor changes

Approve Credentialing and Privileging Policy

PURPOSE:

For the Homeless Outreach Medical Services (HOMES) Program to demonstrate compliance of privileging procedures in conformity with the standards of the Bureau of Primary Health Care, as defined in ~~HRSA's~~Health Resources & Services Administration's (HRSA) Health Center Program Compliance Manual ~~which follows the standards established by the National Committee for Quality Assurance (NCQA) and the guidelines of the *Joint Commission*.~~ .

SCOPE: ~~—~~

The scope of this procedure covers the operating procedures of the HOMES Program for the initial and recurring review (every ~~two~~three years) of credentials for all Parkland Health (Parkland) clinical staff members ~~(licensed independent practitioners~~including Licensed Independent Practitioners (LIPs) providing services on behalf of the HOMES Program~~)~~ who are HOMES Program employees, individual contractors, or volunteers.~~–~~

PROCEDURE:

1. Medical Staff Professional Services (MSPS) will ensure verification of the following:

   A. Current licensure, registration, or certification using a primary source;

   B. Education and training for initial credentialing, using primary sources for LIPs;

   C. Completion of a query through the National Practitioner ~~Databank~~Data Bank (NPDB);

~~C.~~

   D. Clinical staff member's identity for initial credentialing using a government-issued picture identification;

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E. Drug Enforcement Administration (DEA) registration; and

F. Current documentation of basic life support training.

2. The HOMES Program follows the Parkland Health & Hospital System'sParkland's Medical Staff Bylaws for the initial granting and renewal (every twothree years) of privileges for clinical staff members (LIPs providing services on behalf of the HOMES Program) who are HOMES Program employees, individual contractors, or volunteers. These privileging procedures would address the following:

A.G. Verification of immunization and Tuberculosis (TB) surveillance

B.H. For initial privileging, verification of current clinical competence and fitness for duty via training, education, and, as available, reference reviews; verification of fitness of duty to ensure all clinical staff have the physical and cognitive ability to safely perform their duties.

C.I. For renewal of privileges, verification of current clinical competence via peer review or other comparable methods (for example, supervisory performance reviews); andverification of fitness of duty to ensure all clinical staff have the physical and cognitive ability to safely perform their duties.

J. Process for denying, modifying or removing privileges based on assessments of clinical competence and fitness for duty.For denial of initial Privileges or Medical Staff appointment or reappointment, revoke, terminate, or restrict the Medical Staff appointment and/or Privileges, the current process in Medical Staff Professional Services will be followed.

D.

3.2. If the HOMES Program has contracts with provider organizations (for example, group practices, locum tenens staffing agencies, training programs) or formal, written referral agreements with other provider organizations that

provide services within its scope of project, the HOMES Program ensures that such providers are:

A. Licensed~~,~~ and certified, ~~or registered~~ as verified through a credentialing process, in accordance with applicable ~~Federal~~federal, state, and local laws; and

B. Competent and fit to perform the contracted or referred services, as assessed through a privileging process.

~~4.~~3. Approval Process:

~~Parkland Health & Hospital System~~

A. Parkland's Board of Managers serves as the HOMES Program Board of Directors and has sole authority to grant or deny clinical appointment and privileges to licensed independent practitioners.

~~B. Once privileges have been granted, the Project Director of the HOMES Program and the Chair of Parkland Health & Hospital Systems Board of Managers will sign the privilege form.~~

~~C.~~B. The LIP will be notified in writing of the Board's decision.~~–~~

~~5.~~4. Maintenance of Credentials and the Credentialing File~~–~~:

A. Credential files for LIPs are maintained and securely stored by credentialing staff in accordance with the HOMES Program and the Bureau of Primary Health Care guidelines~~, as well as Joint Commission standards.~~ .

B. The file for each provider will contain: ~~-~~a current application, a current privilege list, letters of notification concerning privilege/appointment decisions, current state license, verification of applicable education and training, specialty board certification (~~if~~as applicable), results of NPDB and other queries, claims history information, basic life support training, current resume/Curriculum Vitae (CV~~,~~), and evidence of current competence. Documentation in file should be by a primary and secondary source, as required. For non-employee LIPs, the file should also have proof of current

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~~tuberculosis~~TB surveillance and vaccination.

C. Each LIP is responsible for maintaining his/her licensure, board certifications (as applicable), life support training, TB surveillance and vaccination, and up-~~-~~to-~~-~~date training.~~-~~

1) The LIP assumes responsibility for providing ~~credential~~credentialing staff with renewed credentials prior to the expiration of the credential on file.~~–~~

2) As a courtesy, ~~credentials~~credentialing staff attempts to remind LIPs before credentials expire.~~–~~

3) LIPs with expired mandatory credentials in their file may not provide patient care.

4) Verification of renewed items as described above (a primary or secondary source) is required.

~~D.~~5. ~~The~~MSPS will follow the existing process for exhausted credentialing ~~staff will alert the~~ effort, including notification of Clinical~~ / ~~/Medical ~~Director~~Chief of the HOMES ~~Program~~program, if a primary source verification or other pertinent information is not obtainable~~ after two attempts, if LIPs do not respond to appointment/reappointment requests in timely manner after reasonable follow up has been attempted, if an LIP has allowed a credential to expire, and of any other circumstances which may delay the credentialing and privileging process, which raise questions about an LIP's competency and capability to provide quality care to HOMES Program patients, or which seem otherwise notable.~~.

~~**EQUIPMENT:**~~

~~N/A~~

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Privileges – Requirements for HRSA Providers		Published: ~~6/30/22~~ 9/26/21
Medical Affairs – Medical Staff Services		Page ~~5~~1 of ~~5~~

DEFINITIONS:

Licensed Independent Practitioner (LIP): ~~any~~Any individual permitted by law and the organization to practice independently and provide care and services without direction or supervision, within the scope of the individual's license and consistent with individually granted clinical privileges (e.g. physician, dentist, nurse practitioner).

REFERENCES:

Bureau of Primary Health Care, as defined in HRSA's Health Center Program Compliance Manual ~~which follows the standards established by the National Committee for Quality Assurance (NCQA) and the guidelines of the *Joint Commission*.~~

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Privileges – Requirements for HRSA Providers		Published: 9/26/21
Medical Affairs – Medical Staff Services		Page 1 of 4

PURPOSE:

For the Homeless Outreach Medical Services (HOMES) Program to demonstrate compliance of privileging procedures in conformity with the standards of the Bureau of Primary Health Care, as defined in Health Resources & Services Administration's (HRSA) Health Center Program Compliance Manual.

SCOPE:

The scope of this procedure covers the operating procedures of the HOMES Program for the initial and recurring review (every three years) of credentials for all Parkland Health (Parkland) clinical staff members including Licensed Independent Practitioners (LIPs) providing services on behalf of the HOMES Program who are HOMES Program employees, individual contractors, or volunteers.

PROCEDURE:

1. Medical Staff Professional Services (MSPS) will ensure verification of the following:

   A. Current licensure, registration, or certification using a primary source;

   B. Education and training for initial credentialing, using primary sources for LIPs;

   C. Completion of a query through the National Practitioner Data Bank (NPDB);

   D. Clinical staff member's identity for initial credentialing using a government-issued picture identification;

   E. Drug Enforcement Administration (DEA) registration; and

   F. Current documentation of basic life support training.

   The HOMES Program follows Parkland's Medical Staff Bylaws for the initial granting and renewal (every three years) of privileges for clinical staff members (LIPs providing services on

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behalf of the HOMES Program) who are HOMES Program employees, individual contractors, or volunteers. These privileging procedures would address the following:

G. Verification of immunization and Tuberculosis (TB) surveillance

H. For initial privileging, verification of current clinical competence via training, education, and, as available, reference reviews; verification of fitness of duty to ensure all clinical staff have the physical and cognitive ability to safely perform their duties.

I. For renewal of privileges, verification of current clinical competence via peer review or other comparable methods (for example, supervisory performance reviews); verification of fitness of duty to ensure all clinical staff have the physical and cognitive ability to safely perform their duties.

J. For denial of initial Privileges or Medical Staff appointment or reappointment, revoke, terminate, or restrict the Medical Staff appointment and/or Privileges, the current process in Medical Staff Professional Services will be followed.

2. If the HOMES Program has contracts with provider organizations (for example, group practices, locum tenens staffing agencies, training programs) or formal, written referral agreements with other provider organizations that provide services within its scope of project, the HOMES Program ensures that such providers are:

   A. Licensed and certified, as verified through a credentialing process, in accordance with applicable federal, state, and local laws; and

   B. Competent and fit to perform the contracted or referred services, as assessed through a privileging process.

3. Approval Process:

   A. Parkland's Board of Managers serves as the HOMES Program Board of Directors and has sole authority to grant or deny clinical appointment and privileges to licensed independent practitioners.

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B. The LIP will be notified in writing of the Board's decision.

4. Maintenance of Credentials and the Credentialing File:

A. Credential files for LIPs are maintained and securely stored by credentialing staff in accordance with the HOMES Program and the Bureau of Primary Health Care guidelines.

B. The file for each provider will contain: a current application, a current privilege list, letters of notification concerning privilege/appointment decisions, current state license, verification of applicable education and training, specialty board certification (as applicable), results of NPDB and other queries, claims history information, basic life support training, current resume/Curriculum Vitae (CV), and evidence of current competence. Documentation in file should be by a primary and secondary source, as required. For non-employee LIPs, the file should also have proof of current TB surveillance and vaccination.

C. Each LIP is responsible for maintaining his/her licensure, board certifications (as applicable), life support training, TB surveillance and vaccination, and up-to-date training.

1) The LIP assumes responsibility for providing credentialing staff with renewed credentials prior to the expiration of the credential on file.

2) As a courtesy, credentialing staff attempts to remind LIPs before credentials expire.

3) LIPs with expired mandatory credentials in their file may not provide patient care.

4) Verification of renewed items as described above (a primary or secondary source) is required.

5. MSPS will follow the existing process for exhausted credentialing effort, including notification of Clinical/Medical Chief of the HOMES program, if a primary source verification or other pertinent information is not obtainable.

DEFINITIONS:

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Privileges – Requirements for HRSA Providers		Published: 9/26/21
Medical Affairs – Medical Staff Services		Page 1 of 4

Licensed Independent Practitioner (LIP): Any individual permitted by law and the organization to practice independently and provide care and services without direction or supervision, within the scope of the individual's license and consistent with individually granted clinical privileges (e.g., physician, dentist, nurse practitioner).

REFERENCES:

Bureau of Primary Health Care, as defined in HRSA's Health Center Program Compliance Manual.

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Approve Quality Assessment and Performance Improvement (QAPI) Policy

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 ("Parkland") 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 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 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).

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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

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

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Homeless Outreach Medical Services (HOMES) QAPI	POP.PI.002	Published: XX/XX/XXXX
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2024 Point in Time Count

- Requirement under Federal Law
- Extent of homelessness
- Changing trends
- Measure of their success in making homelessness rare, brief and nonrecurring

Thursday, January 25, 2024

Register to volunteer or provide gender neutral care packages

https://housingforwardntx.org/volunteer/

Questions?