Regular Public Meeting

January 10, 2022

community health center board

Multnomah County

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Multnomah County

Public Meeting Agenda
January 10, 2022
6:00-8:00 PM (via Zoom)

Health Center Mission: Bringing services to individuals, families, and communities that improve health and wellness while advancing health equity and eliminating health disparities.

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Board Members:

Harold Odhiambo – Chair
Fabiola Arreola – Vice Chair
Dave Aguayo – Treasurer
Pedro Sandoval Prieto – Secretary
Tamia Deary - Member-at-Large
Kerry Hoeschen – Member-at-Large
Darrell Wade – Board Member
Brandi Velasquez – Board Member
Aisha Hollands - Board Member

Adrienne Daniels - Interim Executive Director, Community Health Center (ICS)

Our Meeting Process Focuses on the Governance of the Health Center

- Meetings are open to the public
- Guests are welcome to observe/listen
- There is no public comment period
- All guests will be muted upon entering the Zoom

*Please email questions/comments to **Francisco Garcia at f.garcia7@multco.us**. Responses will be addressed within 48 hours after the meeting*

Time	Topic/Presenter	Process/Desired Outcome
6:00-6:05 (5 min)	**Call to Order / Welcome** • Harold Odhiambo, CHCB Chair	Call to order Review processes
6:05-6:10 (5 min)	**Minutes Review** - **VOTE REQUIRED** • Review December Public Meeting minutes for omissions/errors	Board votes to approve
6:10-6:20 (10 min)	**Ryan White Grant** - **VOTE REQUIRED** • Nick Tipton, Regional Manager, HSC & SEHC	Board votes to approve
6:20-6:30 (10 min)	**2022 Meeting Calendar** - **VOTE REQUIRED** • Francisco Garcia, Community Engagement Analyst, ICS	Board votes to approve
6:30-6:40 (10 min)	**Strategic Goals Finalization** - **VOTE REQUIRED** • Adrienne Daniels - Interim Executive Director, ICS	Board votes to approve
6:40-6:50 (10 min)	**Council Business & Updates** • Harold Odhiambo, CHCB Chair	Board receives updates
6:50-7:00 (10 min)	**Media & Outreach Strategies** • Margaux Mennesson & Shawn Masten, ICS Communications	Board receives updates
7:00-7:10	**10 Minute Break**	

7:10-7:20 (10 min)	**No Surprise Act Update** ● Jacqueline Chandler, Project Manager,Quality Team	Board receives updates
7:20-7:40 (20 min)	**HRSA Progressive Action Update** ● Wendy Lear, Deputy Director, Multnomah County Health Department ● Eric Arellano, Chief Financial Officer, Multnomah County ● Jeff Perry, HC Chief-Financial-Officer	Board receives updates
7:40-7:50 (10 min)	**Monthly Budget Report** ● Jeff Perry, HC Chief-Financial-Officer	Board receives updates
7:50-8:00 (10 min)	**Strategic Updates** ● Adrienne Daniels - Interim Executive Director, ICS	Board receives updates
8:00	**Meeting Adjourns**	Thank you for your participation

Public Meeting Minutes
December 13, 2021
6:00 - 8:00 pm (Virtual Meeting)

Health Center Mission: Bringing services to individuals, families, and communities that improve health and wellness while advancing health equity and eliminating health disparities.

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Dave Aguayo – Treasurer
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Kerry Hoeschen – Member-at-Large
Darrell Wade – Board Member
Susana Mendoza – Board Member
Brandi Velasquez – Board Member

Adrienne Daniels - Interim Executive Director, Community Health Center (ICS)

Board Members Excused/Absent: Dave Aguayo

Topic/Presenter	Discussion / Recommendations	Action	Responsible Party	Follow-up Date
Call to Order / Welcome • Chair, Harold Odhiambo	The Board Chair called the meeting to order at 6:05 PM A quorum **was** established. Joseph Leon and Lucia in attendance (Spanish interpretation)	N/A	N/A	N/A
Minutes Review - VOTE REQUIRED • Review November Public Meeting minutes for omissions/errors	Chair Odhiambo asked for approval or changes to the minutes. 11/08/21 CHCB Meeting - Some members did not receive previous minutes in order to approve. Motion to postpone minutes review until next meeting	***Motion to defer review to the January meeting: Tamia*** ***Second: Bee*** Yays: - 9 Nays: - 0 Abstain: - **Decision: Approved**		
Conversation with Commissioner Lori Stegmann (Dist 4) • Chair, Harold Odhiambo	The Commissioner discussed community needs and challenges that Dist 4 has been facing. A strong concentrate to be focused on is geographic areas that have yet to be invested in and more culturally specific areas in order to improve economic conditions for residents. The Commissioner spoke of the The Vance project which is aimed to have the			

	master plan developed by the beginning of 2022. The Vance project is based on Hawaii's concept of resilient hubs. Relisilent hubs are to provide resources to build more connected and prepared communities. A few key factors the Vance Project will provide are : 1. Providing places for the community to go in extreme weather conditions 2. Providing a meeting place for communities or non-profit organizations when not in use 3. Providing a new space for Multnomah County Animal Services The Commissioner expressed looking forward to partnering with the Board. Question was asked to Board members on what the Commissioner can do to support CHCB? Chair Odhiambo shared his own priorities ● Rebranding the Health Center so that we can increase our visibility and improve access to our valuable services. We have been working with the Multnomah County Chair's office on the rebranding project for over 3 years. ● Increasing vaccine access to our most vulnerable communities. We have been very successful so far and we want to continue this work. In partnership with the Chair Kafoury, the first phase of the Enterprise fund was successfully implemented. However, compliance is still an issue. The Health Center received several corrective actions from HRSA related to the County's mismanagement of the Health Center's funds. ICS Leadership and our Board have raised these concerns for many months with the County CFO, Chair Kafoury and Health Department leadership, the issues remain unresolved. The CHCB would like to partner with all Commissioners to swiftly address these issues. Franciscowas asked to schedule a follow up meeting with Commissioner Stegman for a discussion with CHCB about these issues.			

Bylaws Addendum - Article XVII - VOTE REQUIRED ● Chair, Harold Odhiambo	The Chair addressed difficulties to replace and recruit new Board members due to the pandemic. CHCB risks falling below the minimum requirement of 9 members to avoid noncompliance. The Chair proposed an addendum to the Bylaws Article XVII to allow current Board members that are willing to stay an additional 6 months while recruitment continues. There was a discussion as to whether the target of 15 members was too high. It was clarified that 15 is an ideal number, but even recruiting 5 new members to replace those currently terming-out or retiring would only bring us to 13. So if this addendum is approved, the board can then vote to allow Pedro to temporarily remain on the board for 12 months so we don't fall out of compliance. 15 is an ideal target.	***Motion to vote as presented: Tamia*** ***Second: Darrell*** Yays: - 8 Nays: - Abstain: - 1 **Decision:** **Approved**		
Invoke Addendum to Article XVII - VOTE REQUIRED	With the approval of the addendum for Article XVII, the Chair asked if there was a motion for a separate vote to invoke the addendum to allow Pedro to remain on the board for an additional 12 months. There was some confusion with some members thinking that they had just voted on that issue. No, the board just voted on giving any board member the ability to make the case for a temporary suspension of term limits, this vote is the application of the rule in regards to Pedro. (**Pedro excluded from this vote**)	***Motion to vote as presented: Darrell*** ***Second: Aisha*** Yays: - 7 Nays: - Abstain: - 1 **Decision: Approved**		

Executive Officer Elections - VOTE REQUIRED • Chair, Harold Odhiambo	The Board to vote on 3 open positions for 2022 with an effective date of start on January 1, 2022 Board Chair, Board Secretary, and Member-at-Large Chair, Harold Odhiambo expressed interest in running again Tamia indicated that she would be willing to swap roles to run as Secretary, if compliance required. Since there were not self-nominations for Secretary and Member at Large, Nomination Committee Chair asked Kerry and Pedro would be willing to continue their current rolls? Both agreed. Prior to the vote, there was a discussion of Pedro's eligibility since he was technically timing out. Pedro was timing out from two consecutive 3 year board terms, and had served two terms as Secretary, however per Article XIV, section 3. Executive Committee members are able to serve until a successor is elected . It was also clarified that board members could vote for themselves in a ballot election. Votes were submitted to Francisco and announced by Nomination Committee Chair after the break	**Voting results:** ***Board Chair*** *8 votes for Harold Odhiambo* *1 vote for Tamia Deary* ***Harold to remain as Board Chair*** ***Board Secretary*** *8 votes for Pedro Sandoval-Prieto* *1 Abstain* ***Pedro agreed to stay on as Secretary*** ***Member-at-Large (position 1)*** *8 votes for Kerry Hoeschen* *1 Abstain* ***Kerry agreed to stay on as Member-at-Large***		
10 Minute Break				

Primary Care - Change in Hours - VOTE REQUIRED ● Bernadette Thomas, Chief Clinical Officer	Proposal to have HC to resume evening hours ● Staffing and recruitment have made resuming hours challenging since the start of the pandemic ● This would only impact medical and pharmacy ● Short by 5 hours hope to get back to normal by spring 2022 Questions? ● The slide indicates different hours for medical and dental. What will make staff until closing? ○ ICS Pharmacy has been competitive with retail pharmacy. We feel there is a need to have as many hours as possible. Pharmacy patients have other work and patients that come into pickup prescriptions after their working hours. We are looking at and moving toward PC and Pharmacy hours in the future.	***Motion to vote as presented: Kerry*** ***Second: Tamia*** Yays: -9 Nays: - Abstain: - **Decision: Approved**		
Grant Opportunity - Roots and Wings - VOTE REQUIRED ● Adrienne Daniels - Interim Executive Director, ICS	Roots and Wings is a nonprofit based in Wisconsin that provides funding to support their mission and goals contributing to low income children and families. Funding would be used to support our work in child healthcare at HC clinics. Roots and Wings reached out directly to our HC with funding opportunity HC would gain $70-$80k in funding Questions? ● Are these funds to be used for current programs or anticipation for new programs to meet the metrics R&W are looking for? ○ Not enough funding to create new services. The funds to be used for our current work in Youth and Behavior Health Support, SHC or Pediatric work in our Dental and HC programs ● Would the funds provide youth activities? Or school based? ○ Our SHC's would be excellent for support to provide the programming to meet R&W metrics and goals	***Motion to vote as presented: Darrell*** ***Second: Kerry*** Yays: - 9 Nays: - Abstain: - **Decision: Approved**		

PAC Update ● Tony Gaines- Operations Innovation & Process Improvement Manager	PAC is the central point of access to our services. With staff shifting to telework it has caused some delay in patient access, by longer wait times or call abandonment rate. ● Goal abandonment rate 10% or less ● Goal answer 90% of calls or more The PAC dashboard is a high level overview that lets us know when calls come in and how should we plan to have staff on the phone The dashboard reflects the majority of patients called in between 730am and 930am. Heavy weight times are shown to be 11:30am and 1pm. There is a slight gap in data from May 2020 to July 2020 due to not having a system to obtain data Calls offered 249,621 calls during first quarter 2021which less than 2020. About the same amount of calls but less answered calls. The numbers speak to the pandemic A survey to be developed to hear feedback from patients and better serve them. Tony to come back and present more on the PAC redesign after listening and receiving patient feedback. Questions? ● Telework did or did not support an increase in call wait times and caller abondement? ○ Telework did not have the intended effect as we planned. Longer wait times which resulted in decreased access to needs for patient care. ● Is there a system in place where if a patient call drops, staff can call the patient back? ○ Yes, with PAC redesign we are looking at new ways to meet our goals and metrics. Phone trees to leave a message. We also are looking into working with WELL, which would allow patients to text for appointments or cancellations.			
Incidents and Complaints ● Kimmy Hicks, Project Manager, Quality Program (ICS)	Scheduling is is shown to be the #1 complaint ● Appointments being canceled ● Times not available or accessible to the patient need Mid county has had issues and incidents around the parking lot. Some go			

	unreported and reminder to staff to fill out incident reports to obtain better data. We have increased security. ● Found higher incidents when vaccination incentives were offered Immunization Error from the data reported was addressed ● For context - that 6k vaccines were just COVID vaccines during Q3. The total vaccines for the quarter was 42,348. Questions: ● Incident report numbers presented vs. what The Board members received are different? Which is correct and why? ○ Clinical care increased by 1 is the difference. Looking at the report before the weekend and noticed the one off. We asked data to re-run the report and it was too late to send out the new presentation. The presentation presented is correct with raw data. ● Can the complaints report type daa be broken down by site? ○ Yes, we can request that data and bring it to the next meeting. Comments : ● Increase font size for next presentation as it was difficult to see. ● Add Covid Vaccination and Immunization data by site			
Monthly Budget Report ● Jeff Perry, HC Chief-Financial-Officer	$1.3M deficit YTD date which is a result revenue shortfall but not because of spending access Careoregon checks came in late and will show in next period Dental and SHC show the largest shortfall in our target revenue Primary Care and Pharmacy are in good shape CareOregon is our predominant clients while we show a slight decrease in Trillium clients Questions? ● How are you preparing for the upcoming budget? ○ The County has released the budget kick-off to be on Wednesday December 15, 2021. December 23, 2021 the HD to to start working through Bud Tool Training and will continue through the month. December 28, 2021 Budget materials and			

	data are released to programs. January 06, 2022 Bud Tools are due to ICS and will have better overview and training with the Board to answer. Budget is due to the County Chair January 19 through January 28, 2022. The final budget is submitted February 14 through February 18, 2022.			
Strategic Updates ● Adrienne Daniels - Interim Executive Director, ICS	Nick Tipton to present on World AIDS Day starting on December 1st. World AIDS Day highlights the importance of ensuring equitable access to quality, HIV prevention and treatment services and that the voices of all who are living with or affected by HIV are heard and valued in the AIDS response. McCoy will display a World AIDS day quilt through Jan 07, 2022 to provide members of the community an opportunity to celebrate and commemorate 40 years. Encouragement to community and Board members to come to view the quilt as these are the largest pieces of folk art in the world. Health Center partnership with Lutheran Community Services Northwest in a new apprenticeship program. This program will provide in-clinic training and job shadowing that is by and for our refugees and immigrants community. This program will provide 2-3 apprenticeships at a time Budget season kicks off Wednesday. HC is working with the County specifically as well as with CHCB finance board to discuss ideas and gain input to bring back to the County. We hit 25K vaccinations, which was our largest goal milestone and now have surpassed 26K Maintain and exceeding patient diversity exceeding Questions? ● Are booster access clinics planned? ○ No offsite booster clinics at this time. We have weekly vaccinations options for all HC patients. Sign up is easily accessible to our patients through our website access walk in and special hours at the HC clinic are also offered ● Is not offering off site clinic boosters due to funding? ○ There are a few factors that our environment made sense to switch: ■ 1) Decrease for off site service and increase with			

	vaccinations available from other providers. ■ 2) Staff that may need to provide more in depth conversations with patients was easier at a PC / Dental visit vs. Direct outreach. ● How are the Student Health Center challenges in reference to in-person care being addressed and what plans to change what you are doing now based on feedback? ○ We have had 2 Incident reports where the police were called due to our patients being upset. We will look into deescalation training and not calling policing training. This will be reported back on what HC plans or options are.			
Council Business ● Chair, Harold Odhiambo	Challenging year as we are still battling covid, but we have made significant progress and The Chair wanted to end the year by sharing success updates. Successes shared : ● ICS creates more access for our most vulnerable community members to get covid tested and vaccinated. Thank you ICS leadership and staff. ● ICS HRSA funds to assist with covid ● CHCB welcomed 3 new members, Dr. Aisha Hollands, Darrell Wade and Bee Velasquez. ● OPCA Excellent award nominations for Tamia and Harold ● We are proposing to begin hybrid meetings in Jan 2022 that will be voluntary to attend in-person ● CHCB became and incorporated board As you may recall, the County leadership took offense to the CHCB becoming incorporated. In response to this, the County attorney submitted an email cautioning us about the risks of fundraising and using County staff/resources for support, stressing that as an incorporated entity we have no formal relationship with the County, and that being the case, his office also may not be in a position to provide any advice or support going forward. We are a volunteer Board with minimal resources, the implication that we may be at risk of losing access to County staff and resources if we continue to pursue our goals of incorporation, is alarming. In response to the attorney's email, at the November Board meeting the CHCB voted and approved pursuing the next steps to retain our own attorney			

and purchase the necessary insurance for the protection of the Board.

After weeks of trying to navigate the County's process for approval to use our funds to hire an attorney and pay for the insurance, the County finally shared their process with Adrienne. The real question is "When will we finally secure an attorney and why does the County continue to delay the process? We will review the questions at our December Executive team meeting to determine the best response.

As the governing Board for the Community Health Center, we have a responsibility to operate in compliance with HRSA requirements. The most troubling and ongoing concerns have been related to financial mismanagement. The CHCB and ICS leadership have communicated these concerns for almost 2 years. Although they have implemented some changes, the County and Health Department leadership have failed to adequately address these serious issues. Examples are:

- Over $1.5 million in checks were "lost".
- $6M was hidden in a separate account and the only people who knew about this account was the Countyand the Health Department leadership.
- $20M owed to the ICS by the State.
- If you recall, the discussion about the Enterprise Fund started in 2017, over 4 years ago.
- The County didn't pay vendors on time and patient care suffered.
- The County CFO shared with CHCB that he is conducting an audit about the Health Department's mismanagement and lack of proper protocols when handling our funds. We haven't received a response yet.
- The Health Department Director stated she was implementing a CQI process in response to the Health Department mismanagement of our funds. We haven't received a response yet. This is very common practice.

There are also unaddressed quality and compliance issues. The CHCB asked for a security assessment regarding a HIPAA breach that occurred in October last year. It's been a year and while the County is now responding by scheduling meetings, there is no resolution that has been determined, vetted or approved by the CHCB.

In order for the Health Center to be successful, there must be a trusted, collaborative relationship between the CHCB and Board of County Commissioners. It saddens me that we have really tried to build a relationship with the County and Health Department Leadership but there isn't any interest

	from the County for the CHCB to be an effective, functioning, governing Board. Their intimidation and bullying tactics have increased significantly since we incorporated and they have created a hostile working relationship. I am encouraging them to attend a future Board meeting for further discussion about these issues. I am proud of each one of you for standing strong in the face of adversity. We must ensure compliance for the Health Center and all Board members have the right to know and understand these requirements. For those reasons, I would like to allocate an hour of our December Executive Meeting for an emergency meeting. Please invite Ann, the HRSA representative, to share HRSA's expectations and requirements with the CHCB. As I stated it's been a long year, we have been successful but we still have mountains to climb. I am glad that I will climb those mountains in partnership with each one of you. Lastly, thank you to Tasha, Adrienne and the Health Center leadership and staff for your commitment to quality, affordable services to our community...especially during the pandemic.			
Meeting Adjourns	The Board Chair adjourned the meeting at 8:34 PM. The next public meeting will be on January 10, 2022 (Hybrid).			

Signed:_____ **Date:**_____
Pedro Prieto Sandoval, Secretary

Signed:_____ **Date:**_____
Harold Odhiambo, Board Chair

Scribe taker name/email: Crystal Cook crystal.cook@multco.us

Community Health Center Board

Public Meeting Minutes
November 08, 2021
6:00 - 8:00 pm (Virtual Meeting)

Health Center Mission: Bringing services to individuals, families, and communities that improve health and wellness while advancing health equity and eliminating health disparities.

Board Members:

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Kerry Hoeschen – Member-at-Large
Darrell Wade – Board Member
Susana Mendoza – Board Member
Brandi Velasquez – Board Member

Tahsa Wheatt-Delancy - Executive Director, Community Health Center (ICS)

Board Members Excused/Absent: Kerry Hoeschen

Topic/Presenter	Discussion / Recommendations	Action	Responsible Party	Follow-up Date
Call to Order / Welcome Chair, Harold Odhiambo	The Board Chair called the meeting to order at 6:06PM A quorum **was** established. Felipe Nystrom in attendance (Spanish interpretation)	N/A	N/A	N/A
Minutes Review - VOTE REQUIRED	Chair Odhiambo asked for approval or changes to the minutes. 9/27/21 Emergency Meeting - 10/11/21 CHCB Meeting - under council business, invite one CHCB member to Council meeting to partner with one of the commissioners;	***Motion to vote as presented: Tamia Second: David*** Yays: 8 Nays: 0 Abstain: - **Decision: Approved**		
CHCB Candidate - Dr. Aisha Hollands - VOTE REQUIRED Fabiola Arreola, Nominating Committee Chair	The nominating committee chair indicated that Dr. Aisha Hollands has experience with behavioral health and equity training. She is a perfect candidate for membership. After receiving a unanimous vote, Dr Hollands indicated that she is excited about this opportunity, and her belief that her personal and	***Motion to vote as presented: Tamia Second: David*** Yays: 8 Nays: 0		

	professional experience have led in this direction; she is particularly interested in addressing the health disparities and intersections of African American and LatinX populations	Abstain: - **Decision:** **Approved**		
Grant Request: SHC Telehealth Pilot - VOTE REQUIRED *Alexandra Lowell, Manager, Student Health Centers*	2 grants before the board, 1) The State is offering grant funding to three different SHB programs throughout the state to expand services and create more access to schools without a SHC. Pilot funding would allow collaboration with MESD to increase access without expanding SHCs. Yes will allow us to submit letter of interest; State will interview HC and determine grant eligibility; Motion to approve: Fabiola; 2nd: Tamia 8 Yays, motion approved 2) COVID 19 Recovery Grant - submit proposal for $150K for next 18 months January 2022-June 2023, to fund .8 FTE medical assistant to increase culturally specific access to services A question was raised of what is meant by a 'culturally specific response?" - Will likely attach a Spanish language KSA on position. Comment of appreciation for both grants, however it would have been better to offer them individually because it is a little confusing to have them in the same presentation. - They were lumped together since both funds come from the State.	***Motion to vote as presented: Fabiola Second: Tamia*** Yays: 8 Nays: 0 Abstain: - **Decision:** **Approved**		
5 Year Facilities Planning Adrienne Daniels, Director, Strategy and Population Health	Overview of Strategic Facilities and Building Needs and how impact providing services to community The Health Center program occupies multiple buildings for both administrative and clinical functions Vaccine infrastructure has been created using federal dollars - generators, support vaccine services, etc CHCB needs to determine where it wants to invest or cutails funds - several buildings are not aligned with current demand for services Multiple projects are currently underway to repair and improve County owned locations: Leases on some HC buildings do not allow for	N/A		

	remodels Currently evaluating top service needs and demand from community / patients: ○ Patient surveys ○ Healthcare and Medicaid Utilization data ○ Partner feedback ○ Building life Analyzing Market Property Values ○ Purchasing options ○ Leasing options Factors in evaluating building use: longevity score; fair lease rate; long-term processes; A question was raised if anything was in the pipeline for Mid-County, other than power capacity, vaccine infrastructure? – No. This requires more research and discussion on what services are not being provided and which populations are impacted.			
Analysis of PCC Partnership Proposal - VOTE REQUIRED Adrienne Daniels, Director, Strategy and Population Health	Not scope change; Workforce center will provide space and opportunities for local students, employers and community members to create and find jobs. Intentionally designed to co-locate specific types of services: ● PCC - Programs, educational spaces, and career advisory services ● DHS - Housing services and associated benefit programs ● Home Forward - On site housing ● NAYA - Economic development and home buying education Early survey of La Clinica clients: ● Majority of patients are willing to travel less than 2 miles to a new location. ● 1 in 5 patients said they were unsure if they would move to a new location ● Strong majority of patients want to have dental and pharmacy services on site, especially female and Spanish speaking patients ● Patient expressed that they liked the current primary care	***Motion to vote as presented: Tamia*** ***Second: David*** Yays: 8 Nays: 0 Abstain: - **Decision:** **Approved**		

services, but often struggled with parking

Projected student population shares very strong alignment with mission of health center program

Recommendation to forward with planning process to fully scope costs and timeline to propose a formal scope change. A scope change vote would be initiated after the planning process is completed.

Questions:

- Have you spoken to clinic personnel to see if they are okay with this change?
    - Yes, with managers, if board says to move forward, will request feedback from staff on what changes they'd like to see
- What is the impact on current partners at LCBS? What would be the impact for the County to purchase Rockwood?
    - Impact - Contractual agreement that expires;
    - They are building a new development across the street that will offer services there and working with another health center.
- Parking for PCC space will be improved and how much?
    - 25-35 spaces reserved for patients and staff;
- Comment that post-pandemic there is a greater shortage of people to do the jobs and meet needs of the community. This effort supports meeting that challenge;
- This is a particularly high traffic area. What steps would be taken to ensure the safety of patients in the area.
    - Topic has not come up, but can be added to proposal analysis; safety is addressed at all buildings as part of regular operations;
- How would it impact NEHC services?
    - La Clinica program is just over 3.5 miles from NEHC and they each serve different populations; there is no

	expectation that patients will change clinics			
Local Needs Assessment Claire Nystrom Sr. Specialist, Strategy & Grants Development	Annual needs assessment for health center required by HRSA Follows instructions for the most recent Service Area Competition (2018) Describes the overall community and not Health Center Program clients Important for the Board and Health Center Program leadership to see the circumstances under which our clients live and whether the HC Program is meeting the needs of the broader population it is supposed to serve. The assessment is key for strategic planning; Will get into a deeper dive during the board retreat. (Chair had to cut the presentation short due to time.)			
Move into Closed Session	Chair made a motion to go into a Closed Session meeting per the authorization under ORS 192.610 to 192.690 : The motion David 2nd Darrell; Yays 8; motion approved - **Closed session from 7:30pm-8:09pm (note taker not present)** Motion to end the Closed Session by Tamia, 2nd: David Yays: 7 (Fabiola had to transition)	***Motion to vote for closed session: David*** ***Second: Darrell*** Yays: 8 Nays: 0 Abstain: - **Decision:** **Approved** ***Motion to vote to end closed session: Tamia*** ***Second: David*** Yays: 7 Nays: 0 Abstain: - (Fabiola had to		

		transition) **Decision:** **Approved**		
Update on Patient Access Center Tony Gaines, Operations Innovation & Process Improvement Mgr.	Postponed to December 13 meeting			
Monthly Budget Report Jeff Perry, HC Chief-Financial-Officer	Given the late hour, Chair asked CFO to submit their report in writing to be part of the board record			
CHCB Operational Updates Francisco Garcia, Community Engagement Strategist, ICS	Francisco will provide his updates at another meeting			
COVID/ICS/Strategic Updates Tasha Wheatt-Delancy, Executive Director, ICS	CHCB and County leadership received a Request for Information (RFI) from HRSA regarding more information related to CHCB incorporation as Welcome Health; docs are due by 11/16; ICS is working on response We are still waiting on HRSA's response to our submission of materials following our 60 day accelerated timeline. We expect a response soon. Tasha will add additional updates to document sent to CHCB Given the late hour, Chair asked CEO to submit rest of report in writing to be part of the board record			
Council Business Chair, Harold Odhiambo	The County has indicated to us and to HRSA that they do not have sufficient information to understand what Welcome Health is, how that entity seeks to interact with Multnomah County, and what support it will need from Multnomah County. As a result of this, the County Attorney sent an email detailing a few items for consideration: 1) We may no longer receive representation from County Counsel and			

	2) we may need to consider obtaining tort claim insurance as well as Directors and Officer insurance. Based on the recent feedback from the County Attorney in response to the CHCB incorporating, I would like to bring forward a **motion to authorize the use of health center resources to retain independent legal representation for the Board**, to secure Tort Claim insurance as well as Directors and Officers insurance David moved, Tamia 2nd; 6 Yay, Abstain 1 (Bee could not unmute) **Motion to approve the Quality Committee and ICS Leadership to develop the scope for a security assessment** based on the industry standards and best practices related to the management of patient records. This will help inform overall quality improvement for the health center program and mitigate future risks to the health center. move Tamia, 2nd: Bee; Yay: 7 The CHCB has had several meetings with County leadership to discuss staffing issues and continued financial concerns including invoices that were not paid The County responded by saying they are completing an internal audit and a Continuous Quality Improvement plan for Health Department Business Services. We will continue to follow up on this. Tamia inquired about the new data trustee role for the Health Department Director, Ebony Clark and if this would impact compliance with the CHCB's data governance policy. Director Clark clarified that she does not approve any data requests for the Health Center and all decisions are made by the ICS Director. We are asking Director Clark to ensure that all Health Department staff are aware of our data governance policy and ensure they adhere to the policy. We are still very committed to our partnership with Multnomah County. We want to ensure that we are leading this work as equal parties. These values are important for our work going forward.	***Motion to vote as presented: David Second: Tamia*** Yays: 6 Nays: 0 Abstain: 1 (Bee could not unmute) **Decision:** **Approved** --- ***Motion to vote as presented: Tamia Second: Bee*** Yays: 7 Nays: 0 Abstain: - **Decision:** **Approved**		
Meeting Adjourns	The Board Chair adjourned the meeting at 8:23 PM. The next public meeting will be on December 13, 2021 via Zoom.			

Signed:_____ **Date:**_____

Pedro Prieto Sandoval, Secretary

Signed:_____ **Date:**_____

Harold Odhiambo, Board Chair

Scribe taker name/email: Jordana Sardo, jordana.sardo@multco.us

Presentation Summary

Ryan White Part D – Services for Women and Youth

Community Health Center Board (CHCB) Authority and Responsibility
As the governing board of the Multnomah County Health Center, the CHCB is responsible for revising and approving changes in the health centers scope; availability of services, site locations, and hours of operations; and operating budget. Reviewing and approving the submission of continuation, supplemental, and competitive grant applications is part of this review and approval process.

An approval to submit a grant application will allow for budget revisions during the application development process within and between approved budget categories up to 25 percent without CHCB approval. All budget revisions that exceed the cumulative 25% budget revision cap will be presented to the CHCB for a vote prior to grant submission. Upon Notice of Award, the budget approved by the funder will be presented to the CHCB for a final approval.

Date of Presentation: 1/10/2022	Program / Service Area: HIV Health Services Center
Presenters: Nick Tipton	

This funding will support: Primary care Women and Youth living with HIV	**X** Current Operations	⬜ Expanded services or capacity	⬜ New services

Project Title and Brief Description:

- Ryan White Part D – Services for Women and Youth
- The purpose of the RWHAP Part D Women, Infants, Children and Youth (WICY) program is to provide family-centered health care services in an outpatient or ambulatory care setting for low income WICY with HIV. Under this announcement, applicants must propose to provide family-centered care in outpatient or ambulatory care settings to low income women (25 years and older) with HIV, infants (up to two years of age) exposed to or with HIV,

children (ages two to 12) with HIV, and youth (ages 13 to 24) with HIV. HHSC serves women and youth (age 18 -25) and works to connect pediatric cases/exposed infants to OHSU.

What need is this addressing?

- The number of low-income WICY Living with HIV (LWH) with complex medical and psychosocial needs has continued to increase, accompanied by an increase in the cost of care for these individuals and a decrease in insurance reimbursement. This has put an increased burden on the HHSC to provide more services with less funding. Part D funds complement other funds (e.g. Parts A, C, revenue, etc.) are are an essential Part of the funding model to ensure that low-income WICY LWH, especially those who are uninsured and underinsured, have access to comprehensive, quality medical care.

What is the expected impact of this project? (# of patients, visits, staff, health outcomes, etc)

HHSC is committed to ensuring services are accessible to marginalized and hard-to-reach populations. HHSC's primary focus is on serving PLWH who are uninsured, underinsured, and low income, and as a result, slightly over one-fifth of these clients are homeless or unstably housed. MCHD conducts outreach and provides ancillary services, such as transportation assistance, to facilitate engagement in care. Case managers support engagement and retention in care, especially for patients dually or multiply diagnosed with mental illness and/or substance abuse disorders.

Over the past several years, the number of low-income PLWH with complex medical and psychosocial needs has continued to increase, accompanied by an increase in the cost of care for these individuals and a decrease in insurance reimbursement. This has put an increased burden on the HHSC to provide more services with less funding. Ryan White funds are essential to ensure that low-income PLWH, especially those who are uninsured and underinsured, have access to comprehensive, quality medical care. These funds have been instrumental in helping the HHSC create a unique primary care medical home focused on the needs of PLWH. This model of care helps HHSC achieve high rates of retention in care that help improve health outcomes for PLWH and help them to achieve viral load suppression, thus preventing new infections. HHSC serves approximately 1,500 patients/year, 235 (16%) of which are WICY.

Presentation Summary

What is the total amount requested: Up to $374,930/ year for 4 years *Please see attached (projected) budget*
Expected Award Date and project/funding period: The funding period is from 8/1/2022 -7/31/2026.
Briefly describe the outcome of a "YES" vote by the Council *(be sure to also note any financial outcomes)* A "yes" vote means MCHD will submit the Ryan White Part D Competing Continuation application that will support HHSC efforts to provide care to WICY LWH in the region.
Briefly describe the outcome of a "NO" vote or inaction by the Council *(be sure to also note any financial outcomes)* A "no" vote means HHSC will not be able to apply for the grant which means that clinical services for WICY LWH will not continue at current capacity.
Related Change in Scopes Requests: *(only applicable in cases in which project will represent a change in the scope of health center services, sites, hours or target population)*

Proposed Budget (when applicable) – The FY23 budtool is not yet ready to be completed. If Nick Tipton, Regional Manager has budget details by the full CHCB meeting, he can share at that time. If Nick is not able to share the details at that time, the full budget will be shared as soon as available and if the CHCB does not approve the application will be rescinded.

Part D generally cover (partial) FTE/fringe for staff, including: Providers, Clinic Medical Assistants, Medical Case Managers, Navigators/CHWs and mental health providers. Funds also support County Indirect costs. Attached is the budget from last year's Ryan White Part D Grant for reference.

Ryan White Part D
8/1/2022-7/31/2026

Multnomah County Health Department

	Budgeted Amount	**Comments** (Note any supplemental or matching funds)	**Total Budget**
A. Personnel, Salaries and Fringe			

Presentation Summary

	Revenue	Comments (Note any special conditions)	Total Revenue
E. Direct Care Services and Visits			
Medicare			
Description of service, # of visits			
Medicaid			
Description of service, # of visits			
Self Pay			
Description of service, # of visits			
Other Third Party Payments			
Description of Service, # of visits			
Total Direct Care Revenue			
F. Indirect and Incentive Awards			
Description of special funding awards, quality payments or related indirect revenue sources			
Description of special funding awards, quality payments or related indirect revenue sources			
Total Indirect Care and Incentive Revenue			
Total Anticipated Project Revenue (E+F)			

Multnomah County Health Department Ryan White Part D
HIV Health Services Center
LINE ITEM BUDGET
8/1/2021 - 7/31/2022

	Annual Salary	% FTE	Medical Service	Support Service	CQM	Admin	Total
1. Salaries and Wages							
Interim Regional Clinic Manager, Nicholas Tipton (in-kind)	$114,500	0.05	$0	$0	$0	$0	$0
Project Director/ Program Supervisor, Emily Borke (in-kind)	$97,660	0.05	$0	$0	$0	$0	$0
Nurse Practitioner, Erica Harris	$127,682	0.06	$7,661	$0	$0	$0	$7,661
Nurse Practitioner, Maria Kosmetatos	$141,588	0.20	$28,318	$0	$0	$0	$28,318
Physician Assistant, Mary Tegger	$141,588	0.20	$28,318	$0	$0	$0	$28,318
Physician, Virginia Weeks	$199,300	0.11	$21,923	$0	$0	$0	$21,923
Clinic Medical Assistant, Leslie Veenker	$55,416	0.2	$11,083	$0	$0	$0	$11,083
Clinic Medical Assistant, Trese Isom	$55,416	0.2	$11,083	$0	$0	$0	$11,083
Clinic Medical Assistant, Summer Pepper	$47,283	0.20	$9,457	$0	$0	$0	$9,457
Behavioral Health/Medical Case Manager, Bridget Neilson	$74,058	0.15	$11,109	$0	$0	$0	$11,109
Behavioral Health/Medical Case Manager, Emily Burchell	$69,534	0.15	$10,430	$0	$0	$0	$10,430
Behavioral Health/Medical Case Manager, Alexandra Vitale	$81,080	0.04	$3,243	$0	$0	$0	$3,243
Behavioral Health/Medical Case Manager, Kristin Cedar	$70,547	0.15	$10,582	$0	$0	$0	$10,582
Behavioral Health/Medical Case Manager, Vacant	$70,547	0.15	$10,582	$0	$0	$0	$10,582
Community Health Specialist/Navigator, Shannon Redmond	$51,179	0.11	$5,630	$0	$0	$0	$5,630
Lead Community Health Specialist/Navigator, Jamie Christianson	$57,765	0.20	$11,553	$0	$0	$0	$11,553
Community Health Specialist/Navigator, Shane Wilson	$49,978	0.12	$5,997	$0	$0	$0	$5,997
Clinical Psychologist, Renata Ackerman	$102,646	0.05	$5,132	$0	$0	$0	$5,132
On-call Psychiatric Mental health Nurse Practitioner	$53	105 hrs	$5,567	$0	$0	$0	$5,567
Total Salaries and Wages			**$197,668**	**$0**	**$0**	**$0**	**$197,668**
2. Fringe Benefits Fringe benefit costs include percentage-based and flat rate fringe benefits. Please see the Budget Narrative for details.			**$134,216**	**$0**	**$0**	**$0**	**$134,216**
0			**$0**	**$0**	**$0**	**$0**	**$0**
4. Equipment			**$0**	**$0**	**$0**	**$0**	**$0**
5. Supplies			**$0**	**$0**	**$0**	**$0**	**$0**
6. Contractual			**$0**	**$0**	**$0**	**$0**	**$0**
7. Construction			**$0**	**$0**	**$0**	**$0**	**$0**
8. Other			**$0**	**$0**	**$0**	**$0**	**$0**
9. Total Direct Costs Summary							

Salaries and Wages		$197,668	$0	$0	$0	$197,668
Fringe Benefits		$134,216	$0	$0	$0	$134,216
Travel		$0	$0	$0	$0	$0
Equipment		$0	$0	$0	$0	$0
Supplies		$0	$0	$0	$0	$0
Contractual		$0	$0	$0	$0	$0
Construction		$0	$0	$0	$0	$0
Other		$0	$0	$0	$0	$0
Total Direct Costs		**$331,884**	**$0**	**$0**	**$0**	**$331,884**
10. Indirect Costs MCHD charges an indirect cost rate of 13.32 % of personnel costs. Included are costs up to the indirect cap rate of 10%, the remainder is provided in-kind.		**$36,876**	**$0**	**$0**	**$36,876**	**$36,876**
Total Indirect Costs		**$36,876**	**$0**	**$0**	**$36,876**	**$36,876**
11. Total Project Costs		**$368,760**	**$0**	**$0**	**$36,876**	**$368,760**

Multnomah County Health Department Ryan White Part D
HIV Health Services Center
BUDGET NARRATIVE
8/1/2021 - 7/31/2022

	Annual Salary	% FTE	Medical Service	Support Service	CQM	Admin	Total
1. Salaries and Wages							
Interim Regional Clinic Manager, Nicholas Tipton (in-kind)	$114,500	0.05	$0	$0	$0	$0	$0
The Clinic Manager supervises project staff, ensures integration of funded activities in clinic operations. Coordinates with Divisional and Department leadership to ensure on-going support for sustainability. Total FTE = 1.0; Project FTE = .05; Annual Salary = $114,500							
Project Director/ Program Supervisor, Emily Borke (in-kind)	$97,660	0.10	$0	$0	$0	$0	$0
Coordinates grant application processes, reporting cycles, and is the liaison with federal program officers; coordinates data quality improvement activities. Coordinates with community partners. Supervises medical case managers and patient navigators. Total FTE = 1.0; Project FTE = .05; Annual Salary = $97,660							
Nurse Practitioner, Erica Harris	$127,682	0.06	$7,661	$0	$0	$0	$7,661
To provide medical care to Part D participants. Total FTE = 0.6; Project FTE = 0.06; Annual Salary $120,081							
Nurse Practitioner, Maria Kosmetatos	$141,588	0.20	$28,318	$0	$0	$0	$28,318
To provide medical care to Part D participants. Total FTE = 0.8; Project FTE = 0.20; Annual Salary $141,588							
Physician Assistant, Mary Tegger	$141,588	0.20	$28,318	$0	$0	$0	$28,318
To provide medical care to Part D participants. Total FTE = 0.8; Project FTE = 0.20; Annual Salary $141,588							
Physician, Virginia Weeks	$199,300	0.11	$21,923	$0	$0	$0	$21,923
To provide medical care to Part D participants. Total FTE = 0.8; Project FTE = 0.11; Annual Salary $213,686							
Clinic Medical Assistant, Leslie Veenker	$55,416	0.2	$11,083	$0	$0	$0	$11,083
To provide medical care to Part D participants. Total FTE = 1.0; Project FTE =0.2; Annual Salary $55,416							

Clinic Medical Assistant, Trese Isom To provide medical care to Part D participants. Total FTE = 1.0; Project FTE =0.2; Annual Salary $55,416	$55,416	0.2	$11,083	$0	$0	$0	$11,083
Clinic Medical Assistant, Summer Pepper To provide medical care to Part D participants. Total FTE = 1.0; Project FTE =0.20; Annual Salary $47,283	$47,283	0.20	$9,457	$0	$0	$0	$9,457
Behavioral Health/Medical Case Manager, Bridget Neilson To provide bilingual English/Spanish behavioral health interventions and medical case management services to Part D participants in order to support their engagement in care. This position also acts as a lead team member. Total FTE = 1.0; Project FTE = 0.15; Annual Salary $74,058	$74,058	0.15	$11,109	$0	$0	$0	$11,109
Behavioral Health/Medical Case Manager, Emily Burchell To provide behavioral health/medical case management intake services to Part D participants Total FTE = 1.0; Project FTE = 0.02; Annual Salary $69,534	$69,534	0.15	$10,430	$0	$0	$0	$10,430
Behavioral Health/Medical Case Manager, Alexandra Vitale To provide behavioral health interventions and medical case management services to Part D participants in order to support their engagement in care. Total FTE = 0.90; Project FTE = 0.04; Annual Salary $81,080	$81,080	0.04	$3,243	$0	$0	$0	$3,243
Behavioral Health/Medical Case Manager, Kristin Cedar To provide behavioral health interventions and medical case management services to Part D participants in order to support their engagement in care. Total FTE =1.0 ; Project FTE = 0.15; Annual Salary $70,547	$70,547	0.15	$10,582	$0	$0	$0	$10,582
Behavioral Health/Medical Case Manager, Vacant To provide behavioral health interventions and medical case management services to Part D participants in order to support their engagement in care. Total FTE = 0.90 ; Project FTE = 0.15; Annual Salary $70,547	$70,547	0.15	$10,582	$0	$0	$0	$10,582
Community Health Specialist/Navigator, Shannon Redmond Provides intensive navigation and care coordination to WICY with multiple vulnerabilities and WICY who are newly diagnosed as a member of the primary care team. Focus on providing culturally competent services to Black/African American clients	$51,179	0.11	$5,630	$0	$0	$0	$5,630
Lead Community Health Specialist/Navigator, Jamie Christianson Provides intensive navigation and care coordination to WICY with multiple vulnerabilities and WICY who are newly diagnosed as a member of the primary care team. This position also provides day-to-day leadership for the Navigation Team. Total FTE =1.0 ; Project FTE = 0.20; Annual Salary $57,765	$57,765	0.20	$11,553	$0	$0	$0	$11,553

Community Health Specialist/Navigator, Shane Wilson Provides intensive navigation and care coordination to WICY with multiple vulnerabilities and WICY who are newly diagnosed as a member of the primary care team. Total FTE =1.0 ; Project FTE = 0.20; Annual Salary $49,978	$49,978	0.12	$5,997	$0	$0	$0	$5,997
Clinical Psychologist, Renata Ackerman To provide mental health therapy to patients, clinical supervision to medical case managers/behavioral health staff, and training to clinic staff. Total FTE=0.80; Project FTE = 0.05; Annual Salary $102,646	$102,646	0.05	$5,132	$0	$0	$0	$5,132
On-call Psychiatric Mental health Nurse Practitioner To provide mental health and substance abuse assessment, treatment, and medication management. $53.02/hr x 105 hrs.	$53	105 hrs	$5,567	$0	$0	$0	$5,567
Total Salaries and Wages			**$197,668**	**$0**	**$0**	**$0**	**$197,668**
2. Fringe Benefits Fringe benefit costs include percentage-based and flat rate fringe benefits; the projected costs are driven by standard County benefit plans, which vary slightly by union bargaining unit and employment status (full-time, part-time, on-call, etc.). Percentage-based rates include FICA (7.65%), Tri-Met tax (0.79%), Workers Compensation (0.70%), liability insurance (0.85%), unemployment insurance (0.25%), retirement (29.42% avg), health benefits administration (1.10%), County Attorney (1.60%), LTD/STD/Life Insurance (0.75%), retiree medical (2.00%), and VEBA (1.00% for management staff only). Flat rate benefits, which include medical and dental insurance, are charged at $18,547 for a full-time employee.			**$134,216**	**$0**	**$0**	**$0**	**$134,216**
3. Travel			**$0**	**$0**	**$0**	**$0**	**$0**
4. Equipment			**$0**	**$0**	**$0**	**$0**	**$0**
5. Supplies			**$0**	**$0**	**$0**	**$0**	**$0**
6. Contractual			**$0**	**$0**	**$0**	**$0**	**$0**
7. Construction			**$0**	**$0**	**$0**	**$0**	**$0**
8. Other			**$0**	**$0**	**$0**	**$0**	**$0**
9. Total Direct Costs Summary							
Salaries and Wages			$197,668	$0	$0	$0	$197,668
Fringe Benefits			$134,216	$0	$0	$0	$134,216
Travel			$0	$0	$0	$0	$0
Equipment			$0	$0	$0	$0	$0
Supplies			$0	$0	$0	$0	$0
Contractual			$0	$0	$0	$0	$0

Construction		$0	$0	$0	$0	$0
Other		$0	$0	$0	$0	$0
Total Direct Costs		**$331,884**	**$0**	**$0**	**$0**	**$331,884**
10. Indirect Costs MCHD charges an indirect cost rate of 13.32 % of personnel costs. Included are costs up to the indirect cap rate of 10%, the remainder is provided in-kind.		**$36,876**	**$0**	**$0**	**$36,876**	**$36,876**
Total Indirect Costs		**$36,876**	**$0**	**$0**	**$36,876**	**$36,876**
11. Total Project Costs		**$368,760**	**$0**	**$0**	**$36,876**	**$368,760**

CHCB 2022 Calendar

January						
S	M	T	W	T	F	S
						1
2	3	4	5	6	7	8
9	**10**	11	12	13	14	15
16	17	18	19	20	21	22
23	**24**	25	26	27	28	29
30	31					

February						
S	M	T	W	T	F	S
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6	7	8	9	10	11	12
13	**14**	15	16	17	18	19
20	21	22	23	24	25	26
27	**28**					

March						
S	M	T	W	T	F	S
		1	2	3	4	5
6	7	8	9	10	11	12
13	**14**	15	16	17	18	19
20	21	22	23	24	25	26
27	**28**	29	30	31		

April						
S	M	T	W	T	F	S
					1	2
3	4	5	6	7	8	9
10	**11**	12	13	14	15	16
17	18	19	20	21	22	23
24	**25**	26	27	28	29	30

May						
S	M	T	W	T	F	S
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15	16	17	18	19	20	21
22	**23**	24	25	26	27	28
29	30	31				

June						
S	M	T	W	T	F	S
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12	**13**	14	15	16	17	18
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26	**27**	28	29	30		

July						
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10	**11**	12	13	14	15	16
17	18	19	20	21	22	23
24	**25**	26	27	28	29	30
31						

August						
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	1	2	3	4	5	6
7	**8**	9	10	11	12	13
14	15	16	17	18	19	20
21	**22**	23	24	25	26	27
28	29	30	31			

September						
S	M	T	W	T	F	S
				1	2	3
4	5	6	7	8	9	10
11	**12**	13	14	15	16	17
18	19	20	21	22	23	24
25	**26**	27	28	29	30	

October						
S	M	T	W	T	F	S
						1
2	3	4	5	6	7	8
9	**10**	11	12	13	14	15
16	17	18	19	20	21	22
23	**24**	25	26	27	28	29
30	31					

November						
S	M	T	W	T	F	S
		1	2	3	4	5
6	7	8	9	10	11	12
13	**14**	15	16	17	18	19
20	21	22	23	24	25	26
27	**28**	29	30			

December						
S	M	T	W	T	F	S
				1	2	3
4	5	6	7	8	9	10
11	**12**	13	14	15	16	17
18	19	20	21	22	23	24
25	**26**	27	28	29	30	31

Community Health Center Board Meetings
2nd Monday of every month
6:00pm – 8:00pm

Executive Committee Meetings
4th Monday of every month
5:45pm-7:15pm

Community Health Center Board

Board Presentation Summary

Presentation Title	2022 - 2025 Strategic Plan

Type of Presentation: Please add an "X" in the categories that apply.

Inform Only	Annual / Scheduled Process	New Proposal	Review & Input	Inform & Vote
				X

Date of Presentation:	**January 10, 2022**	**Program / Area:**	**All Services**
Presenters:	Adrienne Daniels		

Project Title and Brief Description:

2022 - 2025 Strategic Plan

Every three years, the Community Health Center Board is required to participate in and produce a formal strategic plan. This plan outlines the goals, priorities, and expected work of the health center.

Describe the current situation:

The Community Health Center Board last reviewed the strategic plan in 2020-21. However, this plan was considered an abbreviated timeline due to the COVID19 pandemic. The Board has spent the fall of 2021 reviewing the existing plan and discussing how to best update the strategic goals for the next three years.

Why is this project, process, system being implemented now?

HRSA requires that all health center boards complete a strategic planning process and plan every three years. The Community Health Center Board's current strategic plan will expire in 2022.

Briefly describe the history of the project so far *(Please indicate any actions taken to address needs and cultures of diverse clients or steps taken to ensure fair representation in review and planning):*

The Community Health Center Board holds an annual strategic planning retreat every fall. This year, the Executive Committee began review of the strategic planning goals and key discussion topics in October. The full board met to begin their review of program effectiveness and priorities over two meetings: November 3 and November 10, 2021. During the November 10 meeting, Board members participated in strategic planning exercises and activities to inform how the existing plan should be updated to reflect the highest priority concerns of the health center.

List any limits or parameters for the Board's scope of influence and decision-making:

Strategic planning is intended to set high level, mission driven goals and priorities. It does not capture specific operational or day-to-day projects. The Board is not voting on specific grants, budget items, or program scope decisions as part of the strategic planning process.

Briefly describe the outcome of a "YES" vote by the Board
(Please be sure to also note any financial outcomes):

A yes vote will affirm that the drafted 2022-2025 Strategic Plan should be adopted by the Health Center and will allow the leadership team to begin operationalizing core priorities and setting specific programmatic targets.

Briefly describe the outcome of a "NO" vote or inaction by the Board
(Please be sure to also note any financial outcomes):

A no vote means that an alternative strategic plan will need to be developed. The current strategic plan would remain in place until the end of 2022 or until a new plan is approved by the Board.

Which specific stakeholders or representative groups have been involved so far?

Community Health Center Leadership Staff

Community Health Center Board Members

Who are the area or subject matter experts for this project?
(Please provide a brief description of qualifications)

Adrienne Daniels, Interim Executive Director Fred Dolgin, Health Center Operations Director Jeff Perry, Health Center Finance Director Bernadette Thomas, Health Center Clinical Director
What have been the recommendations so far?
Adopt the proposed 2022-2025 Strategic Plan. The updated plan incorporates many of the same priorities as the existing plan, but adds additional focus areas on financial planning and facilities planning.
How was this material, project, process, or system selected from all the possible options?
Board members met to review the existing strategic plan goals and to discuss how existing COVID19 work would continue to influence patient care needs, access, and operational priorities. The Board also reviewed specific strategies which could be considered over the next three years to assure success and optimal impact of the health center program.

Board Notes:

Multnomah County Community Health Center

2022 - 2025 Strategic Plan

Community Health Center Board

Table of Contents

Executive Summary

The Multnomah County Community Health Center Board is accountable for ensuring that the Community Health Center provides high quality, comprehensive services for patients in alignment with both its mission as well as federal program requirements. The Board establishes expectations and priorities for the Community Health Center through the annual strategic planning process and formal strategic plan. In 2022, the Community Health Center completed a two year strategic plan due to the COVID19 pandemic. The updated 2022-2025 plan takes a longer, more traditional 3+ year outlook.

Under the 2022-2025 Strategic Plan, the Community Health Center Board confirmed that the unique position of the Health Center was to remain focused on racial equity, creating strong partnerships, and to continue high value, mission centered work for the health center workforce (position statements below). The Board also confirmed that the previous strategic goals should be updated to reflect the emerging work centered on value based care, and advancing operation excellence across all service areas. In addition, the 2022-2025 plan includes a review of the facilities needs of the health center, identifying the short and long term needs of buildings for patient-centered care. The Board will work with staff to monitor and review the operational implementation of the strategic plan over the next three years.

Position Statements

For community members in Multnomah County seeking access to health care, your Multnomah County Health Center provides the care you want. Our multiple locations, passionate staff, focus on racial equity and the advancement of health equity and inclusion set us apart.

We will partner with our neighbors in achieving health equity by providing the care you want in the way that works for you. We will listen to you and work with you to reach your wellness goals.

We will provide high-value engagement and mission-centered work to all employees. Specifically, we commit to recruiting and retaining Black and or Indigenous, and Persons of Color (B/IPOC) staff reflective of our patient population by empowering them to be agents and leadership of change and be the voice of the community they represent.

2022-2025 Strategic Objectives:

1. Operational Excellence: Build One Health Center that delivers high touch, high quality care driven by the needs of our community
2. Advance health equity: Nurture thriving healthy communities by centering race in order to advance health equity
3. Our People: Our people are our greatest asset: success is reliant on a strong workforce that can drive goals for decades to come.
4. Health Center of Choice: Be the first place that people want to get their healthcare.
5. Financial Stewardship: Design financial systems and performance so that the health center is here for the next five decades

About Integrated Clinical Services and the Community Health Center Program

Integrated Clinical Services (ICS) provides comprehensive primary care, dental, pharmacy, lab, and associated clinical and quality services as part of the Multnomah County Health Department. ICS operates services as a Community Health Center Program - (Federally Qualified Health Center (FQHC)), assuring that care is available to all persons, no matter their income or insurance status. The community health center model provided by FQHCs was developed under the War on Poverty initiative and associated social investment movements from the 1960s. This model emphasizes and requires a patient-governed healthcare system. All FQHC programs must be located in areas where economic, social, cultural, or geographic barriers limit access to care. In 2019, FQHC programs provided care to nearly 30 million patients in the United States and associated territories.[1]

In addition to participating in the federal community health center program, ICS also participates in the Oregon Health Authority's Person Centered Medical Home model to assure high quality and high access standards. The health center program is accredited by The Joint Commission.

ICS's first federally recognized and accredited community health center location was the Roosevelt High School Student Health Center in 1977. Today, the program offers care at 18 locations across 24 clinics. It is recognized nationally for high levels of clinical quality. The health center program is governed and overseen by the Community Health Center Board (CHCB).

In 2020, ICS's health center program served over 50,000 unique patients who utilized a qualifying visit.[2] 64% of patients identify as an ethnic or racial minority and more than 95% of patients make less than 200% of the federal poverty limit. 71% of patients are enrolled with

[1] Health Resources and Services Administration "Health Center Program: Impact and Growth". Accessed Dec 23, 2020 at https://bphc.hrsa.gov/about/healthcenterprogram/index.html.
[2] HRSA does not include unique patients who accessed services unrecognized as a "visit". This includes only seeking immunization services, dental sealant services, prescription refills, and visits with non independent practitioners.

Medicaid or the Children's Health Insurance Program and 17% are uninsured. More than 30% of the health center's population is under the age of 18.[3]

[3] 2020 Integrated Clinical Services Health Center Program data as reported to the Health Resources and Services Administration's Uniform Data Services (UDS).

The Strategic Planning Process

The Health Resources and Services Administration (HRSA) requires that all community health center programs participate in a formal strategic planning process as overseen by the governing board. Strategic planning should occur at minimum, every three years. Strategic planning is a separate process from the governing board's required annual Quality Plan, although the strategic plan may reference or direct investments into specific quality improvement or quality assurance efforts.

The Community Health Center's Executive Committee reviewed and affirmed the board's retreat topics and approach on October 25, 2021. The Community Health Center Board held their full annual strategic retreat on Saturday, November 13, 2021, with supplemental work and reviews also held on November 8, 2021. This retreat included discussion of:

- November 8:
    - Most recent Health Center Program *Patient Needs Assessment*
    - Review of the three year facilities needs of the health center program
- November 13:
    - COVID19 impact on health center operations and patient populations
    - Discussion of health center access priorities and challenges over the next three years
    - Review of the *Mission, Vision, and Values* of the Health Center Program
    - Drafting the *2022-2025 Strategic Priorities*
    - Updated health center business intelligence reporting capabilities
    - Confirming the three year facilities' needs of the health center program

The Role of the Board

The Community Health Center Board is composed of both health center patients and community members who support the mission and vision of community health centers. Patients must represent at least 51% of the board members. The board is accountable for ensuring that the health center program continues to meet both the regulatory requirements as set by the Health Services and Resources Administration (HRSA) as well as supporting the healthcare and health services needs identified by the community. These specific board roles and responsibilities are detailed in the federal Health Center Program compliance manual.[4]

The Board is responsible for reviewing and setting the strategic plan for the health center program. This includes oversight and approval of the Mission, Vision, and Values, as well as setting regular strategic objectives. The board discusses these strategies during their annual board retreat and regularly reviews performance metrics throughout the year.

[4] HRSA Health Center Program Compliance Manual. "Board Authority: Chapter 19"

The Role of Senior Leadership and Health Center Staff

Health Center program staff are responsible for assuring that the Board's directions and strategic initiatives are supported and implemented. Health Center staff members are accountable to the Executive Director of the Health Center Program, who works with the Board to assure that the strategic plan is accurately documented and communicated to all stakeholders.

Senior Leadership, with the Executive Director, meet regularly with Board members to provide progress updates and discuss goals for the health center program.

Timeline and the Impact of the Coronavirus Pandemic

As part of the 2022-2025 strategic planning process, the Board evaluated the short term impact on operations of the health center and patient population access. The previous two year strategic plan recognized that the coronavirus pandemic would significantly delay and require reprioritization of key initiatives. The evaluation revealed that while access to care was significantly impacted, the overall distribution of care to vulnerable patient populations and the health center's commitment to access to care by race remained strong. The largest differences observed between years was in patients under the age of 18 as well as in dual eligible patients.

Access: Who (2019 vs 2020)

Total of unique 62,168 patients in 2019 and 50,028 patients with a UDS qualifying visit in 2020… and yes, 2020 includes telehealth

Age		
Year	2019	2020
Children (<18 years)	39.92%	33.74%
Adults (18 - 64)	53.44%	58.86%
Older Adults (65+ years)	6.64%	7.4%

Income and Insurance		
Year	2019	2020
Uninsured	17.11%	15.83%
Medicaid / CHIP	72.13%	71.4%
Medicare	6.52%	8.25%
Dual Eligible (Medicare and Medicaid)	4.93%	1.17%
Other Private	4.24%	4.5%

Race / Ethnicity		
Year	2019	2020
Racial or ethnic minority	64.17%	64.6%
% Hispanic / Latino	36.1%	36.9%
% Non Hispanic / White	41.81%	41.53%
% Asian	11.57%	11.28%
% Native Hawaiian	1.46%	1.48%
% Black / African American	15.76%	15.68%
% More than one race	4.23%	4.64%

In addition to reviewing direct care access, the board also discussed the impact of changes to the Patient Access Center (call center) and how this may have also impacted patient care. The

board requested that this work continue to be included as a priority for the health center over the next year; additional reports and monitoring updates for the board were scheduled on the Patient Access Center in the late fall of 2021.

The Board formally approved the updated *Mission, Vision, and Values* of the health center during the December 2020 board meeting. The board did not recommend changes to the current mission, vision, or values as part of the 2022-2025 strategic plan, but will continue to evaluate and update the mission and vision every three years.

Community Health Center staff providing COVID19 vaccines to the healthcare workforce.

Community Health Center Mission, Vision, and Values

Health Center Mission

Bringing services to individuals, families, and communities that improve health and wellness while advancing health equity and eliminating health disparities.

Health Center Vision

Integrated. Compassionate. Whole person health.

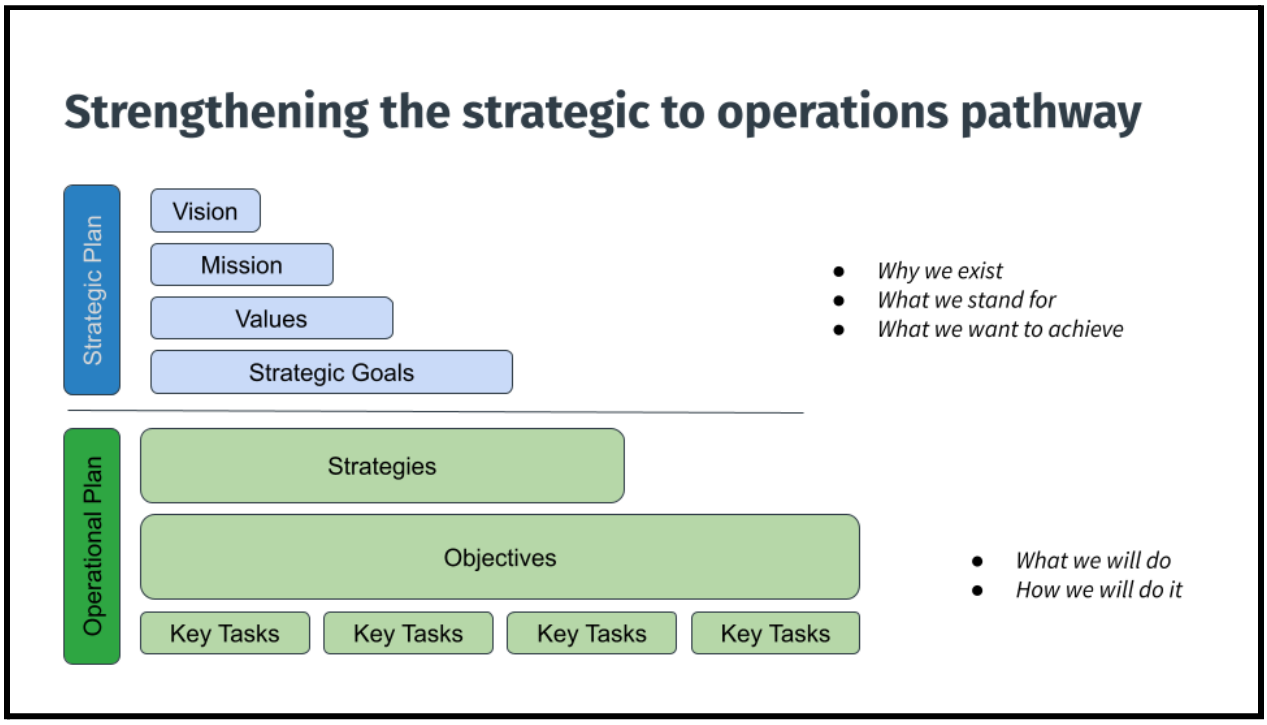
Health Center Values

- *Equitable care that assures all people receive high quality, safe, and meaningful care*
- *Patient and community determined: leveraging the collective voices of the people we serve*
- *Supporting fiscally sound and accountable practices which advance health equity and center on racial equity*
- *Engaged, expert, diverse workforce which reflect the communities we serve*

At the Mid County Health Center, October 2021

2022-2025 Strategic Goals and Strategies

Based upon the historical goals of the health center program, values, and review of health center access needs, the Board reviewed and updated the health center's strategic goals. Each goal includes multiple strategies to address the ultimate desired outcome. An operational plan will be developed by senior leadership to assure that each piece of the plan contains specific, measurable objectives.



Strategic Goals	**Strategies for each goal**
Operational Excellence: Build One Health Center that delivers high touch, high quality care driven by the needs of our community.	• We have a consistent way of understanding and identifying our work • Increase and expand care options • We are efficient, effective, and empowering in the way we do our work • We design the system around the social determinants of health and health equity
Our People: Our people are our greatest asset: success is reliant on a strong, stable, workforce that can drive goals for decades to come.	• Focus on decreasing staff turnover rates and increase retention • Make space for and invest in relationship building across ICS • Talent acquisition • Build better jobs
Health Center of Choice:	• Services are community determined

Be the first place that people want to get their healthcare.	● Increase and expand access options ● Ensure a welcoming, patient centered health center experience which leads to a trusted space for community ● Build a highly visible, accessible public presence
Financial Stewardship: Design financial systems and financial performance so that the health center is here for the next five decades.	● Every role understands their part of the financial cycle. We create strong financial literacy for each staff member of the health center. ● We diversify our revenue sources so that we are not dependent on one payer or service type. Every service and program develops a balanced portfolio / risk model. ● We understand the business model; all programs have a line of sight and can collect information on their financial performance. ● We ask for more: our agreements reflect the true cost of care and we do not undervalue our services.
Advance Health Equity: Nurture thriving, healthy communities by centering race in order to advance health equity.	● We recognize our patients as the experts. No counter narratives without verification of the story. ● Invest in technology that eliminates barriers to care for patients. ● Build trusted partnerships to build better lives with social determinants of health as a core focus. We intentionally connect. ● We create spaces for staff engagement and partnership in health equity, including workforce development. ● Develop a REDI committee to provide consultation and support for the entire health center program.

Measuring Success and Progress of the Strategic Plan

Strategic planning is the process that companies and organizations use to set their priorities and work for the future. It relies on the mission and vision to identify specific values and decisions which must be made. The Strategic Plan for the Health Center Program is intended to set the priorities for investments, program development, and help manage risks that the organization may encounter. Health Center staff must be accountable to the Board by providing regular updates on the strategic plan objectives throughout the year.

Health Center staff will provide the Board with regular updates about the strategic plan through an operational planning cycle, which will include monthly Director updates. Below are example objectives which have been drafted to match board-approved strategic objectives and strategies for the upcoming three years

Strategic Objectives	**Sample Strategy**	**Example Operational Goals**
Operational Excellence	Increase and expand care options	1. By April 2022, patient advice requests to nursing staff are responded to within two hours 2. By June 2022, a separate phone pathway is developed to meet non-clinical client needs 3. A call back option is incorporated into the current patient access center by 2022.
Our People	Talent Acquisition	1. By 2022, a talent acquisition plan is completed and identifies process improvements for recruiting, applicant tracking, interviews/assessments, reference checks, hiring, and onboarding. 2. By June 2022, the recruitment to hire time frame is reduced by 50%.
Health Center of Choice	Services are community determined	1. Implement quarterly patient engagement surveys for each service line by the end of 2021 2. By the end of 2022, a comprehensive market analysis is completed for each major region and service line.
Financial Stewardship	We ask for more. Our agreements reflect the true cost of care and we don't undervalue our services.	1. By 2022, the Change in Scope application costs have been fully implemented and approved by OHA. 2. By 2023, all revenue generating contracts are reviewed and analyzed to determine top changes and negotiation opportunities.
Advance Health Equity	We create spaces for staff engagement and partnerships in health equity, including workforce development.	1. We identify and reserve a minimum number of hours for training and engagement for every staff member to participate in workforce development or WESP activities by the end of 2022. 2. Each health center location chooses specific investments and staff wellness activities by the end of 2022.

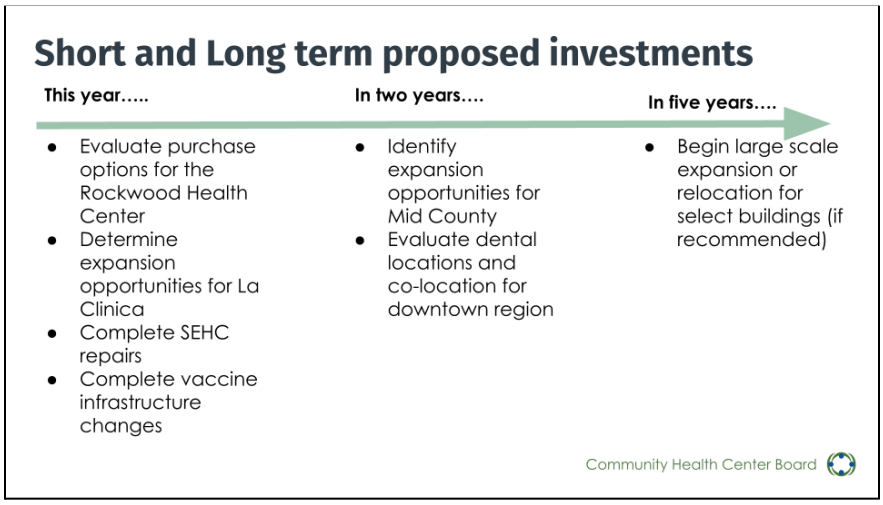
Strategic Facilities Investments and Planning

The 2022-2025 plan also incorporates the top facilities needs of the health center program. The Community Health Center board identified both short term and long term opportunities to align patient care goals with infrastructure needs. A market analysis was reviewed and discussed for the Northern and Rockwood regions as part of the strategic facilities review process. The Board confirmed in their discussion and review of patient data that there remained a strong need to continue providing services in both areas, including the need to evaluate expansion of dental and pharmacy services in the Northern corridor. These investments would build on the previously identified vaccine infrastructure investments approved by the Board in 2021.

In 2022, the Board expects to complete several high profile facilities planning projects:

1. Completion of SE Health Center repairs and investments to improve patient access to care for primary care, dental, and pharmacy services
2. Confirming the purchase options for Rockwood health center, a currently leased building which the Board would like to retain as a service site in partnership with Multnomah County
3. Determine expansion opportunities in the Northern Corridor for the La Clinica site, including how to add dental and pharmacy services or relocation opportunities.
4. Completion of new generators and vaccine infrastructure purchases at key vaccination access points at the Mid County and NE Health Center locations.

In the next two to five years, the board also confirmed its desire to maintain a strong presence and opportunity for expansion at the Mid County health center location, as well as continuous evaluation of co-location opportunities for primary care and dental services. A major facilities investment plan is expected to assure success for a high profile expansion of the Mid County Health Center facility, requiring multiple investment and financial risk scenario planning. Over the same time period, the Board expects to also review space opportunities for the NE Health Center, in alignment with Multnomah County's strategic facility review of the same space.



Executive Director and Board Approval

The Executive Director and Community Health Center Board recognize and approve the 2022-2025 Community Health Center Strategic Plan as voted on January 10, 2021.

Signed: _____

Dated: _____

Adrienne Daniels
Interim Executive Director
Multnomah County Community Health Center

Signed: _____

Dated: _____

Harold Odiambo
Board Chair
Multnomah County Community Health Center

Fact sheet

No Surprises: Understand your rights against surprise medical bills

Jan 03, 2022 Billing & payments, Coverage

The No Surprises Act protects people covered under group and individual health plans from receiving surprise medical bills when they receive most emergency services, non-emergency services from out-of-network providers at in-network facilities, and services from out-of-network air ambulance service providers. It also establishes an independent dispute resolution process for payment disputes between plans and providers, and provides new dispute resolution opportunities for uninsured and self-pay individuals when they receive a medical bill that is substantially greater than the good faith estimate they get from the provider.

Starting in 2022, there are new protections that prevent surprise medical bills. If you have private health insurance, these new protections ban the most common types of surprise bills. If you're uninsured or you decide not to use your health insurance for a service, under these protections, you can often get a good faith estimate of the cost of your care up front, before your visit. If you disagree with your bill, you may be able to dispute the charges. Here's what you need to know about your new rights.

What are surprise medical bills?

Before the No Surprises Act, if you had health insurance and received care from an out-of-network provider or an out-of-network facility, even unknowingly, your health plan may not have covered the entire out-of-network cost. This could have left you with higher costs than if you got care from an in-network provider or facility. In addition to any out-of-network cost sharing you might have owed, the out-of-network provider or facility could bill you for the difference between the billed charge and the amount your health plan paid, unless banned by state law. This is called "balance billing." An unexpected balance bill from an out-of-network provider is also called a surprise medical bill.

People with Medicare and Medicaid already enjoy these protections and are not at risk for surprise billing.

What are the new protections if I have health insurance?

If you get health coverage through your employer, a Health Insurance Marketplace®,[1] or an individual health insurance plan you purchase directly from an insurance company, these new rules will:

- Ban surprise bills for most emergency services, even if you get them out-of-network and without approval beforehand (prior authorization).
- Ban out-of-network cost-sharing (like out-of-network coinsurance or copayments) for most emergency and some non-emergency services. You can't be charged more than in-network cost-sharing for these services.
- Ban out-of-network charges and balance bills for certain additional services (like anesthesiology or radiology) furnished by out-of-network providers as part of a patient's visit to an in-network facility.
- Require that health care providers and facilities give you an easy-to-understand notice explaining the applicable billing protections, who to contact if you have concerns that a provider or facility has violated the protections, and that patient consent is required to waive billing protections (i.e., you must receive notice of and consent to being balance billed by an out-of-network provider).

What if I don't have health insurance or choose to pay for care on my own without using my health insurance (also known as "self-paying")?

If you don't have insurance or you self-pay for care, in most cases, these new rules make sure you can get a good faith estimate of how much your care will cost before you receive it.

What if I'm charged more than my good faith estimate?

For services provided in 2022, you can dispute a medical bill if your final charges are at least $400 higher than your good faith estimate and you file your dispute claim within 120 days of the date on your bill.

What if I do not have insurance from an employer, a Marketplace, or an individual plan? Do these new protections apply to me?

Some health insurance coverage programs already have protections against surprise medical bills. If you have coverage through Medicare, Medicaid, or TRICARE, or receive care through the Indian Health Services or Veterans Health Administration, you don't need to worry because you're already protected against surprise medical bills from providers and facilities that participate in these programs.

What if my state has a surprise billing law?

The No Surprises Act supplements state surprise billing laws; it does not supplant them. The No Surprises Act instead creates a "floor" for consumer protections against surprise bills from out-of-network providers and related higher cost-sharing responsibility for patients. So as a general matter, as long as a state's surprise billing law provides at least the same level of consumer protections against surprise bills and higher cost-sharing as does the No Surprises Act and its implementing regulations, the state law generally will apply. For example, if your state operates its own patient-provider dispute resolution process that determines appropriate payment rates for self-pay consumers and Health and Human Services (HHS) has determined that the state's process meets or exceeds the minimum requirements under the federal patient-provider dispute resolution process, then HHS will defer to the state process and would not accept such disputes into the federal process.

As another example, if your state has an All-payer Model Agreement or another state law that determines payment amounts to out-of-network providers and facilities for a service, the All-payer Model Agreement or other state law will generally determine your cost-sharing amount and the out-of-network payment rate.

Where can I learn more?

Still have questions? Visit CMS.gov/nosurprises, or call the Help Desk at 1-800-985-3059 for more information. TTY users can call 1-800-985-3059.

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[1] Health Insurance Marketplace® is a registered service mark of the U.S. Department of Health & Human Services.

A federal government website managed and paid for by the U.S. Centers for Medicare & Medicaid Services.

7500 Security Boulevard, Baltimore, MD 21244

No Surprises Act- Project Overview

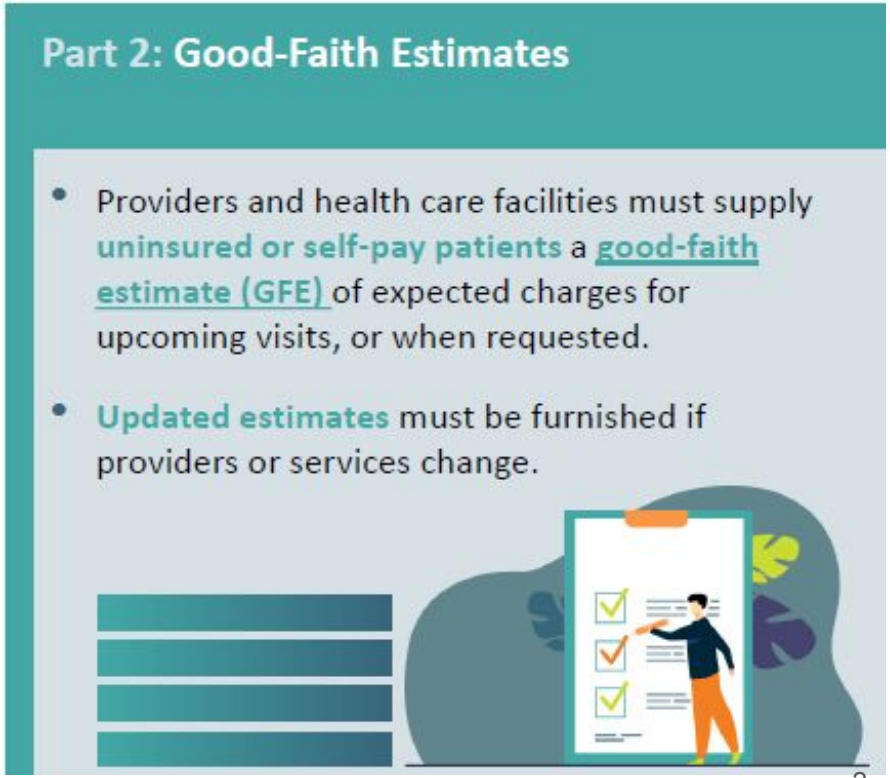
Updated 1/1/21

Community Health Center

No Surprises Act (NSA)

Multnomah County Health Department
Community Health Center

- No Surprises Act protects cash pay/sliding scale patients from receiving surprise medical bills
- Implementation Deadline: January 1, 2022
- Integrated Clinic Services will need to generate Good Faith Estimates (GFEs)
- GFE is only required for:
  - Uninsured-cash-pay or self-pay patients
  - If a patient asks for a GFE



Good Faith Estimate (GFE) Criteria

Multnomah County
Health Department
Community Health Center

If an uninsured or self-pay patient	Is GFE required, and when?
Schedules an appointment >10 business days in advance	Yes, within 3 business days of scheduling
Schedules an appointment 3-9 business days in advance	Yes, within 1 business day of scheduling
Schedules an appointment < 3 business days in advance	GFE is not required
Requests a GFE (or asks about service fees), but does not schedule an appointment	Yes, within 3 business days of request
Schedules the same service on a recurrent basis (e.g. multiple behavioral health appointments)	Yes, A single GFE can apply to such services for a maximum interval of 12 months *fees change frequently-generate new GFE to confirm rates

Things to Note

Multnomah County Health Department
Community Health Center

- **GFEs Accuracy:** GFEs need to have $400 accuracy rate of actual bill (wiggle room)
- **If services change during the appointment**: updated GFE is only required upon request
- **GFE template:** Available in 44 different languages
- **Access to GFE:** At this time only OA2, OA Senior, Clerical Staff, Supervisors and Managers have access to generate the GFE. No clinical staff have access. Eligibility and PAC does not have access
- **Programs are not insurance:** Screenwise, Reproductive Health and Care Bridge Assist look like insurance in the system and will not fall into the workqueue
- **Confidential Accounts:** The GFE must be generated but not printed. Patients can pick up GFE in person. Please verify ID for patients picking up GFE's
- **Editing patient charges:** At this time acupuncture is one of the known costs that must be edited. Please consult site leadership for this cost
- **Applying the slide:** if a patient is eligible and has been approved for programs such as Screenwise, Reproductive Health, and Care Assist you can slide the cost the patients pays to zero. This also applies to Student Health Center grants. Care Bridge does NOT slide to zero as some CPT codes are not covered.

Resources Available

Multnomah County Health Department
Community Health Center

Patient Materials:

- **Patient Information Insert:** Include with every GFE mailed/given to patient, includes language about not being turned away for inability to pay and they may be eligible for insurance and other programs
- **NSA Website:** https://www.multco.us/primary-care-and-dental/no-surprises-act-new-protections-against-surprise-medical-bills
- **New Patient Welcome Packets:** Patient info insert will be added to packets

Staff Materials:

- **EPIC Job Aid:** Provided by CSI team
- **Good Faith Estimate Workflow:** In development
- **NSA Staff FAQ:** Sent out 1/2/2022
- **CPT Cheat Sheet:** In Progress- 1st version sent 1/2/2022

Questions/Concerns?

Multnomah County
Health Department
Community Health Center

- Contact your Supervisor
- Q&A Sessions: Daily check ins available first week of January 2022
- Question Tracker: Google Doc Link here
  - Tracker is reviewed daily, responses will be posted here

community health center board
Multnomah County

HRSA Financial Packet

January 10, 2022

Following the 60-day progressive action conditions placed on the Health Center resulting from the November 2020 Targeted Program Requirement Assessment Site Visit, HRSA has determined that Multnomah County remains out of compliance with two Health Center Program requirements.

- Chapter 15: Financial Management and Accounting Systems-Element a. Financial Management and Internal Control Systems, and
- Chapter 19: Board Authority-Element c. Exercising Required Authorities and Responsibilities.

HRSA has made the determination to immediately place the two 30-day conditions "on hold" for a standard 90-day period to allow Multnomah County (as grantee of record) to complete full implementation of the Enterprise Fund and document the CHCB's governing authority over the Fund. To show compliance, HRSA has required that the CHCB be provided the following monthly reports:

✓ 1. A report with Itemized general journal entries

✓ 2. A report with the following items: adjustments to health center general fund sub-funds, and transfers of health center resources

✓ 3. Monthly reports with balance sheet accounts such as cash, accounts receivable, reserves, incentives, and accounts payable.

✓ 4. A report with itemized details for all indirect cost charges and internal services charges including an itemized detailed report capturing all occupancy costs the health center is paying for (including vacant space) including a detailed list of the spaces as well as the allocation for the Health System. Included in the report should be the County's algorithm for allocating space to the Health Center as well as the indirect expense algorithm.

✓ 5. A projection of health center monthly cash requirements in a user-friendly format, using Excel or other spreadsheet applications, to display projected cash balances for each month for the next 12 months (considering factors such as county funding, projected patient utilization, seasonal variations, incentives, and planned increases in reimbursement rates);

✓ 6. A revenue and expense statement;

✓ 7. A modified health center balance sheet in a user-friendly format to display accounts such as cash, accounts receivable, incentives, accounts payable, and a fund balance;

8. A projected modified health center balance sheet in a user-friendly format to display projected quarterly balances for health center accounts such as cash, accounts receivable, incentives, accounts payable.
(Currently seeking clarity from HRSA as to the parameters of documentation to be provided.)

✓ 9. A monthly report from the health department on all health center vacancies by position, length of vacancy, status of efforts to fill the position and financial costs of each vacancy.

10. A summary with projected expenses to be reviewed with CHCB prior to BCC contract approvals for Labor relations contract negotiations that could increase expenses for the Health Center.
(Contract bargaining in progress. No report for January due to lack of active proposals to be made.)

Multnomah County
Federally Qualified Health Center

Monthly Financial Reporting Package

November FY 2022

Updated 1/4/2022

Prepared by: Financial and Business Management Division

** The financial information in these materials are prepared for and provided to the Health Center by the Health Department's Finance and Business Management division.*

Multnomah County Health Department
Community Health Council Board - Financial Statement
For Period Ending November 30, 2021
Percentage of Year Complete: 41.7%

Community Health Center - Monthly Highlights

Financial Statement: For period 5 in Fiscal Year 2022 (July 2021 - June 2022)

	YTD Actuals	Budget	Difference	% of Budget YTD
Revenue:	$ 53,025,587	$155,495,490	$102,469,903	34%
Expenditures:	$ 53,211,956	$155,495,490	$102,283,534	34%
Surplus/(Deficit)	$ (186,368)			

Recent Budget Modifications:

Period added	Budmod #	Description	Amount
01 July	Budmod-HD-003-22	State CARES Act funding to increase Vaccination Rates	$ 1,146,666
03 September	Budmod-HD-009-22	State CARES Act funding to Health for Vaccine Incentives	$ 250,000
			$ 1,396,666

- Grant Revenue Projection reflects $2.17M in related expenditures invoiced in prior periods. (1)
- Expenditures are tracking at 34% which is slightly behind the expected target of 42% primarily due to Contractual costs, which are tracking at 6%
- PC 330 Grant amount fully spent as of November. Final (November) amounts will post in December. The grant will restart in January. (2)
  - Breakdown of PC 330 amounts (2021 Calendar Year): 5,514,900.80 FY21 (January 21 - June 21) | 3,512,037.91 FY22 (July 21 - Oct 21) | 670,922.29 FY22 (Nov 21) = 9,697,861

Multnomah County Health Department
Community Health Council Board - Financial Statement
For Period Ending November 30, 2021
Percentage of Year Complete: 41.7%

Community Health Center

	Adopted Budget	Revised Budget	Budget Change	01 July	02 Aug	03 Sept	04 Oct	05 Nov	06 Dec	Year to Date Total	% YTD	FY21 YE Actuals
Revenue												
County General Fund Support	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	0%	$ 5,222,198
General Fund Fees and Misc Rev	$ -	$ -	$ -	$ 4,380	$ 5,053	$ 3,851	$ (11,242)	$ -	$ -	$ 2,042	0%	$ 111,693
Grants - PC 330 (BPHC) **(2)**	$ 9,309,724	$ 9,309,724	$ -	$ -	$ -	$ 1,815,488	$ -	$ 1,696,550	$ -	$ 3,512,038	38%	$ 9,515,047
Grants - COVID-19	$ 13,000,000	$ 14,396,666	$ 1,396,666	$ -	$ -	$ 11,571	$ (7,764)	$ 9,560	$ -	$ 13,367	.09%	$ 8,682,545
Grants - All Other	$ 4,235,186	$ 4,235,186	$ -	$ 40	$ 31,261	$ 517,640	$ 98,422	$ 559,053	$ -	$ 1,206,416	28%	$ 8,581,060
Grant Revenue Projection **(1)**	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 2,170,072	$ -	$ 2,170,072	0%	$ -
Quality & Incentives Payments	$ 7,500,159	$ 7,500,159	$ -	$ 647,267	$ 544,656	$ 103,650	$ 41,160	$ 1,743,310	$ -	$ 3,080,043	41%	$ 11,049,279
Health Center Fees	$ 115,169,056	$ 115,169,056	$ -	$ 8,866,217	$ 8,382,679	$ 8,167,450	$ 7,845,968	$ 7,997,021	$ -	$ 41,259,335	36%	$ 92,485,906
Self Pay Client Fees	$ 1,244,879	$ 1,244,879	$ -	$ 51,363	$ 57,006	$ 56,768	$ 58,924	$ 41,623	$ -	$ 265,683	21%	$ 678,121
Beginning Working Capital	$ 3,639,820	$ 3,639,820	$ -	$ 303,318	$ 303,318	$ 303,318	$ 303,318	$ 303,318	$ -	$ 1,516,592	42%	$ 3,145,138
Total	**$ 154,098,824**	**$ 155,495,490**	**$ 1,396,666**	**$ 9,872,585**	**$ 9,323,973**	**$ 10,979,736**	**$ 8,328,786**	**$ 14,520,507**	**$ -**	**$ 53,025,588**	**34%**	**$ 139,470,987**
Expense												
Personnel	$ 88,758,656	$ 89,419,870	$ 661,214	$ 6,843,236	$ 6,720,121	$ 6,894,611	$ 6,743,961	$ 6,700,819	$ -	$ 33,902,749	38%	$ 88,332,034
Contracts	$ 15,756,862	$ 16,496,172	$ 739,310	$ 263,055	$ 149,337	$ 136,835	$ 184,742	$ 272,965	$ -	$ 1,006,934	6%	$ 3,659,777
Materials and Services	$ 21,652,095	$ 21,619,659	$ (32,436)	$ 1,332,384	$ 1,765,936	$ 1,403,011	$ 2,092,054	$ 1,336,120	$ -	$ 7,929,506	37%	$ 18,982,109
Internal Services	$ 27,626,711	$ 27,655,289	$ 28,578	$ 1,165,983	$ 2,228,137	$ 2,652,568	$ 2,526,474	$ 1,792,939	$ -	$ 10,366,101	37%	$ 24,921,085
Capital Outlay	$ 304,500	$ 304,500	$ -	$ -	$ -	$ -	$ 6,666	$ -	$ -	$ 6,666	2%	$ 128,667
Total	**$ 154,098,824**	**$ 155,495,490**	**$ 1,396,666**	**$ 9,604,659**	**$ 10,863,531**	**$ 11,087,026**	**$ 11,553,897**	**$ 10,102,843**	**$ -**	**$ 53,211,956**	**34%**	**$ 136,023,672**
Surplus/(Deficit)	**$ -**	**$ -**	**$ -**	**$ 267,926**	**$ (1,539,558)**	**$ (107,289)**	**$ (3,225,111)**	**$ 4,417,665**	**$ -**	**$ (186,368)**		**$ 3,447,315**

Multnomah County Health Department
Community Health Council Board
FY 2022 YTD Actual Revenues & Expenses by Program Group
For Period Ending November 30, 2021
Percentage of Year Complete: 41.7%

Category	Description	Admin	Dental	Pharmacy	Primary Care Clinics	Quality & Compliance	Student Health Centers
Revenues	County General Fund Support	-	-	-	-	-	-
	General Fund Fees and Miscellaneous Revenue	-	-	-	2,042	-	-
	Grants - HRSA PC 330 Health Center Cluster **(2)**	730,214	146,278	-	2,349,752	-	136,131
	Grants - HRSA Healthy Birth Initiatives	-	-	-	-	-	-
	Grants - HRSA Ryan White	-	-	-	-	-	-
	Grants - DHHS and OHA Ryan White	-	-	-	-	-	-
	Grants - OHA Non-Residential Mental Health Services	-	-	-	-	-	-
	Grants - All Other	45,613	-	-	-	-	341,206
	Grants - Other COVID-19 Funding	39,150	-	-	(46,914)	-	-
	Grants - HHS CARES Act Provider Relief	-	-	-	-	-	-
	Grants - HRSA Health Center CARES Act	-	-	-	-	-	-
	Grants - HRSA Expanding Capacity for Coronavirus Testing	-	-	-	-	-	-
	Grant Revenue Projection **(1)**	708,307	65,253	-	637,894	-	146,364
	Medicaid Quality and Incentive Payments	2,176,903	-	-	-	903,140	-
	Health Center Fees	764,901	6,727,264	13,930,545	17,365,735	10,895	1,232,445
	Self Pay Client Fees	-	35,588	101,691	125,235	-	-
	Beginning Working Capital	1,124,219	204,873	-	-	187,500	-
Revenues Total		5,589,307	7,179,256	14,032,236	20,433,743	1,101,535	1,856,146
Expenditures	Personnel Total	5,717,768	7,541,143	2,897,536	12,564,676	979,106	1,699,202
	Contractual Services Total	495,795	103,802	4,134	329,073	4,373	37,829
	Internal Services Total	1,612,709	2,027,473	1,282,741	3,912,455	267,689	505,466
	Materials & Supplies Total	194,090	389,189	6,535,105	493,075	18,240	107,711
	Capital Outlay Total	-	6,666	-	-	-	-
Expenditures Total		8,020,361	10,068,273	10,719,516	17,299,279	1,269,408	2,350,209
Net Income/(Loss)		(2,431,055)	(2,889,017)	3,312,720	3,134,464	(167,873)	(494,063)
Total BWC from Prior Years		2,293,860	3,593,476	-	15,850	2,575,732	2,000

Multnomah County Health Department
Community Health Council Board

FY 2022 YTD Actual Revenues & Expenses by Program Group
For Period Ending November 30, 2021
Percentage of Year Complete: 41.7%

	Category	Description	HIV Clinic	Lab	Y-T-D Actual	Y-T-D Budget	Revised Budget	% of Budget	FY21 YE Actuals
Revenues		County General Fund Support	-	-	-	-	-	0%	5,222,198
		General Fund Fees and Miscellaneous Revenue	-	-	2,042	-	-	0%	111,693
		Grants - HRSA PC 330 Health Center Cluster **(2)**	149,664	-	3,512,038	-	-	0%	9,515,047
		Grants - HRSA Healthy Birth Initiatives	-	-	-	-	-	0%	673,281
		Grants - HRSA Ryan White	626,381	-	626,381	1,052,153	2,525,167	25%	2,657,247
		Grants - DHHS and OHA Ryan White	84,624	-	84,624	148,125	355,500	24%	347,799
		Grants - OHA Non-Residential Mental Health Services	-	-	-	-	-	0%	2,970,557
		Grants - All Other	108,592	-	495,411	564,383	1,354,519	37%	1,932,177
		Grants - Other COVID-19 Funding	21,131	-	13,367	5,998,611	14,396,666	0%	8,071,838
		Grants - HHS CARES Act Provider Relief	-	-	-	-	-	0%	-
		Grants - HRSA Health Center CARES Act	-	-	-	-	-	0%	-
		Grants - HRSA Expanding Capacity for Coronavirus Testing	-	-	-	-	-	0%	610,707
		Grant Revenue Projection **(1)**	612,253	-	2,170,072	-	-	0%	-
		Medicaid Quality and Incentive Payments	-	-	3,080,043	3,125,066	7,500,159	41%	11,049,279
		Health Center Fees	1,227,146	404	41,259,335	47,987,107	115,169,056	36%	92,485,906
		Self Pay Client Fees	3,169	-	265,683	518,700	1,244,879	21%	678,121
		Beginning Working Capital	-	-	1,516,592	1,516,592	3,639,820	42%	3,145,138
Revenues Total			2,832,961	404	53,025,588	60,910,736	146,185,766	36%	139,470,988
Expenditures		Personnel Total	1,878,149	625,168	33,902,749	37,258,279	89,419,870	38%	88,332,034
		Contractual Services Total	27,584	4,343	1,006,934	6,873,405	16,496,172	6%	3,659,777
		Internal Services Total	555,596	201,973	10,366,101	11,523,037	27,655,289	37%	24,921,085
		Materials & Supplies Total	81,639	110,459	7,929,506	9,008,191	21,619,659	37%	18,982,109
		Capital Outlay Total	-	-	6,666	126,875	304,500	2%	128,667
Expenditures Total			2,542,968	941,942	53,211,956	64,789,788	155,495,490	34%	136,023,673
Net Income/(Loss)			289,993	(941,538)	(186,368)	(3,879,052)	(9,309,724)		3,447,316
Total BWC from Prior Years			724,184	-	9,205,101				

Multnomah County Health Department
Community Health Council Board - Notes & Definitions
For Period Ending November 30, 2021
Percentage of Year Complete: 41.7%

Community Health Center - Notes:

County General Fund Support reflects the amount budgeted (1/12 per month), which may not be the actual amount used by the end of the year.

The Revised Budget differs from the Adopted Budget due to budget modifications, see those listed on the budget adjustments page.

All non-ICS Service Programs were removed from the health center scope effective June 30th, 2021.

Administrative Programs include the following: ICS Administration, ICS Health Center Operations, ICS Primary Care Admin & Support

Quality incentive payments for September were received in October

Multnomah County Health Department
Community Health Council Board - Notes & Definitions

For Period Ending November 30, 2021

Percentage of Year Complete: 41.7%

Community Health Center - Definitions

Budget: Adopted budget is the financial plan adopted by the Board of County Commissioners for the current fiscal year. Revised Budget is the Adopted budget plus any changes made through budget modifications as of the current period.

Revenue: are tax and non-tax generated resources that are used to pay for services.

General Fund 1000: The primary sources of revenue are property taxes, business income taxes, motor vehicle rental taxes, service charges, intergovernmental revenue, fees and permits, and interest income.

General fund Fees & Misc Rev: Revenues from services provided from Pharmacy related activities, including: refunds fro outdated/recalled medications and reimbursements from the state for TB and STD medications.

Grants - PC 330 (BPHC): Federal funding from the Bureau of Primary Care (BPHC) at the Health Resources and Services Administration (HRSA). Funding is awarded to federally qualified health centers (FQHC) to support services to un-/under-insured clients. This grant is awarded on a calendar year, January to December. Sometimes called the 330 grant, the H80 grant or the HRSA grant. Invoicing typically occurs one month after the close of the period because this is a cost reimbursement grant.

Grants - COVID-19, Fund 1515**:** Accounts for revenues and expenditures associated with the County's COVID-19 public health emergency response. Expenditures are restricted to public health services, medical services, human services, and measures taken to facilitate COVID-19 public health measures (e.g., care for homeless population). Revenues are primarily from federal, state and local sources directed at COVID relief.

Grants - All Other, Federal/State Fund 1505**:** Accounts for the majority of grant restricted revenues and expenditures related to funding received from federal, state and local programs. The fund also includes some non-restricted operational revenues in the form of fees and licenses.

Quality & Incentives Payments (formerly Grants – Incentives): Payments received for serving Medicaid clients and achieving specific quality metrics and health outcomes

Grant Revenue Projection: Projection is based on prior months grant related expenditures.

Health Center Fees: Revenue from services provided in the clinics that are payable by insurance companies.

Self Pay Client Fees: Revenue from services provided in the clinics that are payable by our clients.

Beginning working capital: Funding that has been earned in a previous period but unspent. It is then carried over into the next fiscal year to cover expenses in the current period if needed. Current balances have been earned over multiple years.

Write-offs: A write-off is a cancellation from an account of a bad debt. The health department cancels bad debt when it has determined that it is uncollectible.

Multnomah County Health Department
Community Health Council Board - Notes & Definitions
For Period Ending November 30, 2021
Percentage of Year Complete: 41.7%

Community Health Centers - Definitions cont.

Expenses are what the County spends to provide services to the community. Expenditure categories include personnel, materials and supplies, internal services, contracted services, and capital.

Personnel: Costs of salaries and benefits. Includes the cost of temporary employees.

Contracts: professional services that are provided by non County employees: e.g., lab and x-ray services, interpretation services, etc.

Materials and Services: non personnel expenses the program needs to perform its mission: e.g., medical and dental supplies, repairs & maintenance, supplies, etc.

Internal Services	Allocation Method
Facilities/Building Mgmt	FTE Count Allocation
IT/Data Processing	PC Inventory, Multco Align
Department Indirect	FTE Count (Health HR, Health Business Ops)
Central Indirect	FTE Count (HR, Legal, Central Accounting)
Telecommunications	Telephone Inventory
Mail/Distribution	Active Mail Stops, Frequency, Volume
Records	Items Archived and Items Retrieved
Motor Pool	Actual Usage

Capital Outlay: Capital Expenditures- purchase of capital items that cost $5,000 or more that have an expected useful life of more than one fiscal year: e.g., medical and dental equipment.

Unearned revenue is generated when the County receives payment in advance for a particular grant or program. The funding is generally restricted to a specific purpose, and the revenue will be earned and recorded when certain criteria are met (spending the funds on the specified program, meeting benchmarks, etc.) The unearned revenue balance is considered a liability because the County has an obligation to spend the funds in a particular manner or meet certain programmatic goals. If these obligations are not met, the funder may require repayment of these funds.

Multnomah County Health Department
Community Health Council Board - Budget Adjustments
For Period Ending November 30, 2021
Percentage of Year Complete: 41.7%

Community Health Centers

	Original Adopted Budget	Budmod-HD-001-22	Budmod-HD-003-22	Budmod-HD-006-22	Budmod-HD-009-22	Revised Budget	Budget Modifications
Revenue							
County General Fund Support	$ -	$ -	$ -	$ -	$ -	$ -	$ -
General Fund Fees and Misc R	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Grants - PC 330 (BPHC)	$ 9,309,724	$ -	$ -	$ -	$ -	$ 9,309,724	$ -
Grants - COVID-19	$ 13,000,000	$ -	$ 1,146,666	$ -	$ 250,000	$ 14,396,666	$ 1,396,666
Grants - All Other	$ 4,235,186	$ -	$ -	$ -	$ -	$ 4,235,186	$ -
Medicaid Quality &	$ 7,500,159	$ -	$ -	$ -	$ -	$ 7,500,159	$ -
Health Center Fees	$ 115,169,056	$ -	$ -	$ -	$ -	$ 115,169,056	$ -
Self Pay Client Fees	$ 1,244,879	$ -	$ -	$ -	$ -	$ 1,244,879	$ -
Preschool For All	$ -					$ -	
Beginning Working Capital	$ 3,639,820	$ -	$ -	$ -	$ -	$ 3,639,820	$ -
Write-offs	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Total	**$ 154,098,824**	**$ -**	**$ 1,146,666**	**$ -**	**$ 250,000**	**$ 155,495,490**	**$ 1,396,666**
Expense							
Personnel	$ 88,758,656	$ 197,067	$ 446,666	$ 16,718	$ -	$ 89,419,870	$ 660,451
Contracts	$ 15,756,862	$ (191,745)	$ 700,000	$ (18,945)	$ 250,000	$ 16,496,172	$ 739,310
Materials and Services	$ 21,652,095	$ (31,572)	$ -	$ -	$ -	$ 21,619,659	$ (31,572)
Internal Services	$ 27,626,711	$ 26,250	$ -	$ 2,227	$ -	$ 27,655,289	$ 28,477
Capital Outlay	$ 304,500	$ -	$ -	$ -	$ -	$ 304,500	$ -
Total	**$ 154,098,824**	**$ -**	**$ 1,146,666**	**$ -**	**$ 250,000**	**$ 155,495,490**	**$ 1,396,666**

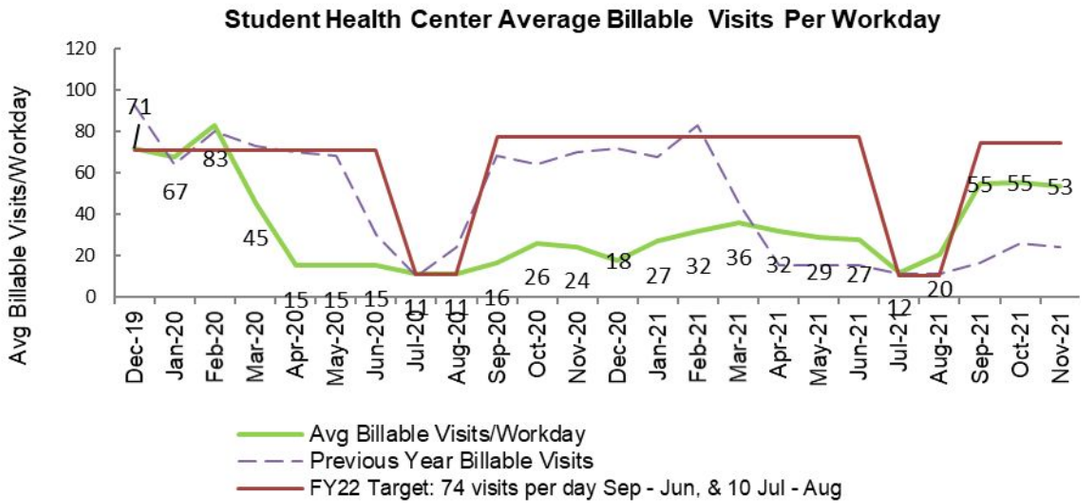
Community Health Centers

Notes:

The Revised Budget differs from the Adopted Budget due to the following budget modifications:

Budget Modification #	Budget Modification Description
Budmod-HD-001-22	12 position reclassifications
Budmod-HD-003-22	State CARES Act funding to increase Vaccination Rates
Budmod-HD-006-22	11 position reclassifications
Budmod-HD-009-22	State CARES Act funding to Health for Vaccine Incentives

FQHC Average Billable Visits per day by month per Service Area



What this slide shows:

This report takes the total number of billable visits for a month and divides it by total number of work days for an Average Billable Visits per work day, and compares to a Target based on the total # of provider FTE.

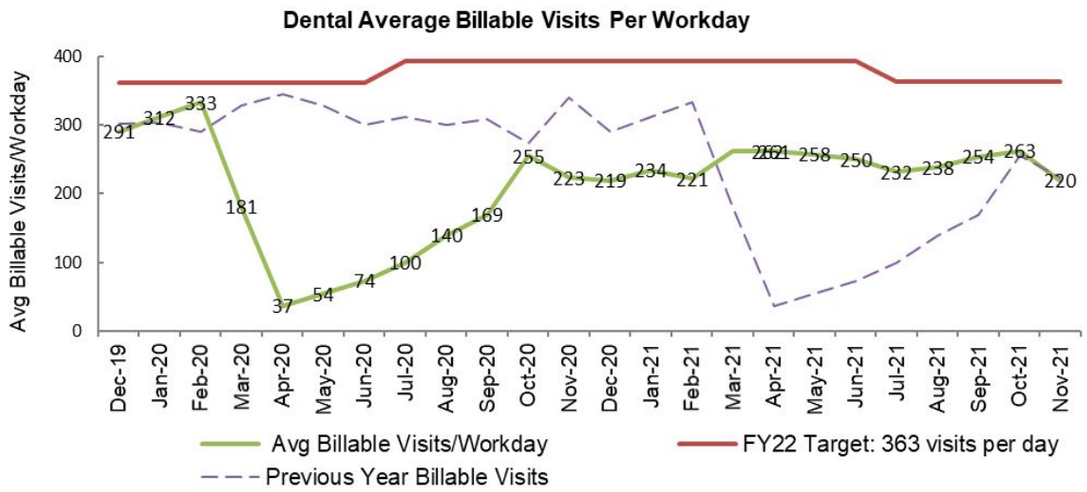
Good performance = the green "actual average" line <u>at or above</u> the red "target" line

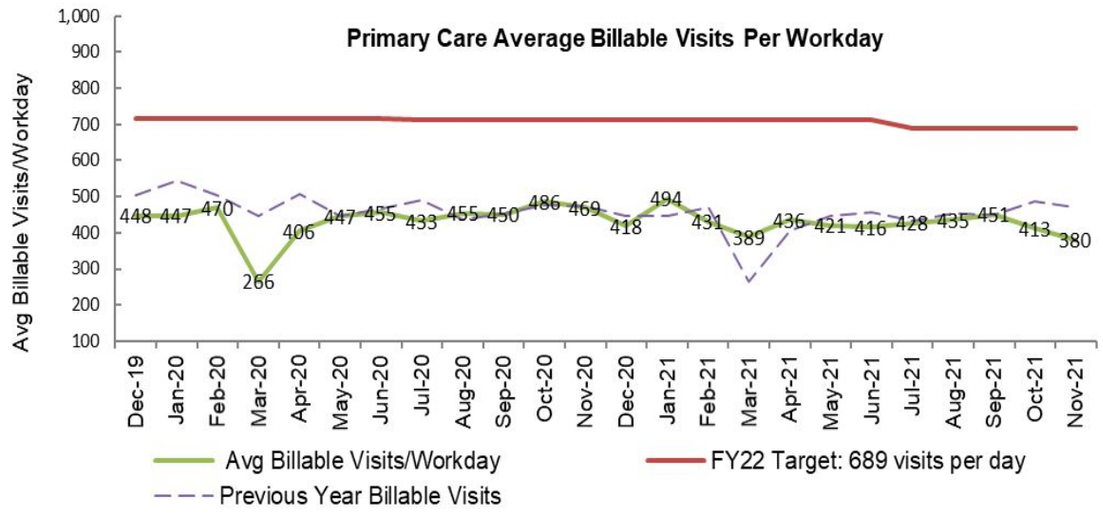
Definitions:

Billable: Visit encounters that have been completed and meet the criteria to be billed.

- Some visits may not yet have been billed due to errors that need correction.
- Some visits that are billed
- may not be paid, or not paid at the full billed amount, due to missing or incorrect documentation or coding, exceeding timely filing, or what is included in the insurance plan's benefits.

Work Days: PC and Dental are based on number of days actually worked. SHC are based on days the clinics are open and school is in session.





Primary Care and Dental visit counts are based on an average of days worked.
School Based Health Clinic visit counts are based on average days clinics are open and school is in session.

Percentage of Uninsured Visits by Quarter

What this slide shows:

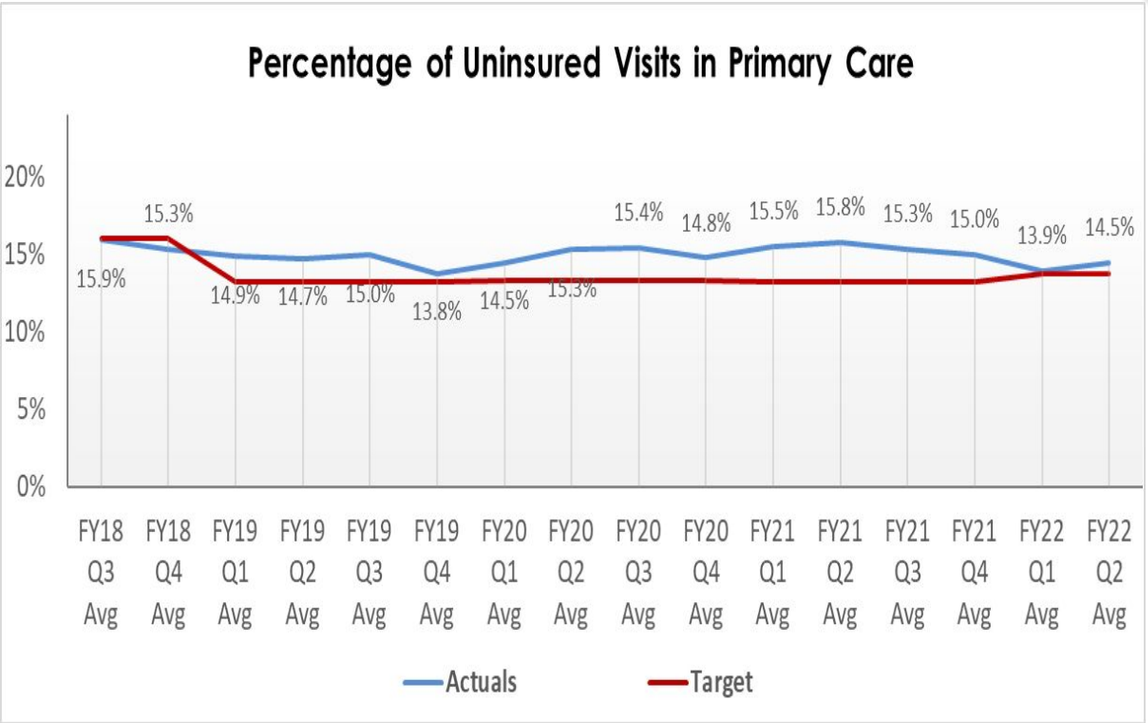
This report shows the average percentage of "self pay" visits per month.

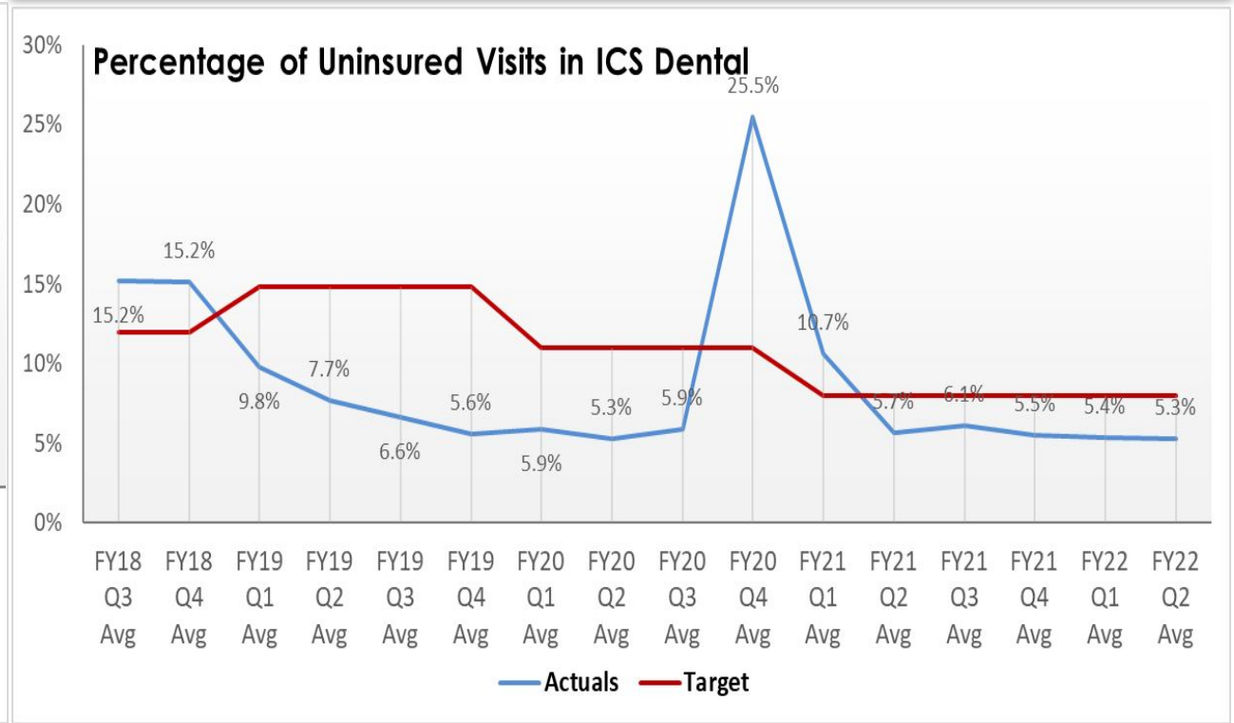
Good performance = the blue "Actual" line is around or below the red "Target" line

Definitions:

Self Pay visits: visits checked in under a "self pay" account

- Most "self pay" visits are for uninsured clients
- Most "self pay" visits are for clients who qualify for a Sliding Fee Discount tier
- A small percentage may be for patients who have insurance, but for various reasons have chosen not to bill the visit to insurance (confidential services, etc)





Primary Care target % of Uninsured Visits for FY18: 16%; for FY19: 13.25%; for FY20 13.27%; FY21 13.23%; FY22 13.77%.
Dental target % of Uninsured Visits for FY18: 12%; for FY19: 14.85%; for FY20 11.00%; FY21 8.00%; FY22 8.00%.

Payer Mix for ICS Primary Care Health Center

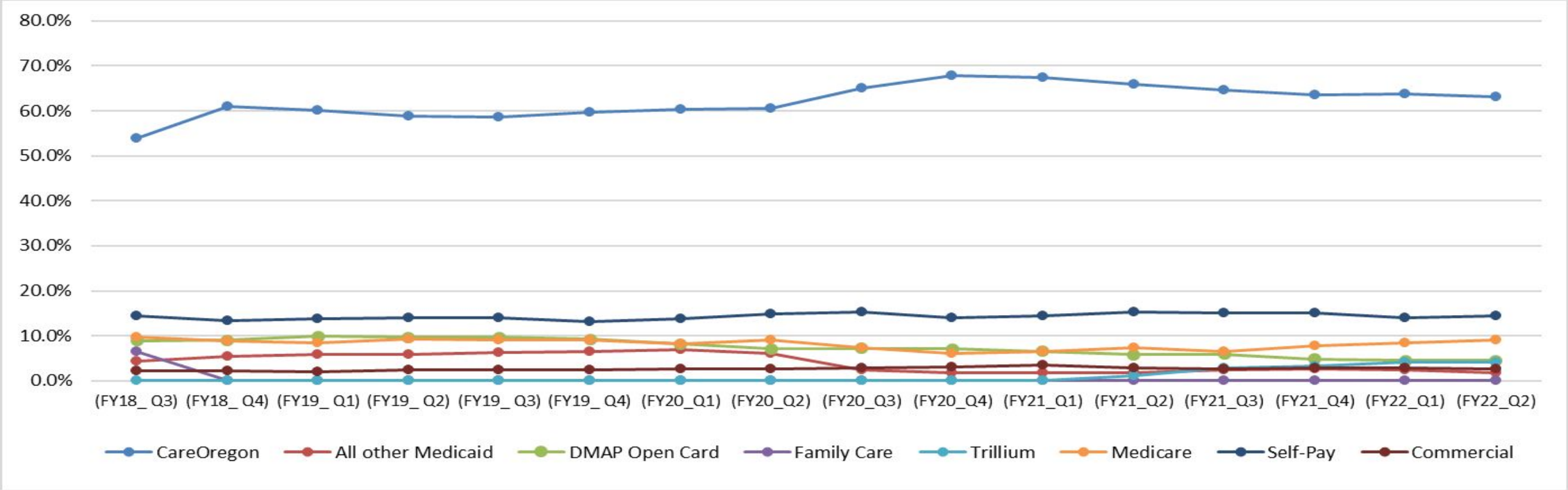
What this slide shows:

This report shows the percentage of total visits checked in to each payer for Primary Care (excludes SHC and HHSC).

This slide is not meant to assess "good performance," but to understand the changes in payer mix. Deviations (such as closure of a Medicaid plan or changes in plan preferred providers) may mean changes in revenue and should be reviewed and explained.

Definitions:

Payer: Who will be billed/charged for the visit, based on the account that the visit was checked in under.



Family Care ceased operations FY18 2nd Quarter

Notes: Payer Mix for Primary Care Health Service Center shows the percentage of patient visits per payer and per Quarter

Payer Mix for ICS Primary Care Health Center

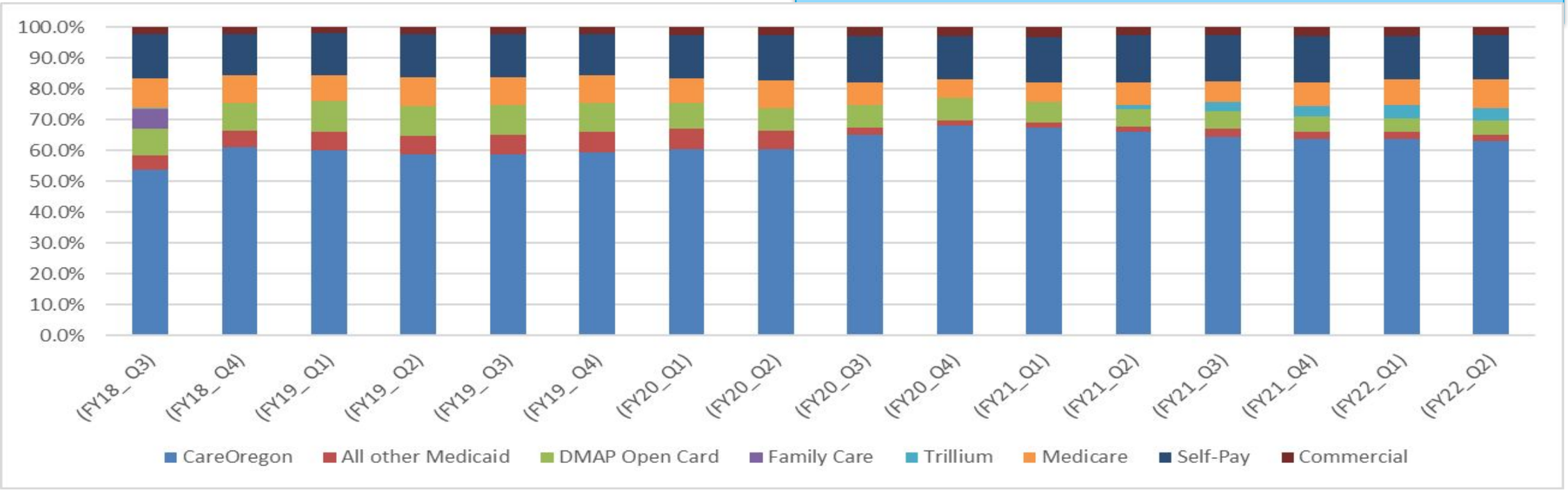
What this slide shows:

This report shows the percentage of total visits checked in to each payer for Primary Care (excludes SHC and HHSC).

This slide is not meant to assess "good performance," but to understand the changes in payer mix. Deviations (such as closure of a Medicaid plan or changes in plan preferred providers) may mean changes in revenue and should be reviewed and explained.

Definitions:

Payer: Who will be billed/charged for the visit, based on the account that the visit was checked in under.



Family Care ceased operations FY18 2nd Quarter

Notes: Payer Mix for Primary Care Health Service Center shows the percentage of patient visits per payer and per Quarter

Number of OHP Clients Assigned by CCO

What this slide shows:

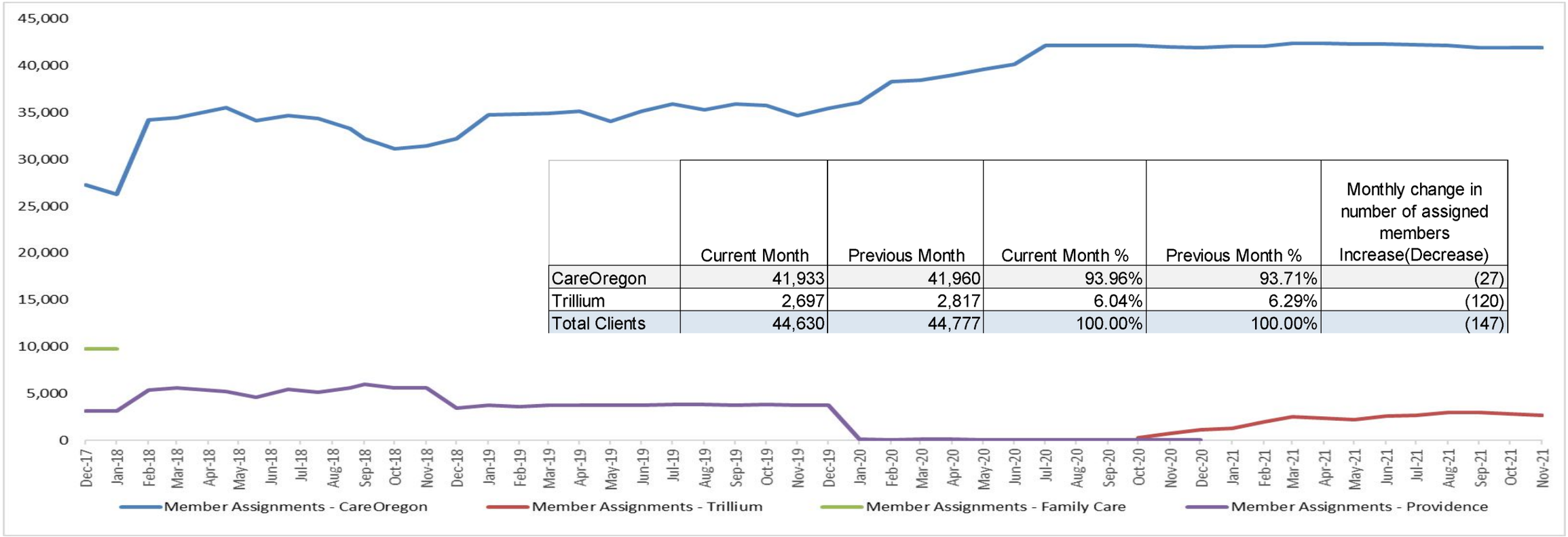
This report shows the total number of patients OHP has assigned to the Multnomah County Health Center Primary Care clinics. *NOTE: Not all of these patients have established care.*

Good performance = increased number of assigned patients, suggesting higher potential APCM revenue

Definitions:

APCM: Alternative Payment and Care Model (aka APM: Alternative Payment Methodology). In addition to billing for services, APCM payers also pay health centers a PMPM rate.

PMPM: Per-Member-Per-Month. PMPM ranges around $50-70/month, depending on payer. This is only received if the patient is assigned to us by their OHP health plan AND meets criteria for being established and engaged in care (has a qualifying visit or care step)



	Current Month	Previous Month	Current Month %	Previous Month %	Monthly change in number of assigned members Increase(Decrease)
CareOregon	41,933	41,960	93.96%	93.71%	(27)
Trillium	2,697	2,817	6.04%	6.29%	(120)
Total Clients	44,630	44,777	100.00%	100.00%	(147)

CareOregon FY21 average 42,178 :: Providence FY21 average 22 :: Trillium FY21 average 1,684
CareOregon FY22 average 42,057 :: Trillium FY22 average 2,825

- Trillium added October 2020

ICS Net Collection Rate by Payer
Sep'21 – Nov'21 vs Jul'21 – Nov'21 (YTD)

	Sept'21 - Nov'21 Payments	YTD Payments	Sept'21 - Nov'21 Net Collection	YTD Net Collection
CareOregon Medicaid	3,427,376	5,557,008	99%	99%
Commercial	267,803	402,352	94%	93%
Medicaid	395,636	740,341	98%	96%
Medicare	561,244	927,236	99%	98%
Reproductive Health	36,488	58,320	100%	99%
Self-Pay	169,802	277,530	48%	46%
	$4,858,349	$7,962,787		

What this slide shows:

This report shows the effectiveness in collecting reimbursements by Payer

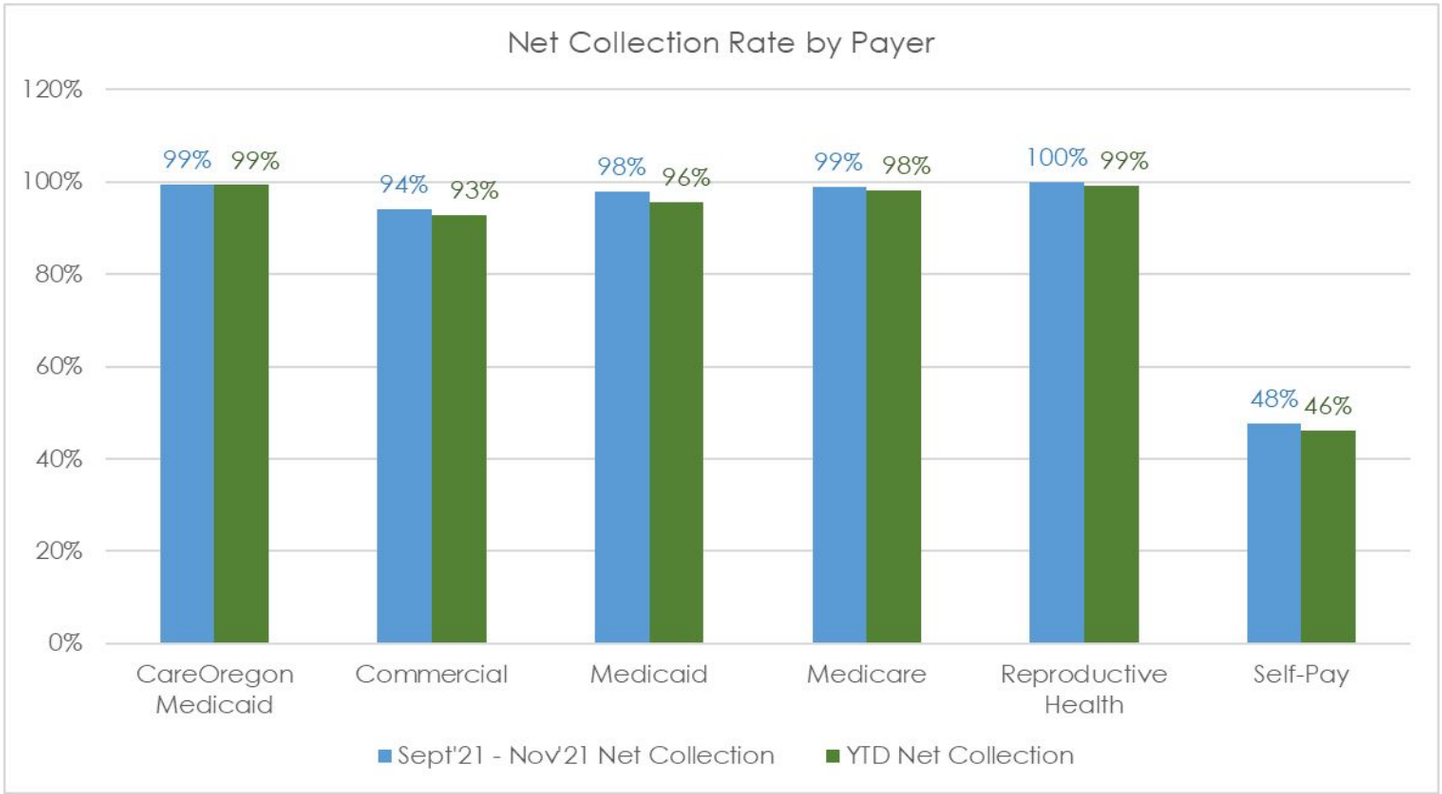
The benchmark for Net Collection Rate is 90% - 100%. Over 95% is ideal per HFMA

Definitions:

Net Collection Rate % = Payments / Payments + Avoidable

Avoidable: Bad Debt, Write-off Past Untimely Filing and DX Not Covered.

Payments: What we received from each payer, based on contracted rates (for insurance plans) and Sliding Fee Discount fees (for self pay)



ICS Net Collection Rate by Service Group
Sep'21 – Nov'21 vs Jul'21 – Nov'21 (YTD)

	Sept'21 - Nov'21 Payments	YTD Payments	Sept'21 - Nov'21 Net Collection	YTD Net Collection
MC Dental	$ 1,668,605	$ 1,668,605	97%	97%
MC HSC Health Service Cente	$ 281,190	$ 281,190	98%	98%
MC Pharmacy - Self Pay Only	$ 94,776	$ 94,776	60%	59%
MC Primary Care	$ 2,711,285	$ 2,711,285	95%	94%
MC School Based Health Cent	$ 124,454	$ 124,454	99%	98%
	$4,880,310	$4,880,310		

What this slide shows:

This report shows the effectiveness in collecting reimbursements by Service Group

The benchmark for Net Collection Rate is 90% - 100%. Over 95% is ideal per HFMA

Definitions:

Net Collection Rate % = Payments / Payments + Avoidable

Avoidable: Bad Debt, Write-off Past Untimely Filing and DX Not Covered.

Payments: What we received from each payer, based on contracted rates (for insurance plans) and Sliding Fee Discount fees (for self pay)