

Community Health Council

Community Health Council Board Meeting Minutes

Date: Monday, June 11, 2018

Time: 6:00 PM

Location: McCoy Building, 10th Floor Conference Room

Approved:

Recorded by: Erin Halton

Attendance:

Board Members	Title	Y/N
David Aguayo	Board Member	Y
Fabiola Arreola	Board Member	Y
Sue Burns	Member-at-Large	N
Jon Cole	Board Member	Y
Robyn Ellis	Board Member	N
Tara Marshall	Chair	Y
Pedro Sandoval Prieto	Member-at-Large	Y
Wendy Shumway	Vice-Chair	Y
Iris Hodge	Board Member	Y
Staff	Title	Y/N
Vanetta Abdellatif	Interim Health Department Co-Director	Y
Lucia Cabrejos	Interpreter, Passport to Languages	Y
Adrienne Daniels	ICS Deputy Director	Y
Erin Halton	Executive Specialist Medical & Dental Directors	Y
Ritchie Longoria	Director of Pharmacy and Lab Services	Y
Mark Lewis	Interim Business Services Director	Y
Alexandra Lowell	Student Health Center Manager	Y
Linda Niksich	Community Health Council Liaison	Y
Christine Palermo	Dental Program Manager	Y
Dawn Shatzel	Quality Director	Y

Guests: Debra Abney, Myranda Harris, Joyce Holland, Chanda McClure, Harold Odhiambo

Action Items:

- Mark to provide write off estimates over a year to show multiple data points.

Decisions:

- Approved the May 2018 Board Meeting Minutes.

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- Approved the Scope Change in SHC Hours
- Accepted the Monthly Budget Report
- Approved the 2018 Quality Plan
- Approved the Community Health Center Services Fee Policy
- Approved the Write Off Policy
- Accepted the ICS/Strategic Plan updates
- Accepted the Nominating and Executive Committee Reports

The meeting was called to order at 6:01 pm by Chair, Tara Marshall.

The Meeting Ground Rules were presented by Vice-Chair, Wendy Shumway.

Noted that quorum was met.

May 2018 Meeting Minutes Review

(See Document - May 2018 CHC Meeting Minutes)

No other questions or comments were raised by CHC members.

Motion by Wendy to approve the May 2018 Meeting Minutes.

Seconded by Fabiola.

7 aye; 0 nay; 0 abstain

Motion carries

Scope Change - SHC Hours

(See Document - Scope Change in Hours for SHCs)

Alexandra Lowell, Student Health Center Manager, said that they are open 5 days a week currently at the high schools sites, with one late day per week for those who need the access. Over the years, have heard feedback from client base that there just isn't the same demand for evening hours, and the data backs that up. Morning slots are now more in demand and as such, the proposal is to shift most sites to a 30 min earlier opening time, while still keeping late hours available until 5:45 at Roosevelt and until 6 pm at Centennial. Proposed changes in red

Questions and comments raised by CHC members:

- Wendy asked if Franklin's Monday hours were changing?
 - Answer: Alex said no, nothing is changing that is in black ink in the handout.
- Jon asked if this is going impact MCHD financially?

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- Answer: Alex said she expects that productivity will be increased.
- Pedro asked when the change will take effect and will clients be happy?
 - Answer: Alex said that if approved, this will begin when school starts during the last week of August. She said while staff have not announce the change with the public yet, the several years of data suggest there are more clients that would prefer earlier morning appointments.
- Wendy asked what happens to the SHCs during the summer?
 - Answer: Alex said that Parkrose stays open to provide services in the summer. The teams work hard to identify clients that will need services over the summer and they set up appointments ahead of time to ensure continuity of care.

No other questions or comments were raised by CHC members.

Motion by Pedro to accept the Scope Change
Seconded by Fabiola
7 aye; 0 nay; 0 abstain
Motion carries

The Budget Report through April 2018

(See Document - Monthly Dashboard-April 2018)

Mark Lewis, Interim Director of Business Operations, said the Board of County Commissioners adopted the budget for FY'19 and thanks to CHC for their support. He reported that weekly billable visits dropped to 525; this is another decrease from the previous month and staff are looking into root causes for declines. Uninsured visits were 15.2%, just below the budget estimate of 16%. Dental uninsured visits were at 14.9%. Mark added that staff are working on reporting for the May incentives and if all tracks as projected, there may be a surplus in some areas.

Questions and comments raised by CHC members:

- Pedro asked about the first page of graphs; what made the numbers drop in all three areas?
 - Answer: Mark said yes, that is uncommon, and staff are still digging to determine the cause.
- Wendy said she heard of some clients that had to leave their providers at MCHD due to the Family Care Closure.
 - Answer: Vanetta said the number of patients on our rosters have stayed fairly steady, but data shows there were fewer completed visits and this is why we are below budget for FY18 visits.

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- Wendy followed up and asked if the source could be that the care clients are receiving is so good that they don't need visits?
 - Answer: Vanetta said that would not explain this level of a drop.
- Iris said she would really like to know what is actually being done to track the drop.
 - Answer: Vanetta said we've been very diligent with Family Care data; this trend is different and we need to look deeper. We will get back to you with what we find.
- David asked about slide 4; is there possibly something new in the information that new clients receive?
 - Answer: Vanetta said we have gotten about 11,000 total assignments from FamilyCare transition. We found that the majority were already assigned to us, but they had never engaged fully. We have heard from OHP that redetermination may be a factor in getting fewer new assignments than estimated.
- Tara asked about the last slide; for the grants and incentives, can you explain the March number?
 - Answer: Mark said they hired a new grant accountant, so the 1.3 million is the make up from the previous month.

No other questions or comments were raised by CHC members.

Motion by Jon to accept the Budget Report

Seconded by Wendy

7 aye; 0 nay; 0 abstain

Motion carries

2018 Quality Plan

(See Document - 2018 Quality Management Plan)

Dawn Shatzel, Quality Program Manager, shared changes to the 2018 Quality Plan that stemmed from the recent HRSA survey. She noted the focus on quality initiatives, and said that on page 20 is a list of reports shared with CHC. The client satisfaction survey will be reviewed quarterly and patient complaints and clinical quality summary will be shared more often. Also pages 21-22 of the plan illustrate the priority objectives. Dawn asked CHC members if they had any questions about the priorities at this time.

No questions or comments were raised by CHC members.

Motion by Iris to accept the 2018 Quality Management Plan

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*Seconded by Jon
7 aye; 0 nay; 0 abstain
Motion carries*

Community Health Center Services Fee Policy

(See Document - Proposed Community Health Center Services Fee Policy - AGN.10.03)

Adrienne Daniels reported that the new fee policy reflects fair treatment and continued access to care. The policy applies to patients without insurance - or insurance that doesn't cover what is needed. During the HRSA visit in 2017, surveyors determined that parts of the policy needed to be aligned so that patients were charged equally. Adrienne said that those impacted by this new policy are at 200% under FPL. Biggest change is that formerly had different % for different patients, which made it difficult to estimate how much a patient would owe for their visit. She said staff worked closely with business services to create a new flat fee. She described the proposed fee structure: a 5 tier system based on where the patient sits on the FPL. Fee waivers will now ask detailed questions, and policy has been updated; this policy also represents a change to the process for how we screen for eligibility.

Questions and comments raised by CHC members:

- Fabiola said that have heard in past that some clients shared that \$25 was a barrier to care - and now raising to \$35 - is that right?
 - Answer: Adrienne said that since the \$25 fee has not changed in 10 years, the move to \$35 seems reasonable.

On page 2 there is new language to support the HRSA recommendation that our policy language match the OHP definition of "family." If clients are under the age of 19 and are no longer financially dependent, they are considered to be their own family. Fees and chargemaster did not address how often fees should be updates p new policy will allow for fee review annually. Changes to pharmacy fees will match those seen in medical.

Questions and comments raised by CHC members:

- Pedro asked what will happen to those who just arrived to OR, if they have a job but no Social Security number, can they come to the clinics for care?
 - Answer: Adrienne said we can provide care and make sure they get discounts, but we may have to ask more questions to determine eligibility.
 - Pedro added that some families he knows are still hesitant to come in.
 - Adrienne asked Pedro to help spread message that MCHD clinics will provide care, and staff doesn't ask about immigration status.

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Adrienne concluded by saying the proposal is for the fee changes to take place August 1st.

Questions and comments raised by CHC members:

- David asked how long ago was it that the prior fee change was made?
 - Answer: Mark said it was a long time ago.

No other questions or comments were raised by CHC members.

Motion by Pedro to accept the Fee Policy AGN.10.03 as presented
Seconded by Fabiola
7 aye; 0 nay; 0 abstain
Motion carries

Write off Policy

(See Document - Write Offs for Uncollectible Patient Accounts - FIS.01.06)

Adrienne said that in this policy they describe uncollectible accounts as those with low balance and with no activity in 6 months; for these the balance will be written off. Each quarter staff will review outstanding balances with no visit in 6 months or no statement in 6 months. She said there are some circumstances where clients have an inability to pay for health care and staff want to be sure we're doing everything we can to support them getting care they need.

Questions and comments raised by CHC members:

- Tara asked where we might see this captured in financial updates from Mark?
 - Answer: Mark said in self pay, on the last page of the budget report.
- David asked how much the write off would be?
 - Answer: Mark said he can provide that data over a year to show multiple data points.
- Fabiola said she was surprised that no one gets sent to collections...is this something you're thinking about?
 - Answer: Vanetta said the decision to start using collections would be a board conversation. If collections were to be done, we would want to have really good rules and be thoughtful about it.
 - Mark added that MCHD would not want anyone to not come for their appointment because they couldn't pay

No other questions or comments were raised by CHC members.

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*Motion by Wendy to accept the Write-off policy #FIS.01.06 as presented
Seconded by Jon
7 aye; 0 nay; 0 abstain
Motion carries*

ICS/Strategic Plan and HD Updates

Vanetta Abdellatif, ICS Director and Co-Interim Health Department Director, provided ICS/Strategic Plan updates as they relate to the ICS Values.

Person-Centered and Culturally Relevant

Vanetta reported that the partnership with Care OR and Public Health staff to support latin families in East County is going well. They held an event called Dia de las Madres on May 9th. The "Empezando con salud" team highlighted the strong connections that our health workers have made with moms and families. Yesenia Avellaneda in dental also does outreach calls to clients; she is first dental community health worker.

Engaged, Expert and Diverse Workforce

Vanetta recalled the recent "Health Department All Staff" meetings held for nearly 1900 staff. She felt the meetings feel went well, and leadership heard from staff that they have a high level of interest in the new HD Director recruitment process, the new headquarters, productivity and mental health developments.

Vanetta noted that the the strategic plan development retreat for CHC members is happening on June 16th; the same facilitator will also do a training for Clinic Leadership and other key staff on Friday June 15th.

Fiscally Sound and Accountable

Vanetta recalled that Student Health Center Manager Alex Lowell previously came to CHC to talk about closure for middle school student health centers. At the same time, District 4 has been looking to develop two new student health centers: Reynolds and Gresham-Barlow. Vanetta shared an update that Gresham secured Wallace as their sponsor. Reynolds is still interested in MCHD as sponsor, but they would need to raise an additional \$180,000 and would also need that much more in county general funds.

Questions or comments raised by CHC members:

- Iris asked how we get the BOC to dedicate funding?
 - Answer: Vanetta said that first the BOC has to have it to give, and they have to have a forecast for county general funds that allows for future spending.
 - Commissioner Stegmann from District 4 will likely come forward as a

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- supporter, along with Alex and then the CHC.
- Wendy asked if state resources might be pursued as well?
 - Answer: Vanetta said yes there is a state office for student health clinics. If certified, centers can become eligible for an offset of around \$58,000 per year. If two centers open in the state within the same year, they can get those funds re-allocated.
- Jon asked how rapidly could it come together if all goes well?
 - Answer: Vanetta said she feels they would need a funding commitment from the BOC first as Reynolds is not likely to have the funds to build. Alex would like to aim for Fall of 2019.

Len Barozzini is exploring a new software option for the dental program that will support Medical and Dental integration. The EPIC software is called "Wisdom." Staff will be looking at pricing and whether the county can support the transition. The soon to be "old" McCoy building at 426 SW Stark Street is on the market and the new headquarters is just a few blocks to the north, sharing the same block as Bud Commons.

Quality and Safety

Vanetta shared that at the SEDC, a sterilization indicator strip that help staff determine whether proper sterilization had been completed, could not be confirmed. A staff member could not identify conclusively that all sterilization steps had been completed on one specific batch and because of this, it was determined that a public notification had to be done regarding potential exposure. CDC experts said the risk level is "very very low to zero", but as it is not zero, MCHD leadership decided to contact all dental patients seen between May 11th - May 24th to offer testing. Vanetta believes that there won't be any issues discovered among the patients affected, and she also wanted to let CHC members know of this as there has been some media coverage.

Comments:

- Wendy said that she feels very comforted to hear the report, and she is aware of all the procedures that are in place to keep clients and staff safe and accountable

Volunteer Recognition Event

Vanetta shared that there is County recognition for the CHC team this year and she described the typical flow of things for this celebration event. Please come one and all and celebrate the work of the CHC.

- Pedro said he feels very proud to be nominated and for the new CHC members,

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you will enjoy feeling proud like he does.

Vanetta shared that the Executive Committee recently asked questions about the in-house labs and fees for lab services. Vanetta shared that examples of the lab tests that are sent out to third party, Quest, include; metabolic panels, Pap smear, biopsies, HIV, hemoglobin A1c. Vanetta said that if a patient is uninsured, MCHD provides Quest with the sliding fee scale.

***Motion by Wendy to accept the ICS Strategic Plan and HD Updates.
Seconded by Iris
7 aye; 0 nay; 0 abstain.
Motion carries***

Nominating Committee Update:

- Tara said the committee met on June 4th
- Reminder to guests that they must attend 3 meetings and interested parties are to contact Tara or Linda for more information on board membership.

No questions or comments were raised by CHC members.

Executive Committee Update:

- Tara said the committee met on June 4th
- They reviewed the May minutes and crafted agenda for this evening
- Dawn previewed the Quality Plan

No questions or comments were raised by CHC members.

***Motion by Fabiola to accept the Committee Updates.
Seconded by Wendy
7 aye; 0 nay; 0 abstain.
Motion carries***

Executive Officers

Tara shared that there are two vacancies for executive officer positions; per the bylaws, the appointments will be to Sue Burns as Vice Chair, Pedro as Secretary/Treasurer and Fabiola and Jon as members at large.

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*Motion by Wendy to accept the Executive Officers
Seconded by Fabiola
7 aye; 0 nay; 0 abstain.
Motion carries*

Meeting Evaluation:

- Food was delicious
- Thank you to Wendy for all her work on the executive committee and the CHC
- Vanetta thanked the council members for a long week and a lot of work.

Board Retreat is Saturday June 16th

Meeting Adjourned at 7:57 pm.

Signed: _____

Tara Marshall, Chair

Date: _____

7/9/18

Community Health Council
Public Meeting Agenda

Monday, June 11, 2018

6:00-8:00 pm

McCoy Building: 426 SW Stark St., 10th
Floor



Integrated Clinical Services Mission: "Providing services that improve health and wellness for individuals, families, and our communities."

**Our Meeting Process Focuses on
the Governance of Community Health Centers**

- Use Group Agreements (in English and Spanish) located on name tents
- Meetings are open to the public
- Guests are welcome to observe**
- Use timekeeper to focus on agenda
- Use note cards for questions/comments outside of agenda items and for guest questions

Council Members

Dave Aguayo; Fabiola Arreola; Sue Burns (Member-at-Large); Jon Cole; Robyn Ellis; Iris Hodge; Tara Marshall (Chair); Pedro Sandoval Prieto (Member-at-Large); Wendy Shumway (Vice-Chair)

Item	Process/Who	Time	Desired Outcome
Call to Order/Welcome	<ul style="list-style-type: none">Chair, Tara Marshall	6:00-6:05 (5 min)	Review meeting processes
Minutes VOTE REQUIRED	<ul style="list-style-type: none">Review and approve May CHC Minutes	6:05-6:10 (5 min)	Council votes to approve and Chair signs for the record
Scope Change SHC Hours VOTE REQUIRED	<ul style="list-style-type: none">Student Health Center Manager, Alexandra Lowell	6:10-6:20 (10 min)	Council discussion and vote to approve
Monthly Budget Report VOTE REQUIRED	<ul style="list-style-type: none">Interim Director of Business Operations, Mark Lewis	6:20-6:30 (10 min)	Council discussion and vote to accept report
2018 Quality Plan VOTE REQUIRED	<ul style="list-style-type: none">Quality Director, Dawn Shatzel	6:30-6:45 (15 min)	Council discussion and vote to approve

BREAK	<ul style="list-style-type: none"> All 	6:45-6:55 (10 min)	Meet and greet
AGN.10.03 (includes Chargemaster) & FIS.01.06 VOTE REQUIRED	<ul style="list-style-type: none"> ICS Deputy Director, Adrienne Daniels 	6:55-7:25 (30 min)	Council Discussion and vote to approve policies
ICS/Strategic Plan UPdates VOTE REQUIRED	<ul style="list-style-type: none"> Co-Interim Health Department Director and ICS Director, Vanetta Abdellatif 	7:25-7:40 (15 min)	Vote to accept report
Council Business Committee Reports & Executive Officer Slate (Succession Plan) VOTE REQUIRED	<ul style="list-style-type: none"> Chair, Tara Marshall 	7:40-7:55 (15 min)	Vote to accept reports and vote to approve Executive Officer Slate
Meeting Evaluation	<ul style="list-style-type: none"> Vice-Chair, Wendy Shumway 	7:55-8:00 (5 min)	Discuss what went well and what needs improvement
Adjourn Meeting	<ul style="list-style-type: none"> Chair, Tara Marshall 	8:00	Goodnight!

Presentation Summary



Scope Change in Hours for SHCs

Inform Only	Annual/ Scheduled Process	New Proposal	Review & Input	Inform & Vote X
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Date of Presentation: June 11, 2018	Program / Area: SHC/ Changes in Hours
Presenters: Alexandra Lowell, Student Health Centers Program Manager	
Project Title/Scope Change and Brief Description <ul style="list-style-type: none">Slight changes in SHC operating hours on the one day a week that we offer late hours	
Describe the current situation: <ul style="list-style-type: none">For many years, the SHCs located in high schools have offered late afternoon/evening hours one day a week to increase access to services for families from other schools who need to travel to the SHC site. We have promoted these hours in all of our communications to feeder school and SHC site communities. We have monitored client demand for these afternoon appointments over the years and seen the consistent trend that client use of these hours has been limited at some of our sites. At the same time, we have experienced the consistent higher demand for services in the morning. The one exception to this situation Centennial SHC who are shifting to later hours.	
Why is this project, process, system being implemented now? <ul style="list-style-type: none">Some of our SHC site teams have been communicating to administration for years that by maintaining underutilized late afternoon hours we are reducing productivity because there is higher demand for services in the mornings.We conducted an assessment of completed appointments by hour of the day and see that this staff perception is clearly documented in the evidence. The one exception to this situation Centennial SHC who are shifting to later hours.	
Briefly describe the history of the project so far <i>(be sure to note any actions taken to address diverse client needs and cultures; to ensure fair representation in review and planning)</i>	

Presentation Summary



<ul style="list-style-type: none"> The idea behind late hours is to create access for families who cannot make our regular 7:30-4:00 hours. In reality, there is very little demand for these late afternoon hours and more demand for the morning hours. We suggest a slight change (30 min shift) to some of our high school SHC late day hours that will still maintain afternoon appointments while increasing access in the morning. There are no recommended changes to SHC sites where there is consistent evidence that evening hours are well used.
<p>List any limits or parameters for the Council's scope of influence and decision-making</p> <ul style="list-style-type: none"> N/A
<p>Briefly describe the outcome of a "YES" vote by the Council (<i>be sure to also note any financial outcomes</i>)</p> <ul style="list-style-type: none"> The revised hours recommended will be adopted. We expect this change will result in more service productivity and FFS revenue and at the same time, still allow access for clients and their families who need a later afternoon access.
<p>Briefly describe the outcome of a "NO" vote or inaction by the Council (<i>be sure to also note any financial outcomes</i>)</p> <ul style="list-style-type: none"> SHC hours will remain as is and while there will be less service productivity and FFS revenue, there will be more late afternoon access.
<p>Which specific stakeholders or representative groups have been involved so far?</p> <ul style="list-style-type: none"> SHC site teams Client use patterns have been documented in a report and reviewed by SHC leadership and Primary Care leadership (Tasha Wheatt-Delancy and Marty Grasmeder)
<p>Who are the area or subject matter experts for this project? (<i>& brief description of qualifications</i>)</p> <ul style="list-style-type: none"> SHC site teams, SHC leadership, Primary Care leadership
<p>What have been the recommendations so far?</p> <ul style="list-style-type: none"> SHC leadership recommends the 30 minute shift in hours as a good solution to increasing productivity while maintaining late afternoon access for the families who need it. The SHC site teams would have preferred an hour shift rather than 30 minutes, however SHC leadership feels it is important to maintain some late afternoon access.
<p>How was this material, project, process, or system selected from all the possible options?</p>

Presentation Summary



- Review of data, discussions with SHC site teams, and SHC leadership discussions.

Council Notes:

Open Clinic Hours: 2018 – 2018 **DRAFT CHANGES**

Blue denotes evening hours. **Pink** = Clinic closed. Proposed changes in **Red**

SBHC Site	Monday	Tuesday	Wednesday	Thursday	Friday
George MS (503) 988-3829	CLOSED (contact Cesar Chavez)	8:15am – 4:15pm 8:45am – 4:45pm	12:45pm – 3:45pm	CLOSED (contact Cesar Chavez)	8:15 – 4:15
Cleveland HS (503) 988-3350	7:45am – 3:45pm	7:45am – 3:45pm	9:15am – 5:15pm 8:45am – 4:45pm	7:45am – 3:45pm	7:45am – 3:45pm
Centennial HS (503) 988-5488	7:45am – 3:45pm	7:45am – 3:45pm	7:45am – 3:45pm	9:30-6:00 10:00am – 6:30pm	7:45am – 3:45pm
Jefferson HS (503) 988-3360	7:45am – 3:45pm (7:30-4)	CLOSED	9:15am – 5:15pm 8:45am – 4:45pm	7:45am – 3:45pm	7:45am – 3:45pm
Madison HS (503) 988-3382	8:45am – 4:45pm 7:30am – 3:45pm	8:45am – 4:45pm	7:45am – 3:45pm	7:45am – 3:45pm (7:30-4)	7:45am – 3:45pm
Franklin HS (503) 988-3370	7:45am – 3:45pm (7:30-4)	7:45am – 3:45pm	9:45am – 5:45pm 9:15am – 5:15pm	7:45am – 3:45pm	7:45am – 3:45pm
Parkrose HS (503) 988-3392	7:45am – 3:45pm	7:45am – 3:45pm	7:45am – 3:45pm	9:45am – 5:45pm 9:15am – 5:15pm	7:45am – 3:45pm
Roosevelt HS (503) 988-3909	7:45am – 3:45pm	9:45am – 5:45pm 9:15am – 5:15pm	7:45am – 3:45pm	7:45am – 3:45pm	7:45am – 3:45pm

Multnomah County Health Department

Monthly Dashboard

April 2018

Prepared by: [Papa Diallo](#)

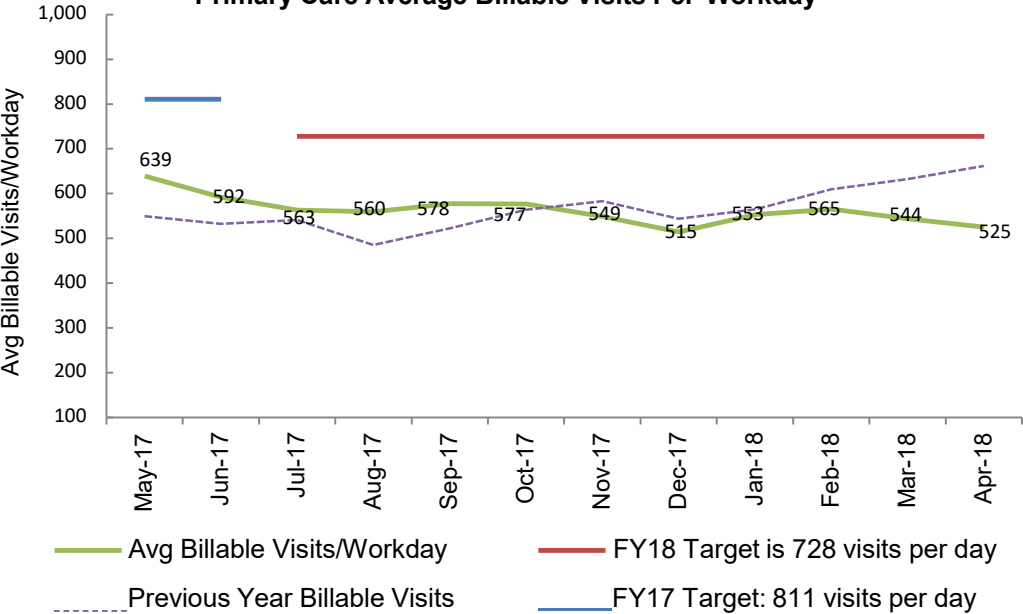




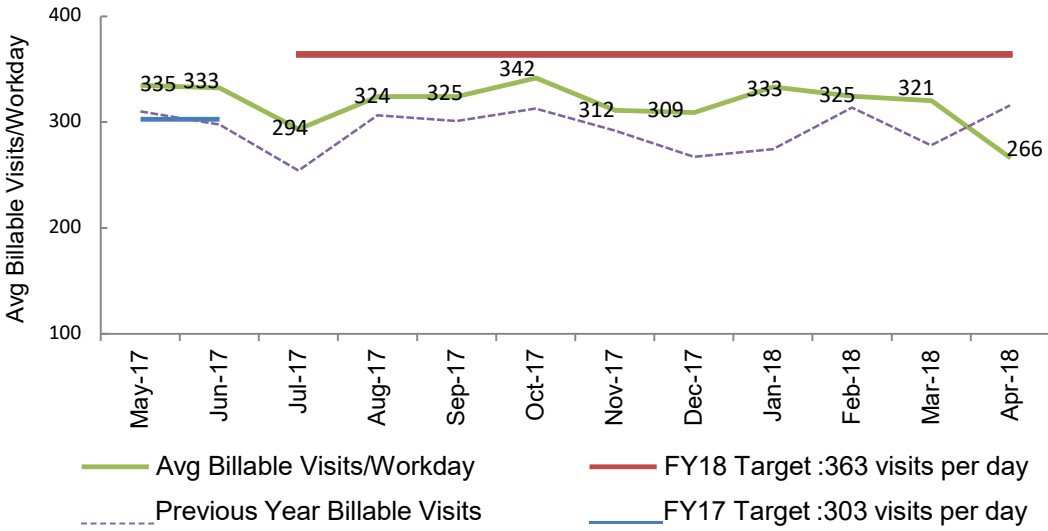
Multnomah County Health Department

Weekly Billable Visits Per Department

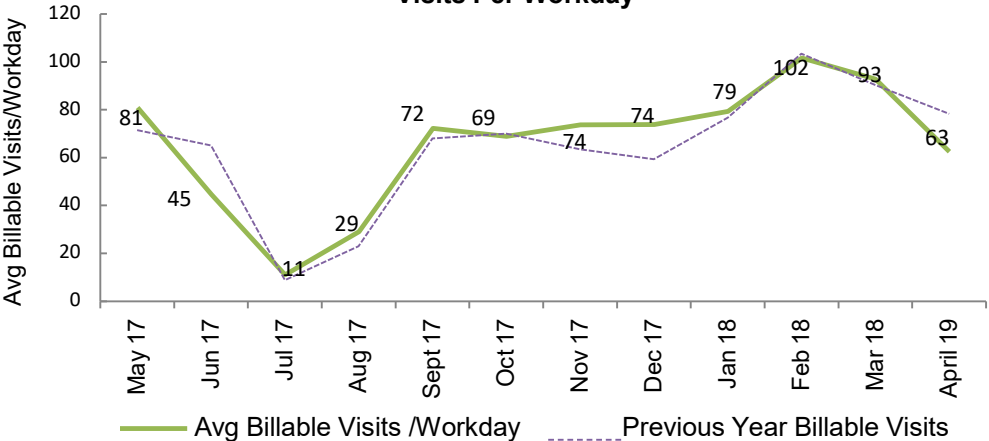
Primary Care Average Billable Visits Per Workday



Dental Average Billable Visits Per Workday



School-Based Health Center Average Billable Visits Per Workday



Notes: 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.

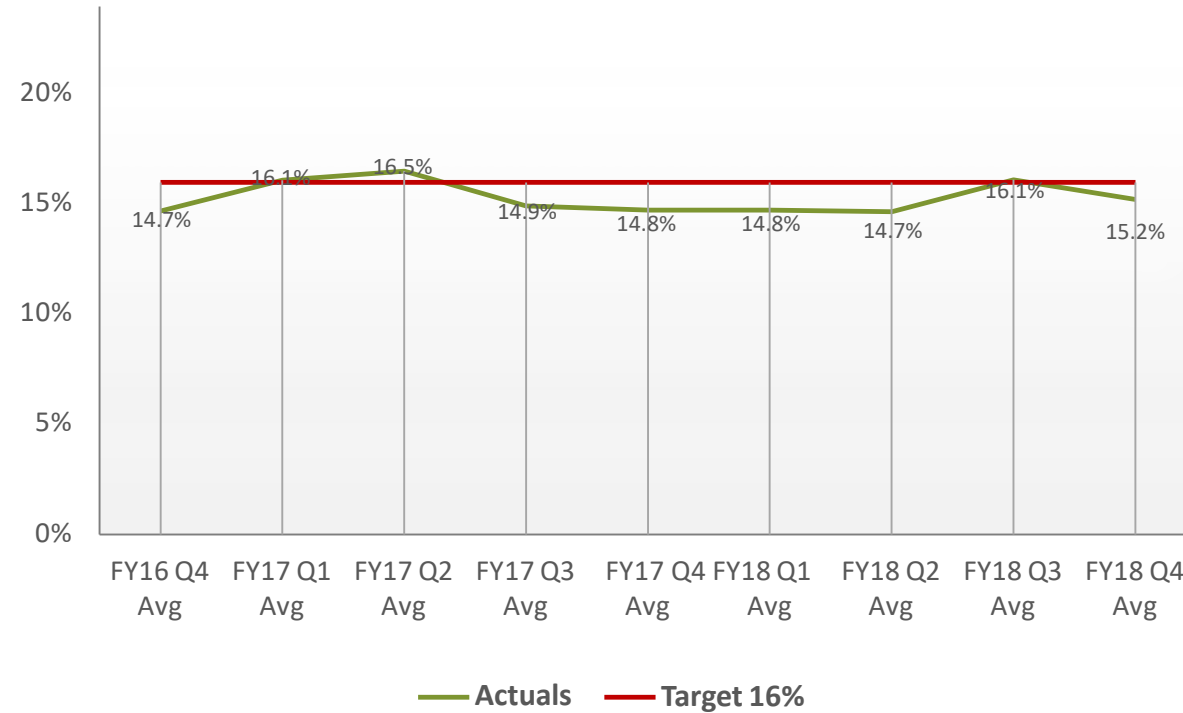




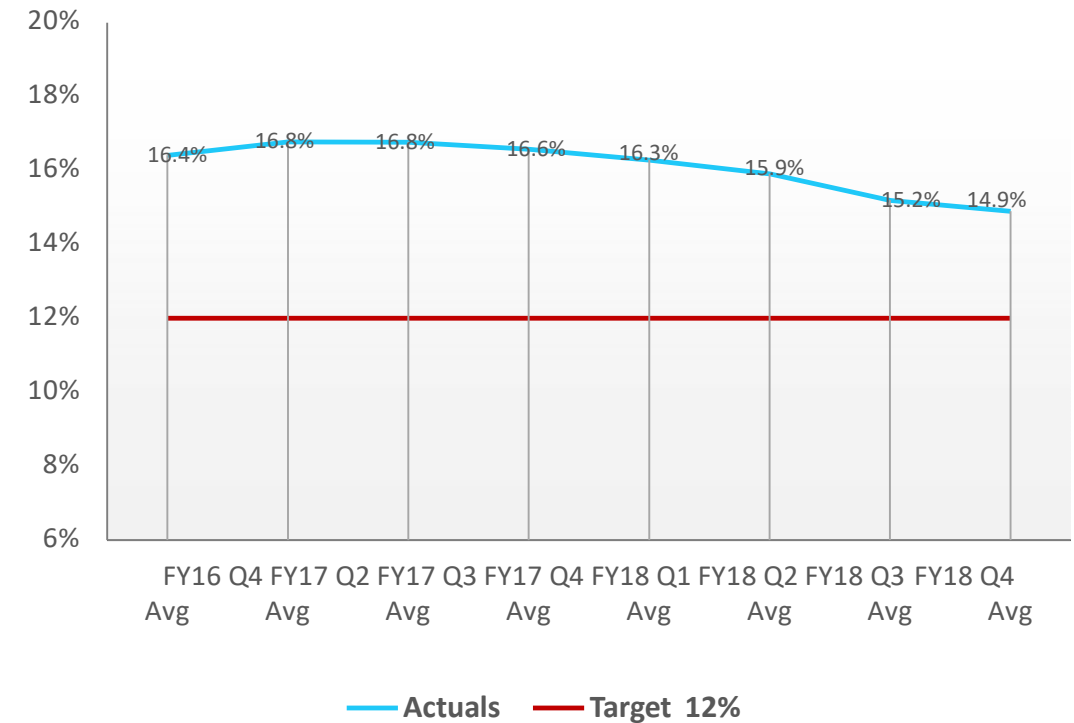
Multnomah County Health Department

Monthly Percentage of Uninsured Visits for ICS Primary Care Health Center

Percentage of Uninsured Visits in Primary Care



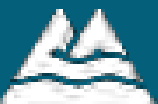
Percentage of Uninsured Visits in ICS Dental



Comments:

ICS Dental data shows a slight change between run dates with the amount of uninsured patients declining with each new week.

The reason for this is the Dental Clinics try to check insurance coverage two days prior to the appointment. If they are unable to establish insurance coverage a client is marked as self-pay. Once insurance is confirmed via the re-work self-pay report the status is then changed to reflect correct coverage.

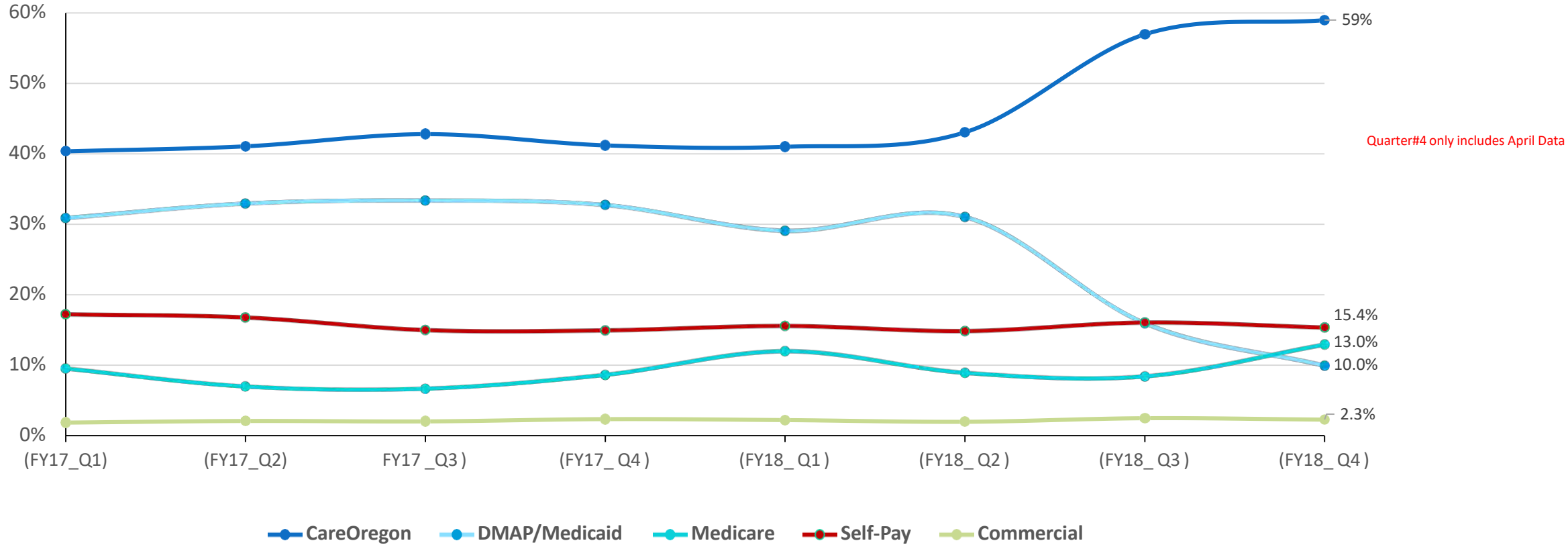




Multnomah County Health Department

Monthly Percentage of Visits by Payer for ICS Primary Care Health Center

Payer Mix for ICS Primary Care Health Center

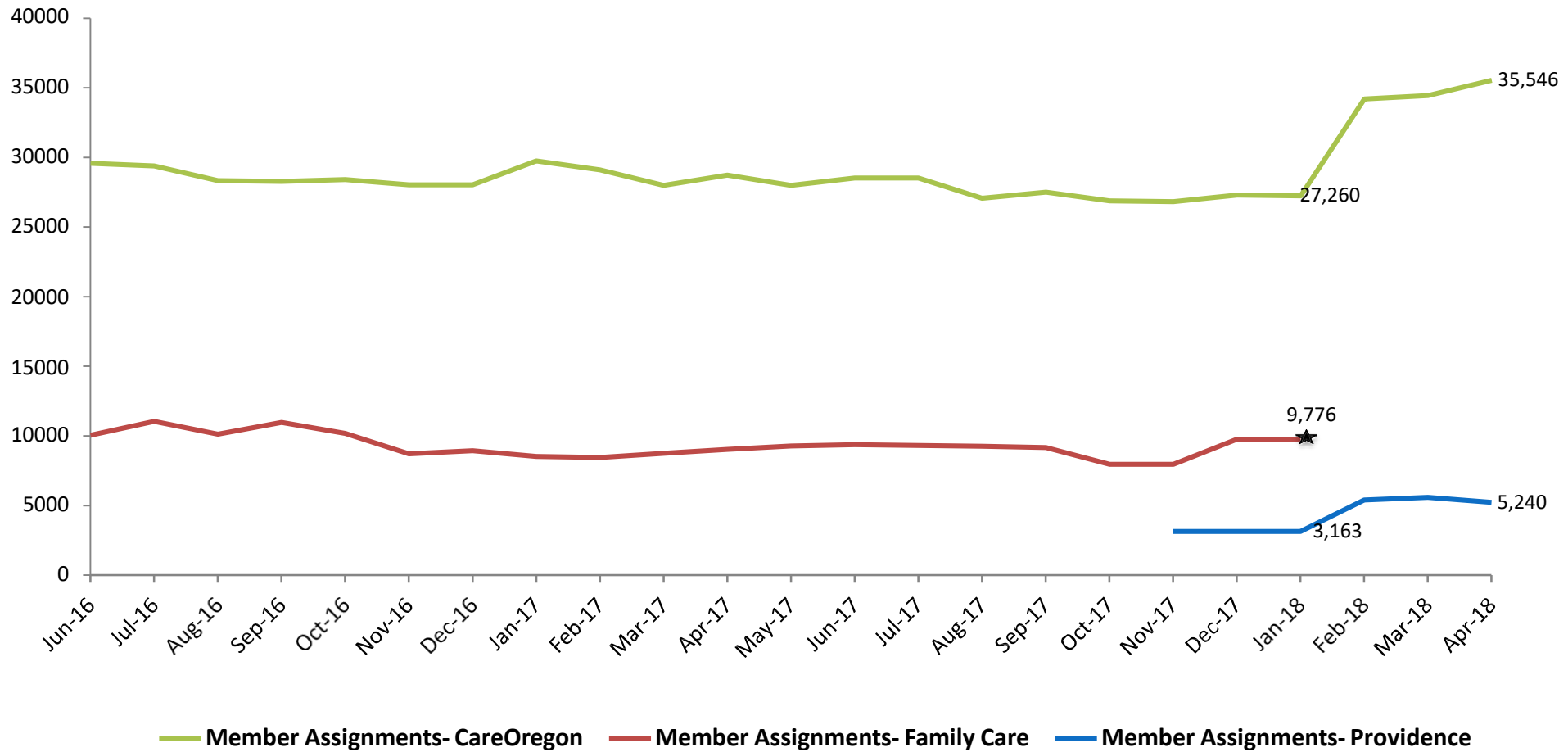


Notes: Payer Mix for Primary Care Health Service Center shows the percentage of patient visits per payer and per Quarter





Primary Care Member Assignments



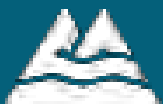
Notes:

FamilyCare FY17 average is 9,466

FamilyCare FY18 average is 9,039

CareOregon FY17 average is 28,561

CareOregon FY18 average is 29,566





Multnomah County Health Department
Community Health Centers: Financial Statement
For Period Ending April 2018

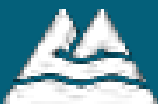
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April Target:

83%

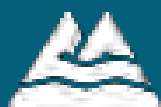
	Revised Budget	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17
Revenue							
General Fund	\$ 5,912,269	\$ 546,166	\$ 537,811	\$ 499,415	\$ 511,418	\$ 537,604	\$ 553,374
Grants - BPHC	\$ 9,557,198	\$ -	\$ -	\$ -	\$ 1,674,851	\$ 839,677	\$ 1,793,244
Grants - Incentives	\$ 5,903,961	\$ -	\$ 120,749	\$ 754,674	\$ 1,579,331	\$ 994,901	\$ 2,158,618
Grants - All Other	\$ 4,914,201	\$ -	\$ 291,825	\$ 345,545	\$ 456,837	\$ 505,626	\$ 706,797
Health Center Fees	\$ 91,743,442	\$ 6,958,089	\$ 7,469,051	\$ 7,520,606	\$ 7,584,293	\$ 8,270,340	\$ 6,817,334
Self Pay Client Fees	\$ 909,786	\$ 86,287	\$ 108,524	\$ 82,488	\$ 109,307	\$ 91,564	\$ 95,729
Total	\$ 118,940,857	\$ 7,590,542	\$ 8,527,960	\$ 9,202,728	\$ 11,916,037	\$ 11,239,712	\$ 12,125,096
Expense							
Personnel	\$ 77,084,758	\$ 6,004,330	\$ 6,917,202	\$ 6,102,184	\$ 5,861,741	\$ 6,396,686	\$ 5,954,438
Contracts	\$ 2,347,826	\$ 55,756	\$ 293,303	\$ 284,187	\$ 270,815	\$ 304,417	\$ 229,617
Materials and Services	\$ 17,206,493	\$ 1,346,379	\$ 1,132,461	\$ 1,122,410	\$ 1,482,379	\$ 1,232,232	\$ 1,245,577
Internal Services	\$ 22,147,322	\$ 1,192,466	\$ 1,916,329	\$ 1,907,025	\$ 2,261,847	\$ 1,832,303	\$ 2,955,382
Capital Outlay	\$ 154,458	\$ 14,762	\$ -	\$ -	\$ 6,095	\$ -	\$ -
Total	\$ 118,940,857	\$ 8,613,693	\$ 10,259,295	\$ 9,415,806	\$ 9,882,877	\$ 9,765,638	\$ 10,385,014
Surplus/(Deficit)	\$ -	\$ (1,023,151)	\$ (1,731,335)	\$ (213,078)	\$ 2,033,160	\$ 1,474,074	\$ 1,740,082

Note: Financial Statement for Fiscal Year 2018 (July 2017 - June 2018). Columns are blank/zero until the month is closed



	Revised Budget	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Year to Date Total	% YTD
Revenue									
General Fund	\$ 5,912,269	\$ 535,613	\$ 568,462	\$ 558,267	\$ 477,171	\$ -	\$ -	\$ 5,325,301	90%
Grants - BPHC	\$ 9,557,198	\$ 858,784	\$ 941,935	\$ 867,820	\$ 891,396	\$ -	\$ -	\$ 7,867,707	82%
Grants - Incentives	\$ 5,903,961	\$ 421,420	\$ -	\$ 1,310,179	\$ -	\$ -	\$ -	\$ 7,339,872	124%
Grants - All Other	\$ 4,914,201	\$ 466,552	\$ 932,846	\$ 418,960	\$ 151,419	\$ -	\$ -	\$ 4,276,407	87%
Health Center Fees	\$ 91,743,442	\$ 7,684,192	\$ 8,464,510	\$ 7,595,973	\$ 7,182,097	\$ -	\$ -	\$ 75,546,485	82%
Self Pay Client Fees	\$ 909,786	\$ 94,503	\$ 86,599	\$ 109,267	\$ 70,518	\$ -	\$ -	\$ 934,786	103%
Total	\$ 118,940,857	\$ 10,061,064	\$ 10,994,352	\$ 10,860,466	\$ 8,772,601	\$ -	\$ -	\$ 101,290,558	85%
Expense									
Personnel	\$ 77,084,758	\$ 6,357,261	\$ 6,200,610	\$ 6,148,522	\$ 5,980,549	\$ -	\$ -	\$ 61,923,523	80%
Contracts	\$ 2,347,826	\$ 151,362	\$ 346,608	\$ 144,237	\$ 169,618	\$ -	\$ -	\$ 2,249,920	96%
Materials and Services	\$ 17,206,493	\$ 1,049,991	\$ 1,158,831	\$ 1,344,439	\$ 1,566,918	\$ -	\$ -	\$ 12,681,617	74%
Internal Services	\$ 22,147,322	\$ 1,605,606	\$ 2,240,607	\$ 2,181,724	\$ 1,807,105	\$ -	\$ -	\$ 19,900,394	90%
Capital Outlay	\$ 154,458	\$ -	\$ -	\$ 38,323	\$ 14,872	\$ -	\$ -	\$ 74,052	48%
Total	\$ 118,940,857	\$ 9,164,220	\$ 9,946,656	\$ 9,857,245	\$ 9,539,062	\$ -	\$ -	\$ 96,829,506	81%
Surplus/(Deficit)	\$ -	\$ 896,844	\$ 1,047,696	\$ 1,003,221	\$ (766,461)	\$ -	\$ -	\$ 4,461,052	

Note: Financial Statement for Fiscal Year 2018 (July 2017 - June 2018). Columns are blank/zero until the month is closed





Multnomah County Health Department
Community Health Centers: Financial Statement
 For Period Ending April 2018

Community Health Centers - Page 1

April Target:

	Revised Budget	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17
Revenue							
General Fund	\$ 5,912,269	\$ 546,166	\$ 537,811	\$ 499,415	\$ 511,418	\$ 537,604	\$ 553,374
Grants - BPHC	\$ 9,557,198	\$ -	\$ -	\$ -	\$ 1,674,851	\$ 839,677	\$ 1,793,244
Grants - Incentives	\$ 5,903,961	\$ -	\$ 120,749	\$ 754,674	\$ 1,579,331	\$ 994,901	\$ 2,158,618
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Expense							
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Capital Outlay	\$ 154,458	\$ 14,762	\$ -	\$ -	\$ 6,095	\$ -	\$ -
Total	\$ 118,940,857	\$ 8,613,693	\$ 10,259,295	\$ 9,415,806	\$ 9,882,877	\$ 9,765,638	\$ 10,385,014
Surplus/(Deficit)	\$ -	\$ (1,023,151)	\$ (1,731,335)	\$ (213,078)	\$ 2,033,160	\$ 1,474,074	\$ 1,740,082

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Multnomah County Health Department
Community Health Centers: Financial Statement
 For Period Ending April 2018

Community Health Centers - Page 2
April Target:

	Revised Budget	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Year to Date Total
Revenue								
General Fund	\$ 5,912,269	\$ 535,613	\$ 568,462	\$ 558,267	\$ 477,171	\$ -	\$ -	\$ 5,325,301
Grants - BPHC	\$ 9,557,198	\$ 858,784	\$ 941,935	\$ 867,820	\$ 891,396	\$ -	\$ -	\$ 7,867,707
Grants - Incentives	\$ 5,903,961	\$ 421,420	\$ -	\$ 1,310,179	\$ -	\$ -	\$ -	\$ 7,339,872
Grants - All Other	\$ 4,914,201	\$ 466,552	\$ 932,846	\$ 418,960	\$ 151,419	\$ -	\$ -	\$ 4,276,407
Health Center Fees	\$ 91,743,442	\$ 7,684,192	\$ 8,464,510	\$ 7,595,973	\$ 7,182,097	\$ -	\$ -	\$ 75,546,485
Self Pay Client Fees	\$ 909,786	\$ 94,503	\$ 86,599	\$ 109,267	\$ 70,518	\$ -	\$ -	\$ 934,786
Total	\$ 118,940,857	\$ 10,061,064	\$ 10,994,352	\$ 10,860,466	\$ 8,772,601	\$ -	\$ -	\$ 101,290,558
Expense								
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Contracts	\$ 2,347,826	\$ 151,362	\$ 346,608	\$ 144,237	\$ 169,618	\$ -	\$ -	\$ 2,249,920
Materials and Services	\$ 17,206,493	\$ 1,049,991	\$ 1,158,831	\$ 1,344,439	\$ 1,566,918	\$ -	\$ -	\$ 12,681,617
Internal Services	\$ 22,147,322	\$ 1,605,606	\$ 2,240,607	\$ 2,181,724	\$ 1,807,105	\$ -	\$ -	\$ 19,900,394
Capital Outlay	\$ 154,458	\$ -	\$ -	\$ 38,323	\$ 14,872	\$ -	\$ -	\$ 74,052
Total	\$ 118,940,857	\$ 9,164,220	\$ 9,946,656	\$ 9,857,245	\$ 9,539,062	\$ -	\$ -	\$ 96,829,506
Surplus/(Deficit)	\$ -	\$ 896,844	\$ 1,047,696	\$ 1,003,221	\$ (766,461)	\$ -	\$ -	\$ 4,461,052

Note: Financial Statement for Fiscal Year 2018 (July 2017 - June 2018). Columns are blank/zero until the month is closed

83%

83%

% YTD

90%

82%

124%

87%

82%

103%

85%

80%

96%

74%

90%

48%

81%

**Multnomah County Health Department
Integrated Clinical Services (ICS)
2018 Quality Management Plan**

I. Introduction and Organization Overview

- Vision, Mission, Values
- Quality Management Framework

II. Community Health Center Quality Structure

- Governance
- Board Leadership
- Community Health Center Leadership
- Program Leadership
- Clinic Leadership

III. Core Quality Program Functions

- HIPAA Compliance and Patient Records Management
- Patient Satisfaction and Complaint Management
- Patient Safety
- Incident Reporting and Event Management
- Employee Safety
- Provider Licensing and Credentialing
- Employee Training and Education
- Visual Performance Management
- Quality Improvement

IV. Community Health Centers Quality Priorities

- Medical
- Dental
- Pharmacy

V. Appendix

- Review and Approval Tracking
- Glossary of Terms

Glossary of Terms

BCC	Board of County Commissioners
BPHC	Bureau of Primary Health Care
CHC	Community Health Council, the Community Health Center's consumer-majority governing board
COACH	Clinical Oral Advocates for Coordinated Health
DCLT	Dental Care Leadership Team
HIPAA	Health Insurance Portability and Accountability Act
HRSA	Health Resources and Services Administration
HVA	Hazard Vulnerability Analysis
ICS	Integrated Clinical Services, a division of MCHD that includes the Community Health Center
IT	Information Technology
MCHD	Multnomah County Health Department
PST	Pharmacy Services Team
OSHA	Occupational Safety and Health Administration
PSS	Patient Satisfaction Survey
QA	Quality Assurance
QI	Quality Improvement
QLT	Quality Leadership Team
SLICS	Senior Leadership for Integrated Clinical Services
TJC	The Joint Commission

SECTION I:

INTRODUCTION AND ORGANIZATION OVERVIEW

Integrated Clinical Services(ICS) is part of the Multnomah County Health Department (MCHD), which serves a population of more than 766,135 residents. MCHD employs over 1,300 full time equivalent staff (FTE) who provide services in disease prevention, food service inspections, emergency preparedness, environmental health, mental health and addiction services, and other core public health services.

ICS operates a Federally Qualified Health Center (FQHC) across Multnomah County. The FQHC offers primary care, dental care, behavioral health, pharmacy, laboratory, and enabling services. The ICS 2018 Quality Management Plan pertains to these services offered within the Community Health Centers. The Quality Management Plan establishes a quality improvement and quality assurance program that addresses requirements for health centers including:

- The quality and utilization of health center services
- Patient satisfaction and patient grievance processes; and
- Patient safety, including adverse events.

ICS Vision: Integrated. Compassionate. Whole person health.

Mission: Providing services that improve the health and wellness for individuals, families and communities

Strategic Values:

- Quality and Safety
- Patient-Centered and Culturally Relevant
- Fiscally Sound and Accountable
- Engaged, Expert, Diverse Workforce

Quality Management Framework

Purpose: An integrated and comprehensive approach that leads to a culture of quality, safety and excellence.

Goals:

1. Enable ICS leaders and key stakeholders (e.g., Community Health Council, Board of County Commissioners) to have a shared understanding about quality goals.
2. Support ICS to identify priorities, allocate resources, and monitor progress.
3. Provide guidance and support for high-quality person and family-centered services.

Key Assumptions:

- Creating a culture of quality, safety and excellence is a shared responsibility.
- Staff members at all levels (department, division, program and individual) have shared accountability for goals, outcomes and timelines.
- Sufficient resources will be allocated to implement quality activities.
- ICS staff members will use consistent language, tools and document management systems in implementing quality principles.

Key Components:

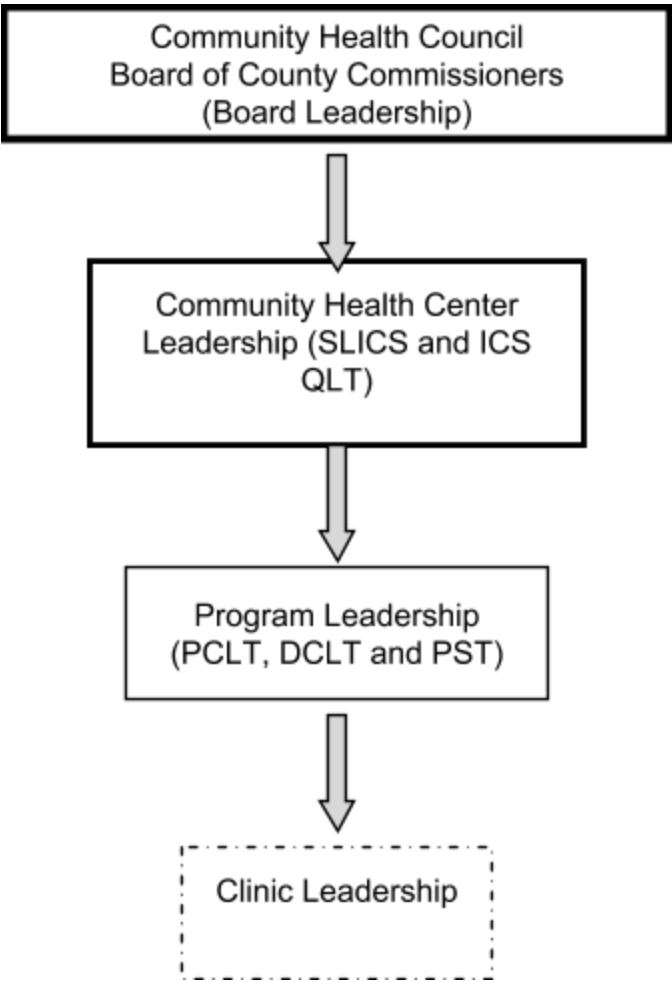
The Quality Management Framework guides our work and has four components:

1. **Quality Assurance:** An organizational system that ensures and monitors regulatory compliance for all patient care, treatment and services and manages risks across the full range of health center activities. The Quality Assurance Program includes: the assessment or evaluation of the quality of services delivered; identification and correction of problems or shortcomings in the delivery of services; and follow-up to ensure that corrections are sustained.
2. **Quality and Performance Improvement:** Quality Improvement continuously assesses the current state and looks for opportunities for performance improvement. Performance Improvement is the practice of using data to monitor progress toward goals. If target goals are not met or exceeded, improvement efforts need to happen. Together they create an organizational culture of proactive monitoring. The outcome should result in staff satisfaction, patient satisfaction, and overall improvements in program delivery or patient care.
3. **Clinical Systems Information / Health Information Services:** Clinical Systems Information includes information technology infrastructure, hardware and software applications, and support. Health Information Services encompasses the practices and policies to ensure client/patient confidentiality,
4. **Systems Performance Management:** A systems approach to achieving strategic goals through the management and organization of data and processes.

SECTION II:

COMMUNITY HEALTH CENTER QUALITY STRUCTURE

Governance



Board Leadership

The Community Health Council (CHC) is the consumer-majority governing board mandated by the HRSA’s Bureau of Primary Health Care (BPHC) to provide oversight of MCHD’s Federally-Qualified Health Center (FQHC).

As a Co-Applicant Board, the CHC shares governance responsibilities with Multnomah County’s Board of County Commissioners. The Board of County Commissioners (BCC) retains authority over fiscal and personnel policies, while the CHC retains other governance responsibilities required by HRSA. The Co-Applicant Board Agreement details specific sharing of governance responsibilities.

CHC governance includes:

- **Annual QA/QI plan:** A new QA/QI plan is developed by management and approved by the CHC each year. The plan includes the scheduled QA/QI activities and the goals for the BPHC core and other performance measures.
- **Staff QA/QI program reports:** The nature and frequency of QA/QI reports by health center staff made to the CHC will vary but board reporting is essential. QA/QI reports are presented to the CHC and Senior Leadership for Integrated Clinical Services (SLICS) as specified in this plan. Significant findings are noted at the CHC meeting and provided regularly from clinical leaders.
- **Accreditation/certification reports:** The CHC receives results of surveys by accrediting bodies such as The Joint Commission (TJC) Primary care Medical Home, TJC Ambulatory Health Care Accreditation Program, and TJC lab accreditation program.
- **External program and financial audit reports:** Funding sources often conduct on-site or other program and financial performance reviews. These reports are reviewed and shared with the CHC as appropriate. Often these auditors meet with CHC members as well. The auditor presents the required annual financial audit report to the full BCC for their approval. The BCC reviews and approves management's responses to audit findings and assure responses are incorporated into upcoming QA/QI activities as appropriate.
- **Patient satisfaction surveys:** Patient satisfaction surveys are a program requirement and an important component of a QA/QI program. These surveys are conducted at least annually and reported to the full CHC.
- **Adverse incident reports:** The QA/QI program includes arrangements for identifying, documenting and reporting adverse incidents affecting patient satisfaction, staff satisfaction, safety, possible professional and general liability insurance claims, and the quality of clinical and management services. These reports and management's responses are regularly reported to the CHC.
- **HRSA/BPHC required clinical and financial measures and the health center's performance:** The results of the HRSA/BPHC performance measures are reported at least annually. Other internally designated measures may be assessed and reported more frequently. Some may be incorporated into regular reports reviewed by the CHC and in other QA/QI reports.

Meeting Frequency:

- CHC Board: Monthly and as needed
- Executive Committee: Monthly and as needed
- Nominating Committee: Monthly and as needed
- Bylaws, Strategic Planning, Ad-Hoc Committees: As needed

Membership:

- The Community Health Council has a range of nine to 25 members.
- A majority of CHC members are patients who are served by MCHD/ICS Community Health Centers, consumer members, and who as a group represent the individuals being served. We have a member who represents homeless patients as a Health Care for the Homeless grantee.

The Multnomah County Board of Commissioners has four commissioners, each of whom are elected to the board by district. Elected countywide are a board chair, sheriff, district attorney and auditor. The elected officials represent the people of Multnomah County. The Board of County Commissioners also operates as the Multnomah County Board of Health for public health oversight. In this role, the commissioner's exercise budget and personnel authority over the community health center.

Meeting Frequency:

- Weekly and as needed

Membership:

- Chair
- Four County Commissioners (Districts 1, 2, 3 and 4)

Community Health Center Leadership

The Senior Leadership for Integrated Clinical Services (SLICS) team sets the direction and assures leadership alignment to achieve the vision and mission for the community health center. Clinical and operational leaders from each service area are represented on this team. SLICS is led by the community health center's Executive Director, whose working title is Integrated Clinical Services Director.

SLICS responsibilities include:

- Strategic planning and implementation of operational policies
- Assuring alignment and progress toward accomplishing strategic goals
- Providing quality and safety oversight for Community Health Centers
- Development, review and response to operational, clinical and financial measures.

Meeting Frequency:

- Twice per month and as needed
- Retreats at least twice per year and as needed

Core Membership:

- Director, Integrated Clinical Services
- Deputy Director, Integrated Clinical Services
- Medical Director
- Primary Care Services Director
- Dental Director
- Pharmacy and Lab Services Director
- Quality Director

Extended Membership:

- Deputy Medical Director and Deputy Nurse Practitioner Director
- Deputy Dental Director
- MCHD Human Resources Manager
- County IT Senior Manager
- Dental Manager

The Quality Leadership Team (QLT) provides a forum for coordinated decision-making and implementation of quality across ICS. QLT looks for opportunities to coordinate quality initiatives across ICS including: planning, assuring outcomes, and communicating key activities to stakeholders. This team is led by the Quality Director and the Community Health Center Care Medical Director.

QLT responsibilities include:

- Reform and define its purpose in a new organizational structure

Meeting Frequency:

- 3x per year

Membership:

- Senior Clinical and Administrative Leadership from Integrated Clinical Services
- Ad Hoc members
 - Quality Team Members
 - Public Health Leadership

Program Leadership

The Primary Care Leadership Team (PCLT) provides program leadership for the community health center's medical and behavioral health services. The team includes clinical and operational leaders from each primary care site. This team decides service delivery changes, project implementations, and plans initiative roll-outs. They facilitate

clinical and operational partnerships. The team identifies annual primary care and behavioral health quality improvement priorities.

PCLT responsibilities include:

- Review patient satisfaction results and identify improvement opportunities
- Review clinical performance measures and identify improvement opportunities
- Evaluate and approve operational and clinical initiatives
- Evaluate and approve quality improvement initiatives
- Ensure all initiatives align with ICS strategic goals.

Meeting Frequency:

- Monthly and as needed

Membership:

- Primary Care Services Director
- Medical Director
- Deputy Medical Directors
- Primary Care Operations Innovation and Process Improvement Manager
- Health Center Program Supervisor
- Health Center Managers
- Site Medical Directors
- Student Health Center (SHC) Program Manager
- Nurse Practitioner Manager, SHC Program
- Behavioral Health Program Supervisor
- Operations Supervisors
- Nursing Supervisors
- Program Supervisors
- Quality Director
- Clinical Information Services Manager
- Pharmacy and Lab Services Director
- Health Information Services Manager

The Dental Care Leadership Team (DCLT) provides program leadership for the community health center's dental clinics, School and Community Oral Health Program and student rotations. The team includes clinical leadership and operations leaders from each dental care site. This team decides service delivery changes, project implementations, and plans initiative roll-outs. They build partnerships with organizations who have a stake in preventive services. The team evaluates the utility of services offered to identify quality improvement efforts with particular emphasis on increasing patient-centeredness and improving clinical outcomes.

DCLT responsibilities include:

- Review patient satisfaction results and identify improvement opportunities

- Review clinical performance measures and identify improvement opportunities
- Evaluate and approve operational and clinical initiatives
- Evaluate and approve quality improvement initiatives

Meeting Frequency:

- Monthly and as needed

Membership:

- Dental Director
- Dental Operations Manager
- Deputy Dental Director
- Dental Operations Administrators/Supervisors (each site)
- School and Community Oral Health Program Supervisor
- Quality Assurance (Aron does this role, and she is a dental program specialist senior, so i would recommend retaining one)
- Dental Program Specialist Senior

The Pharmacy Services program utilizes the lead pharmacist positions, pharmacist-in-charge (PIC), to provide program clinical and operational leadership for the community health center's pharmacy services. This group meets to review program decisions focused on project implementations, quality improvement and initiative roll-out planning. The review of this information leads to the implementation and evaluation of program policies and procedures to optimize medication safety and therapy adherence.

PIC responsibilities include:

- Review patient satisfaction results and identify improvement opportunities
- Review clinical performance measures and identify improvement opportunities
- Implement and evaluate operational initiatives
- Implement and evaluate quality improvement initiatives

Meeting Frequency:

- Monthly

Membership:

- Pharmacy and Lab Services Director
- Pharmacist Lead (Pharmacist in Charge -PIC) from each site
- Clinical Pharmacist Lead
- Ad-hoc: Pharmacy Supervisor and Operation Supervisors

Clinic Leadership

Primary Care Clinic Leadership Teams are clinic-specific and represent the managers, supervisors, and clinic leads. The Clinic leadership team manages staff, operations, budgets, and the direction for the clinical practice.

Primary Care Clinic Leadership responsibilities include:

- Review site-specific patient satisfaction results and identify improvement opportunities
- Review site-specific clinical performance measures and identify improvement opportunities
- Implement and evaluate the effectiveness operational and clinical initiatives
- Implement and evaluate the effectiveness of quality improvement initiatives

Meeting Frequency:

- Monthly and as needed

Membership (as applicable):

- Health Center Manager
- Site Medical Director
- Operations Supervisor
- Nursing Supervisor
- Program Supervisor (where applicable)
- Lead Staff

Primary Care Sustainability Teams are clinic-specific and represent different patient care teams and role groups, including clinic management. The role of sustainability teams is to sustain quality management successes and to address and resolve clinic-specific concerns, including issues related to patient services and workflows. All team members have a role in problem solving and implementing new initiatives.

Sustainability Leadership responsibilities include:

- Sustain quality improvements
- Review local workflows
- Initiate quality improvement projects at the local level

Meeting Frequency:

- At least monthly and as needed

Membership may include:

- Provider representative
- Nurse representative
- Medical assistant representative
- Team clerical assistant representative

- Management representative
- Community Health Worker representative

Quality Improvement Committee

The Quality Improvement Committee meets monthly and is responsible for reviewing: Quality Improvement initiatives, who is responsible for each initiative, timelines for each initiative, as well as the review of PDSA cycles.

SECTION III:

QUALITY PROGRAM CORE FUNCTIONS

The quality program's mission is to implement and sustain a culture of quality, safety, equity, and excellence within ICS. This is achieved by integrating the core functions of the Quality Team throughout the Community Health Centers. Under the leadership of the Quality Director, quality team members provide analysis, consultation, project management, program oversight, technical support, training and education. The Quality Team is divided into the following five areas:

- Quality Assurance
- Quality and Performance Improvement
- Infection Prevention
- Information Systems / Health Information Services
- Systems Performance Management

The Quality Program core functions include:

- HIPAA compliance and patient records management
- Patient satisfaction and complaint management
- Patient safety
- Incident reporting and event management
- Employee safety
- Provider licensing and credentialing
- Employee training and education
- Visual Performance Management
- Quality improvement
- Quality Assurance
- Risk Management

CORE FUNCTIONS	FIVE AREAS OF THE QUALITY TEAM				
	Quality Assurance	Quality and Performance management	Infection Prevention	Information Systems/Health information Services	Systems Performance Management
HIPAA compliance and patient records management				X	
Patient satisfaction and complaint management	X	X			
Patient safety	X		X		
Employee Safety	X		X		
Incident reporting and event management	X		X		
Provider licensing and credentialing				X	
Employee training and education	X	X	X	X	X
Visual performance management	X	X	X		X
Quality improvement and quality assurance	X	X	X		
Risk management	X	X	X	X	X

HIPAA Compliance and Patient Records Management

MCHD's Health Information Services unit is responsible for the release of information from patient medical records (approximately 1,000 requests for medical records are processed each month), reviewing chart codes for accuracy, and scanning documents into the electronic medical record and electronic dental record systems. This unit is also responsible for HIPAA privacy compliance for the Health Department.

The primary purpose of Health Information Systems is to ensure that information is released from patient medical records in accordance with all laws, rules and regulations governing confidentiality of medical records, and to process visits for billing as quickly as possible.

This Health Information Services unit is responsible for providing information about patient's HIPAA rights and responsibilities. This is provided in multiple languages and formats including brochures, websites, clinic front desks, and waiting room signage. This unit investigates each HIPAA breach. Each HIPAA breach requiring patient notification is reviewed and approved by the Integrated Clinical Services Director. In collaboration with the County Privacy Office, this unit develops HIPAA education for Community Health Center staff and providers.

Primary functions include:

- Protect the privacy/confidentiality of patient information by complying with all federal and state laws
- Respond promptly and appropriately to patient requests to exercise their privacy rights
- Provide efficient, timely, and accurate scanning and indexing of documents into the electronic medical and dental records
- Investigate all HIPAA privacy incidents, breaches and complaints
- Lead the ethical use of quality health information

Patient Satisfaction and Complaint Management

Patient Satisfaction

The Client Feedback and Awareness Program collects feedback through phone-based surveys and client comment cards from clients from Primary Care, Dental, and Pharmacy Services. This information guides decision makers and supports quality improvement.

Patient satisfaction surveys occur yearly (Primary Care and Dental) or biannual (Pharmacy Services) and are reported annually to the Community Health Council to update and seek recommendations. In addition to patient satisfaction the Client

Feedback and Awareness program also supports programs and pilot projects with specific client-focused evaluation and survey needs. These have included a Dental “did not arrive” studies, and a telephone/telemedicine pilot evaluation for school based and primary care.

Complaint Management

Each complaint is investigated within five business days by clinic management at the location in which the complaint originated. Complaints may be filed in multiple ways:

- At the clinic site in person
- Via telephone
- Via email
- Via an anonymous comment card
- On patient satisfaction surveys
- Anonymously through the Multnomah County Auditor’s Good Government Hotline
- Through HRSA, the Joint Commission, or patient’s insurance carrier
- Through Coordinated Care Organization

If there is evidence that the complaint exposes process failures or deficiencies, clinic management will coordinate with Quality Assurance to initiate any corrective actions that may be needed, which may include collaboration with Quality Improvement. All complaints targeting Community Health Center services are compiled and reported to leadership for review on a monthly basis.

Patient Safety

Performance-Based Audits

The Quality Assurance Program, conduct quarterly performance-based audits using electronic health records data. The purpose of the audit is to ensure compliance with practice standards in primary care and dental services. Examples include:

- Appropriate use of the pain scale
- Use of the “time out” protocol prior to invasive procedures
- Length of time patient visit encounters are left “open” in electronic health record systems.

Clinical Audits

Clinical Audits are an essential component to patient safety through the evaluation of patient records and provision of care. The Medical and Dental Directors, or designees, conduct clinical audits annually for each provider using a standardized template. The review covers patient assessment, treatment plans, progress notes, and closure summaries. For dental: diagnostic criteria, medication review, and medical problems, clinical skills

Infection Control Risk Assessment

A Health Department Infection Control Risk Assessment is conducted annually by the various departments embedded within ICS and Public Health. The assessment identifies infection control risk factors present within the Health Department. The Annual Infection Control Improvement Plans goals and objectives are based on these identified risks.

Infection Control Surveillance

Surveillance is an integral function within the Infection Control Program. Audits are conducted by the Health Department Infection Preventionists. The findings, along with identified action items, are shared with leadership within each department. The purpose of the audits is to ensure patient and employee safety, identify learning needs, and ensure that employees are competent in infection control and following best practice.

Incident Reporting and Event Management

The MCHD's guidelines (AGN.11.03) describe two classifications of events that must be reported. These are:

- **Incidents:** Any event (or near miss) that is not consistent with the routine operation of Health Department services and has resulted in a preventable adverse consequence, or the risk thereof. Some incidents may be identified after being reported by clients/patients in the form of a documented complaint."
- **Serious Patient Safety Event:** Any unanticipated and preventable event during, or as a result of clinical care that resulted, or could have resulted, in unexpected and significant physical or psychological harm to the patient.

The Quality Assurance Program, working in collaboration with Infection Prevention, sets reporting requirements, reviews event reports, coordinates investigations, analyzes results, presents findings, and maintains records of all reports. Monthly report summaries and an annual detailed summary of all events, injuries, errors, and complaints are provided to Community Health Center and SLICS leadership. The reports help identify trends or changes in clinic incidents and events as well as opportunities for improvement.

Reported events are reviewed by senior leadership. Based on this review, senior leadership may request an investigation. This investigation is conducted by the Quality Assurance Program who will include an event analysis and recommendations for corrective actions. Analytical methods, such as root-cause-analysis,

failure-modes-effects-analysis, process analysis, and detailed interviews are used in the investigations and recommendations for corrective actions. Once corrective actions are in place, the program continues to monitor the corrections to ensure that similar events will not occur. Results of analyses and corrective actions are reported to the appropriate clinic leaders monthly.

Employee Safety

The Quality Assurance Program, in collaboration with Infection Prevention, ICS Risk Management within the Quality Program, Primary Care Senior leadership, Dental Senior Leadership, Pharmacy Senior Leadership and County Risk Management office, facilitates employee risk reduction by ensuring that applicable safety regulations, guidelines, and standards are being followed. Quality Assurance activities include:

- Monthly assessment of new staff to identify licensing and training needs
- Regular review of clinic site plans and policies such as HAZCOM, Bloodborne Pathogens, Safety and Evacuation, Workplace Violence Response, and Utility Failure Response
- Quarterly inspections as mandated by OSHA
- Semi-annual on-site tours at every primary care, school-based health center and dental site to assess compliance to Joint Commission, OSHA, HRSA, and MCHD requirements

Additionally, the Quality Program collaborates with Community Health Center leadership annually to assess a variety of risks due to natural, technological or human causes with the annual Hazard Vulnerability Analysis (HVA). Each clinic performs a local risk assessment by evaluating the risks for site-specific issues such as violence, crime, fires, and confidentiality violations. These assessments allow groups such as the Sustainability Teams and Safety Committees to analyze probability and risk over time and prepare when there is demonstrated increase of risk.

Provider Licensing and Credentialing

All MCHD providers are credentialed at the time of hire and are re-credentialed at least every two years. MCHD establishes and maintains credential files for each provider in compliance with HRSA, Joint Commission, and MCHD policies.

MCHD credentialing and privileging policy HRS.04.03 is reviewed and approved by the CHC. Quarterly, the Medical Director presents fully credentialed and privileged Licensed Independent Practitioners (LIP) to the CHC for review and approval.

Provider credential files are maintained in a secure, locked location and/or in secure, restricted-access electronic files to prevent unauthorized access and in order to protect the privacy and confidentiality of providers.

The responsibility for maintaining licenses, credentials and privileges aligns with each Community Health Center program area:

- Dental Director – dentists, dental hygienists, other dental program staff
- Medical Director – physicians, nurse practitioners, physician assistants, LCSWs, other primary care program staff
- Human Resources - nurses and other nursing staff, and CMAs

Clinical leaders (Dental Director, Medical Director) conduct privilege reviews and approvals for the clinicians who operate under their responsibility. Documentation of competence can be provided through training documentation and demonstrated proficiency.

Human Resources is responsible for monitoring licenses and certifications for other Licensed or Certified Practitioners

Employee Training and Education

MCHD has an employee training and education program. All new MCHD employees are required to take trainings, i.e. new nurse orientation, new provider orientation, or review policies that are specific to their role within the department.

Additionally, providers and other staff have training budgets allocated for professional development and maintaining clinical competencies. Provider, RN, and CMA trainings occur regularly through Grand Rounds.

MCHD tracks required staff trainings in various systems, SAP and HealthStream are two examples.

Visual Performance Management

Visual Performance Management is a quality management tool used throughout the Community Health Centers. This is accomplished by using Sustainability Boards which are located in each clinic to ensure that staff are aware of quality initiatives and obtain the same information in the same way at the same time. All staff can see and understand workplace priorities, target measures, and current performance status at a glance.

Providers, clinic staff, and management use dashboards and other visual displays to track clinical, financial, and operations performance measures. These dashboards are integrated into quality management at all levels of leadership and support decision-making and oversight of the clinics.

Quality Improvement

Quality Improvement recommendations identify the change that is needed, determine deadlines for corrective action and assign responsibility. The Quality Program is accountable to the clinical and senior leadership of primary care, dental, and pharmacy services, for the findings, conclusions, recommendations, actions taken, and results of the corrective or improvement actions taken. The Primary Care Medical Director and the Dental Director have responsibility for clinical quality measures within their areas.

Quality Assurance

An essential part of quality management is the on-going review and maintenance of data reports that fall within the Quality Program core functions to assure conformance to internal and external standards. Oversight by the Quality Program, working in collaboration with the Primary Care Medical Director and Dental Director, includes data collection, monitoring performance measures, the appropriateness of patient care delivered, coordinating reporting, making recommendations and leading initiatives to address the recommendations. The Quality Assurance activities monitor the compliance to Joint Commission Standards as well as all applicable State and Federal requirements and regulations.

Risk Management

Risk Management activities are performed to support the overall mission and vision of the health centers as they pertain to clinical risk and patient safety. This part of the Quality Program supports the establishment of a safety culture that emphasizes implementing evidence-based best practices, learning from error analysis, and ensuring that risks across the spectrum of clinical services are identified and either eliminated or controlled through assessments, reporting, analyses and proactive mitigation.

The following reporting schedule outlines key reports, the frequency of review and by whom it will be reviewed and/or approved. By keeping with this schedule, the Community Health Centers have a clear process for continual quality improvement, leadership oversight, decision making, and communication opportunities throughout the organization.

abbreviations

CHC= Community Health Council

SLICS= Senior Leadership, Integrated Clinical Services

QLT = Quality Leadership Team

Quality Program Reports	Frequency and Reviewed By			
	Bi-weekly	Monthly	Quarterly	Annually
Patient Satisfaction Survey Results			SLICS Clinic Leadership Teams CHC	
Summary Report of Patient Complaints (Patient complaints are reviewed as they are received by the Quality Assurance staff, Dental and Medical Director and other pertinent leadership)			SLICS Clinic Leadership Teams CHC	
Summary Report of Clinical Safety Events (Patient and Employee Incidents)			SLICS Clinic Leadership Teams CHC	
Clinical Performance Measures, UDS Report	Clinic Leadership Teams	Clinic Leadership Teams	SLICS Clinic Leadership Teams CHC	CHC
Financial Performance Measures		SLICS Clinic Leadership Teams CHC	SLICS Clinic Leadership Teams	CHC
Operational Performance Measures		Clinic Leadership Teams	SLICS Clinic Leadership Teams	CHC (UDS)
Risk Management Activities				CHC SLICS

SECTION IV:

Community Health Centers Quality Priorities for 2018/2019

Every year the Community Health Center selects focus areas for delivering better patient-centered care. Priorities are identified at each leadership level (CHC, Community Health Center, Program, and Clinic) based on the key quality reports, data trends and performance outcomes from the previous year. Program and Clinic Leadership staff develop specific measures to address these priorities, and Community Health Center leadership ensures that the priorities are applied across ICS. Patient Services and Disease Management are the leading priorities for 2017. Prioritizing these areas will improve patient health outcomes while also improving how that care is delivered.

Patient Services			
	Goals	Objectives	Measurements
Medical	Engaged patients will experience improved health care and have increased satisfaction.	Increase patient participation in the patient satisfaction Survey(PSS) by 5% each year. The PSS are conducted on an annual basis to provide feedback to clinic leadership regarding the experience of the patients in the primary care practices	Measurement will be conducted to: <ul style="list-style-type: none"> • Determine overall patient satisfaction for routine clinical services • Determine patient's patient perception of the continuity and comprehensiveness of care, treatment and services • Improve patient access to services when requested.
Dental	Engaged patients will experience improved health care and have increased satisfaction.	Increase patient satisfaction scores by 5% in 2018 patient satisfaction survey for questions asked Trainings to providers and clinics to increase scores when consistent shortcomings are identified.	Measurement will be conducted to: <ul style="list-style-type: none"> • Determine overall patient satisfaction for routine services and patient/staff interaction • Determine the effectiveness of customer services training

Pharmacy	MCHD health clinic clients choose in-house MCHD pharmacies due to expected high level quality of care and customer service.	Providing high quality patient services that are meaningful and viewed as helpful by the client.	MCHD clients are surveyed for client satisfaction. Targeted measures: <ul style="list-style-type: none"> of pharmacy staff providing desired and useful information in an understandable way at >90%.
Disease Management			
	Goals	Objectives	Measurements
Medical	Clients will have the best quality of life.	Simplify disease management and promote preventive care outreach and management.	50% of the teams in each clinic will develop team specific clinical performance dashboards to drive local improvement for processes and health outcomes. 100% of all nurses will utilize the new Diabetes Education Protocol.
Dental	Reduce disease by improving preventive services and completing treatment Proper disease management, including acute pain with meds other than potentially addictive opioids	Emphasize treatment completion in a timely manner to improve patient's overall health Urge providers to use non-opioid prescribing treatment for acute pain/discomfort	85% of providers will have a minimum of 45% treatment plans completed within a 12 month period Opioid prescribing will be maintained at 2017 levels (approximately 1100 Rx total)
Pharmacy -Clinical	Achieve Multnomah County Health Department Clinical Metrics for Diabetes and Hypertension	Reduce Morbidity and Mortality associated with Diabetes and Hypertension	The percentage of patients who meet the Multnomah County Health Department metrics for Diabetes and Hypertension, as

			<p>defined by HealthShare and the HRSA UDS guidelines. The 2018 Goals are:</p> <ul style="list-style-type: none"> • 60% of patients have controlled blood pressure in the past 12 months • <20% of patients have A1C of 9% (lower is better)
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Review and Approval Tracking

Quality Management Plan-2018/2019

Community Health Council <ul style="list-style-type: none"> • Reviewed and approved annually • Record of approval in meeting minutes 	
Approval by Community Health Council (represented by Council Chair):	Signature and Date:
Senior Leadership for Integrated Clinical Services (SLICS) <ul style="list-style-type: none"> • Reviewed and approved annually • Record of approval in meeting minutes 	
Approval by SLICS (represented by ICS Director):	Signature and Date:

Title:	Write-offs for Uncollectible Patient Accounts		
Policy #:	FIS.01.06		
Section:	Fiscal and Ordering	Chapter:	Fiscal Procedures
Approval Date:	Enter policy approval date.	Approved by:	Mark Lewis, /s/ Deputy Director Tara Marshall, /s/ Chair, Community Health Council
Related Procedure(s):		Not applicable	
Related Standing Order(s):		Not applicable	
Applies to:		Multnomah County's Federally Qualified Health Centers	

PURPOSE

This policy describes the specific circumstances when the health center will waive uncollected fees or payments due to any patient's inability to pay.

DEFINITIONS

Term	Definition
N/A	

POLICY STATEMENT

It is the policy of the Health Department to adhere to accepted accounting practices and to therefore write off patient account balances that are deemed to be uncollectible. In addition, maintaining client balances for protracted periods of time tends to create a barrier to care for clients without resources to pay.

Small balances

Patient self-pay balances under \$5 and which have no activity in the past six months should be written off. This write-off should be coded to 1025 – Small Balance Write-off. At no time should a credit balance be written off. Small balance write-offs should only be done by administration/medical billing staff.

Quarterly write-off policy

Medical billing staff will conduct a quarterly write-off based on the document write-off criteria listed at the end of this policy.

- Patient self-pay balance is aged >365 days
- Patient has not made a payment on the account in the past 365 days
- Patient has not had a visit in the past 6 months
- Patient has not received a statement in the past 6 months

Quarterly accounts that are recommended for write-off will be listed and reported to ICS leadership and medical billings manager for approval.

Deceased patients

Upon verification, self-pay balances for deceased patients will be written off to code 1662 – Deceased Write-off.

Staff recommendations for write-off

Staff can recommend patient self-pay balances to be written off by assuring the balances meet the write-off criteria and communicating to business services staff. The following information must be provided by interoffice, email or phone:

- The client's account number
- The client's last visit date
- The amount to be written off (which dates of service)
- The approval of the clinic manager's/ops supervisor from the client's last visit
- The reason that the write-off is recommended

Write-off Criteria

1. Client's account has an aged self-pay balance according to the following schedule:
2. Client has not received a statement in the last 6 months.
3. Client has not made a payment within the last 365 days.
4. Client balance has been verified as correct. This means all services have been billed to all third-party carriers. Reset any visits for billing to third parties as appropriate. Ensure that all remaining balances are for services for which there is no third-party coverage. Ensure that all appropriate sliding-fee discounts have been applied to client self-pay balances remaining.

Miscellaneous guide

Balances on client accounts can be either due from the client or a third-party payer. Third-party payers include Medicare, Medicaid, CareOregon, private insurance companies, other health maintenance organizations (HMOs) and other special billing programs such as the Oregon Contraceptive Program (OCP). When a client's charges are not covered by third-party payers, the charges become the responsibility of the client. All third-party billings should be completed

before transferring an account balance to client responsibility. Charges to the client are always discounted based on Multnomah County Health Department existing sliding fee discount rules. All sliding-fee adjustments should be provided to the client prior to writing off uncollectible amounts.

Example 1: A client's insurance company has been billed for services totaling \$100. The insurance company has denied these charges for payment because the client has not met his annual deductible. The entire \$100 balance is transferred to the client. The balance is then discounted based on the client's sliding-fee scale. If the client were at the full discount level, this would mean that an adjustment of \$90 is applied leaving a balance due of \$10. If after six months the client has not been able to pay the ten dollars, it can be recommended for write-off.

Example 2: A client's insurance company has been billed for services totaling \$100. The insurance company has allowed \$80, and paid \$64 dollars. Twenty dollars (\$100 minus \$80) is adjusted off as an insurance company adjustment. The remaining \$16 dollars (\$80 minus \$64) is transferred to the client. The balance is then discounted based on the client's sliding-fee scale. If the client were at the full discount level, this would mean that an adjustment of \$6 is applied leaving a balance due of \$10 dollars. If after six months the client has not been able to pay the \$10, it can be recommended for write-off.

Note that some balances remaining after third-party payment are not transferable to the client. Balance remaining after Medicaid, CareOregon and some special billing programs are not transferable. Amounts denied by Medicare as "unnecessary" are not billable to the client. Amounts not transferable to the client are adjusted off.

Sample write-off recommendation

"Recommend that self-pay balances remaining from visit dates 01/01/2018 through 06/30/2018 for client account number 1234567 be written-off. The client was last seen at this clinic in June 2017. The remaining balance of \$15.00 from his visits is considered uncollectible."

REFERENCES AND STANDARDS

HRSA's Health Center Compliance Manual, [Chapter 16: Billing and Collections](#)

PROCEDURES AND STANDING ORDERS

Not applicable

N/ARELATED DOCUMENTS

Name

Attachment A – N/A

POLICY REVIEW INFORMATION

Point of Contact: M. Lewis – Health Department Deputy Director

Supersedes: N/A

Title:	(Proposed) Community Health Center Services Fee Policy		
Policy #:	AGN.10.03		
Section:	Agency Wide Clinical	Chapter:	Fiscal
Approval Date:	Enter policy approval date.	Approved by:	V. Abdellatif, MPH Director, Integrated Clinical Services Tara Marshall Chair, Community Health Council
Related Procedure(s):		Not applicable.	
Related Standing Order(s):		Not applicable.	
Applies to:		All services provided within the health center scope, including primary care, dental, behavioral health, pharmacy and specialty services.	

PURPOSE

The fee policy provides a consistent payment model approach to ensure access to health center services and fiscal sustainability. It offers clients an equitable, affordable and accessible means for receiving health care through services provided under the scope of the Multnomah County Community Health Center. Discounts are provided in accordance with federal guidelines and apply uniformly to all clients. Clients will be provided services regardless of ability to pay. This policy intends to educate staff and clients about payment and coverage options.

DEFINITIONS

Term	Definition
Sliding Fee Discount Schedule (SFDS)	Also known as a sliding fee scale, this schedule describes the range of discounts on fees for clients based on family income, size and federal poverty guidelines.
Flat Fee	The flat fee is the amount charged for a visit regardless of the amount of time and complexity of services provided during the visit.

Deposit	Deposit for services is the amount asked for from clients determined to be in Tier 5 at check-in. The remaining balance will be collected or billed at the end of the appointment.
Nominal Fee	The nominal fee is the amount requested at check-in for clients who are at or below 100% of the FPL. The nominal fee must be nominal from the perspective of health center clients. Nominal charges are not “minimum fees,” “minimum charges,” or “co-pays.”
330 Grant	MCHD receives funding from the Health Resources and Services Administration (HRSA) Bureau of Primary Health Care (BPHC). Health centers must meet all grant requirements to receive funding.
Reproductive Health Program	Reproductive Health Program is a federal grant program dedicated solely to providing individuals with comprehensive family planning and related preventive health services. The Reproductive Health Program is legally designed to prioritize the needs of low-income families or uninsured people (including those who are not eligible for Medicaid) who might otherwise not have access to these health care services.
Family	<p>Family is defined as a group of two or more persons related by birth, marriage, or adoption who reside together. Components of the definition of family size include the client; spouse/other person having a child (or pregnancy) in common with the applicant; unmarried dependent children under age 19 (or needing to complete their senior year in high school) and living at home; and a child with disabilities, who is unmarried, living at home, and incapable of self-support.</p> <p>Clients under the age of 19 may be determined to be a family size of one if they are responsible for their own health care decisions, in a foster care program, emancipated or independently living from parents/guardians, or receiving confidential or grant-directed care services (such as Title X and Ryan White).</p>
Income	17 different types of income are considered when evaluating a family's income and eligibility for the SFDS: money wages; salaries before deductions; self-employment income; Social Security; Railroad Retirement; Unemployment Compensation; Workers Compensation; strike benefits; public assistance (i.e. Aid to Family with Dependent Children, General Assistance

	payment, SSI, etc.); training stipends; students loans and grants; alimony; child support; military family allotments; private and government employee pensions; regular insurance and annuity payments; dividends; interest; rent; royalties; or periodic receipts from trusts, or estates; Veteran's Benefits; regular support from an absent family member or someone not living in the household. Income does not include food or rent received in lieu of wages; food stamps; savings withdrawn from a bank; gifts; tax refunds; WIC vouchers; lump-sum inheritance; one-time insurance payments; income from the sale of property, house or car; or imputed value of Medicaid or public housing.
MCHD Formulary	A preferred list of over-the-counter and prescription drugs, that are available to clients at MCHD health center pharmacies. This formulary is reviewed and maintained in collaboration between Pharmacy, Primary Care, and Dental Services.

POLICY STATEMENT

ELIGIBILITY FOR SLIDING FEE DISCOUNT PROGRAM

Clients who complete an eligibility screening and are determined to be at or below 200% of the Federal Poverty Level (FPL) are eligible for a sliding fee discount. The sliding fee discount schedule (SFDS) describes discounts by family income and size. Only family income and family size will be used in determining eligibility for Sliding Fee Discount Program, once the patient completes the required registration process and provides required proof of income and family size, in accordance with this policy.

Clients are not required to apply for insurance in order to receive a discount; all clients will be offered an insurance eligibility screening. Should the client decide to apply for insurance, an Eligibility Specialist will assist in completing the application process. Clients are not eligible for a discount or services paid by 330 grant if their eligibility is not determined.

ELIGIBILITY SCREENING and DETERMINATION

Clients are screened annually. Their eligibility status is valid for one year unless the client's income or family size changes at which time the client is required to notify the registration staff and go through the screening process.

The process of providing documentation should not be overly burdensome to the client. If the client refuses to provide required documentation the client is

not eligible for the SFDP. Sample documentation required to determine discount levels for uninsured clients may include:

Income Documentation

- Current month and last 3 months paycheck stubs
- Financial award letter from Social Security or Department of Veterans Affairs
- State Employment Division – unemployment compensation statement
- Proof of Workers Compensation monthly payments
- Rental property agreement documenting monthly rent payment
- Support Enforcement documentation of Child Support payment
- Self-Employment form documenting proof of income
- Statement of no income
- Self-declaration of family size and income

SLIDING FEE DISCOUNT SCHEDULES (SFDS)

The SFDS apply to clients who have completed the eligibility screening process. All services listed in the HRSA Form 5A, whether required or additional, are provided on a SFDS. Only family income and family size will be used to determine eligibility. Individuals and families with annual incomes at or below 100% of the FPL will receive a full discount for services.

If a client is determined to be eligible for a Sliding Fee Discount, even if they have insurance, they will pay the lowest tier of SFDS and will not be charged more for any service than the clients, in a higher SFDS tier (table below) for the services provided. The SFDS will be applied to services not covered by insurance plans.

Service fees are based upon the usual and customary fees in the Multnomah County area as well as information provided by the Centers for Medicare and Medicaid. Service fees are evaluated and updated annually.

The federal poverty guidelines (FPL) are updated annually as prescribed by the Federal Registry for the purpose of updating increases in the Consumer Index. The Electronic Health Record updates the SFDS based on FPL after the updated FPL are published. The Community Health Council must review and approve the SFDS every 2 years.

Business Services, in collaboration with the health center, evaluates, at least once every three years, the sliding fee discount program. At a

minimum, the health center:

- Collects utilization data that allows it to assess the rate at which patients within each of its discount pay classes, as well as those at or below 100% of the FPG, are accessing health center services;
- Utilizes this and, if applicable, other data (for example, results of patient satisfaction surveys or focus groups, surveys of patients at various income levels) to evaluate the effectiveness of its sliding fee discount program in reducing financial barriers to care; and
- Identifies and implements changes as needed.

All services provided within the health center scope (required and additional health services) are provided on a sliding fee discount schedule including those provided through contract or formal written referral agreement.

Discounts and fees established through contract, by grant requirements, laws or local, state or federal requirements may augment, supplant or limit the applicability of the sliding fee discount program (e.g. Vaccines for Children program, School of Oral and Community Health, and Student Health Centers).

Sliding Fee Discount Schedules

Service and Discount Tier	Tier 1 0% to 100% (Nominal Charge)	Tier 2 >100% to 133%	Tier 3 > 134% to 167%	Tier 4 > 168% to 200%	Tier 5 > 200%
Medical Care (Including in-house lab fees)	\$35	\$45	\$55	\$65	No Discount (Pay Full Fee, \$75 deposit at Check-In)
Dental Care (Including lab fees)	\$45	\$55	\$65	\$75	No Discount (Pay Full Fee, \$85 deposit at Check-In))
Mental Health Care/ Behavioral Health Care*	\$0	\$0	\$0	\$0	No Discount (Pay Full Fee, \$5 deposit at Check-In)
Enabling & Other	\$0	\$0	\$0	\$0	No Discount (Pay Full Fee if

Services**					applicable)
Service and Discount Tier	Tier 1 0% to 100% (Nominal Charge)	Tier 2 >100% to 133%	Tier 3 > 134% to 167%	Tier 4 > 168% to 200%	Tier 5 > 200%
Acupuncture	\$5	\$8	\$10	\$12	No Discount (Pay Full Fee, \$15 deposit at Check-in)
In house LAB Only Visit	\$0	\$18	\$19	\$20	No Discount (Pay Full Fee, \$25 deposit at Check-In)
Contracted lab services	\$0	75% Discount	50% Discount	25% Discount	No Discount (pay full fee)
Service and Discount Tier	Tier 1 0% to 100%	Tier 2 >100% to 150%	Tier 3 >151% to 200%	Tier 4 > 201% to < 250%	Tier 5 ≥ 250%
Reproductive Health Program Title X Service & Supply Discount Schedule	100% Discount	75% Discount	50% Discount	25% Discount	No Discount (Pay Full Fee)

*Includes Substance Use Disorder services provided by the health center.

**Enabling services includes case management (including nursing visits for chronic disease management) eligibility assistance, radiology, health education, nutrition, outreach, transportation, and translation. Other visits include telemedicine, flu vaccine-only, clinical pharmacy, nurse visits that do not require lab services, blood pressure checks, nursing case management in maternal, child and family health programs.

Service / Discount Tier	Tier 1 0% ≤ 100%	Tier 2 100% < 133%	Tier 3 133% < 150%	Tier 4 150% < 200%	Tier 5 200% ≤ 300%	Tier 6 > 300%
Ryan White Services	\$0	\$45	\$55	\$65	No Discount	No Discount

(per visit)					(Pay Full Fee, \$75 deposit at Check-In))	(Pay Full Fee, \$75 deposit at Check-In))
Ryan White Services (max out-of-pocket)	\$0	No More than 5% of Annual Income			No More than 7% of Annual Income	No More than 10% of Annual Income

FEES AND DISCOUNTS FOR RYAN WHITE SERVICES

In order to comply with Ryan White legislative requirements, the HIV Health Services Center offers a sliding fee scale to assist uninsured/underinsured patients who have difficulty paying for HIV primary care services. People living with HIV/AIDS (PLWHA) whose incomes are at or below 100% of the federal poverty level (FPL) will not be charged for HIV primary care, while PLWHA with incomes at 101% FPL or above who rely on Ryan White for access to HIV primary care will be charged for the services they receive, based on a sliding fee scale. There is an annual limitation on amounts charged to clients for Ryan White HIV/AIDS. PLWHA who are charged for the services they receive will have their annual charges capped at a percentage determined by their family size and income level.

- Patient charge is equal to the part of medical expense care not covered by insurances.
- All medical expenses count toward the maximum charge (CareAssist, cost-shares, co-pays, etc.) MCHD is allowed to charge to patients. This includes insurance premiums, co-pays, any medical charges at outside clinics or hospitals.

Oregon Health Authority Reproductive Health Program

In addition to completing the eligibility form, the Reproductive Health Program requires that the client is asked to self-report income and family size. Clients who have been enrolled into the Reproductive Health Program will not be charged for reproductive services. Clients with greater than 250% FPL are not eligible for the program.

Reproductive Health Program funds may still be used for these services if a client refuses to share their income and family size. If a client refuses to apply for the RH program, or is not screened for it, by clinic staff, the [reproductive health program's sliding fee discount](#) will be applied, according to income and family

size.

Minors who request confidential Reproductive Health services, will have their sliding fee discount evaluated on their own income, and a family size of one, per Title X requirements.

LAB FEES

All dental labs are covered by the nominal or flat fee. In-house labs within a primary care visit are covered by the nominal or flat fee. Lab Only Visits are charged in accordance with the SFDS. Labs provided by a third-party/contracted provider will be discounted using the primary care SFDS (or a separate SFDS). This SFDS is in accordance with the Federal Poverty Level and can be viewed by contacting the vendor. Any uncollected client debt by the lab vendor will be billed to MCHD.

PHARMACY CHARGES

Self-pay clients

To ensure that health center clients lacking prescription benefits are able to obtain necessary prescribed medications, the MCHD-formulary contains medications available through MCHD's in-house pharmacies offered at an FPL-based Sliding Fee Discount Schedule. The fee includes a dispensing fee, for uninsured clients who are prescribed medications that are not on the MCHD formulary, if no formulary option is available, the prescriber may request a formulary exception (Tier 3). If upon clinical review, the exception is approved, MCHD Pharmacy Services may dispense up to 1 month supply of medication.

Pharmacy Sliding Fee Discount Schedule

Medication and Discount Tier	Maximum Days Supply	Tier 1 0-100% FLP (Nominal Fee)	Tier 2 101-133% FPL	Tier 3 134-167% FPL	Tier 4 168-200% FPL	Tier 5 Over 200% FPL (No Discount)
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Level 1	30	\$4	\$6	\$8	\$10	\$12
	90	\$10	\$12	\$14	\$16	\$18
Level 2	30	\$10	\$12	\$14	\$16	\$18
Level 3 (Non-formulary)	30	\$15	\$20	\$25	\$30	\$35

Insured Clients

For insured clients, pharmacy services follows the requirements outlined in the contract with the insurance plan or its third party processors (pharmacy benefits management company) regarding medication coverage and client copays according to the client's benefit plan. The pharmacy requests payment of copays specified by their insurance. In the event a medication is not covered by the client's pharmacy benefit, the pharmacy will alert the prescriber of the need to request prior authorization or formulary exception from the plan or advise the prescriber of covered alternatives. Clients seen in the clinic with prescription coverage under a plan that Pharmacy Services is not contracted with, will be encouraged to obtain services at an external pharmacy.

Collection of Payment

Clients will be asked to provide their insurance co-pay or the uninsured formulary drug price at the time of dispensing/pick-up. Clients who are unable to pay may have the charge applied to their client account. Health center clients receive their medication regardless of their ability to pay.

SERVICES PROVIDED VIA A CONTRACT

For services provided via a contract, the health center ensures that fees for such services are discounted in a manner such that:

- A full discount is provided for individuals and families with annual incomes at or below 100% of the current FPG, unless a health center elects to have a nominal charge, which would be less than the fee paid by a patient in the first sliding fee discount pay class above 100% of the FPG.
- Partial discounts are provided for individuals and families with incomes above 100% of the current FPG and at or below 200% of the current FPG,

and those discounts adjust based on gradations in income levels and include at least three discount pay classes.

- No discounts are provided to individuals and families with annual incomes above 200% of the current FPG.

SERVICES PROVIDED VIA A FORMAL WRITTEN REFERRAL AGREEMENT

For services provided via a formal written referral agreement, the health center ensures that fees for such services are either discounted according to the health center's schedule or discounted in a manner such that:

- Individuals and families with incomes above 100% of the current FPG and at or below 200% of the FPG receive an equal or greater discount for these services than if the health center's SFDS were applied to the referral provider's fee schedule; and
- Individuals and families at or below 100% of the FPG receive a full discount or a nominal charge for these services.

CLIENT PAYMENT SCHEDULE and NOMINAL CHARGE

All clients determined eligible in accordance with this policy are asked to pay at the time of check-in and will be charged for services according to the tier they qualify for based on family size and income. To determine if the nominal amount would be "nominal" from the perspective of the client one or more of the following will be used; board member input, patient surveys, review of collection % or bad debt or co-payment amounts.

Clients will be asked to pay any outstanding account balances. Clients who are unable to pay charges will not be denied services. Insured clients are asked to pay co-payments at the time of check-in, not to exceed the amount they would pay under the Sliding Fee Discount Schedule, whichever is lower, which may vary according to insurance coverage and services provided to the client. The nominal charge does not include any service or supply. The nominal charge will be applied the same day before applying to any outstanding balances the client owes prior to or future charges that are reflected on the client's account.

Prepayment For Service

All clients that do not qualify for a discount will be asked to pay an amount at check-in. Any remaining balance will be determined after services are rendered and collected/billed accordingly.

Write-offs for Uncollectible client Accounts

The Multnomah County Community Health Center does not turn away clients for the inability to pay for services. Due to Multnomah County's policy to not turn away clients for the inability to pay there may be costs that go unpaid in which Multnomah County may write off from the client account. Criteria for write off is listed in MCHD policy FIS.01.06.

Services exempt from all client charges (after insurance billing)

Services funded by Medicaid and Medicare (payments by Medicaid and Medicare are considered full payment and client can not be charged for amounts not covered by insurance.)

- Services funded by Reproductive Health (RH) clients who completed the application for RH and whose FPL is below 250% only.
- Maternal Child Family Health (MCFH)
- HIV Health Services Center visits after clients reach annual cap on charges (in accordance with federal Ryan White rules)
- Telemedicine (phone) visits
- Enabling services such as case management, eligibility assistance, transportation and translation
- Clinical pharmacist visits
- Family planning visits for enrolled clients
- Flu vaccine visits
- Blood pressure checks

Notification of Sliding Fee Discount Program

All clients are notified of the sliding fee discount program by one more of these methods: Notices in the waiting areas, by the registration staff, publications and web site. All communication is done at a literacy level that is appropriate for our patient population and in more than one language to reflect the patients served.

REFERENCES AND STANDARDS

Health and Human Services

[Reproductive Health Program Requirements](#)

Health Resources and Service Administration

[HRSA Health Center Program Compliance Manual, "Sliding Fee Discount Program"](#)

[HRSA HIV/AIDS Bureau Ryan White Programs Sliding Fee Scale Information](#)

Federal Register

- [Poverty Guidelines](#)

PROCEDURES AND STANDING ORDERS

Not Applicable.

RELATED DOCUMENTS

Name	
FIS.01.06: Write-offs for Uncollectible client Accounts	
FIS.01.15: Medical Insurance Write Off Policy	

POLICY REVIEW INFORMATION

Point of Contact:	Adrienne Daniels, ICS Deputy Director
Supersedes:	Not applicable