Community Health Council

Community Health Council Board Meeting Minutes
Date: Monday, August 13, 2018
Time: 6:00 PM
Location: McCoy Building, 10th Floor Conference Room

Approved: **Recorded by:** Jordana Sardo

Attendance:

Board Members	Title	Y/N
David Aguayo	Board Member	N
Fabiola Arreola	Member-at-Large	Y
Sue Burns	Vice Chair	Y
Jon Cole	Member-at-Large	Y
Robyn Ellis	Board Member	N
Tara Marshall	Chair	Y
Pedro Sandoval Prieto	Secretary/Treasurer	Y
Wendy Shumway	Board Member	Y
Iris Hodge	Board Member	Y
Staff	**Title**	**Y/N**
Vanetta Abdellatif	Interim Health Department Co-Director	Y
Hasan Bader	Finance Project Manager	Y
Len Barozzini	Dental Director	Y
Lucia Cabrejos	Interpreter, Passport to Languages	Y
Adrienne Daniels	ICS Deputy Director	Y
Nicole Dewees	Senior Management Auditor	Y
Rosalio Espinoza	Executive Specialist/Pharmacy	Y
Leslie Gellert	Behavioral Health	Y
Marc Harris	Grants Development Administrator	Y
Mark Lewis	Interim Business Services Director	Y
Sarah Lochner	Deputy Director, Government Relations	Y
Ritchie Longoria	Director of Pharmacy and Lab Services	Y
Linda Niksich	Community Health Council Liaison	Y
Jordana Sardo	Executive Specialist	Y
Tasha Wheatt-Delancy	Primary Care Services Director	Y

Guests: Debra Abney, Ashey Arnold, Izzy Meda, Susana Mendoza, Harold Odhiambo, Hannah Taube

Action Items:

- Mark Lewis will bring FY18 year end financial statement and drivers for internal service rates to September Public Meeting.

Decisions:

- Approved the July 2018 Meeting Minutes
- Approved Budget Report
- Approved HRSA Needs Assessment Report
- Approved HRSA Grant Submission Report
- Approved Correction SFD Policy Report & National HC Week Update
- Approved Co-Applicant Board Memorandum of Agreement between CHC and BCC to bring health center into compliance with HRSA requirements

The meeting was called to order at 6:02pm by Chair, Tara Marshall.

The Meeting Ground Rules were presented by Board Member, Wendy Shumway.

Noted that quorum was met.

July 2018 Meeting Minutes Review
(See Document - July 2018 CHC Meeting Minutes)

No questions or comments were raised by CHC members.

Motion by Wendy to approve the July 2018 Meeting Minutes.
Seconded by Jon.
6 aye; 0 nay; 0 abstain
Motion carries

Capital Dental to CareOregon Dental
(See Document - Strengthening our Partnership with CareOregon Dental)

Len Barozzini, ICS Dental Director, reported that HealthShare CCO is reducing the number of Dental Care Organizations (DCO's) it will administer in Multnomah County. Capitol Dental Care (CDC), a plan that Multnomah County Health Department Dental is currently contracted with, will be eliminated. Patients currently with CDC will be reassigned to CareOregon Dental. The transition of patients from CDC to CareOregon is expected to take place on October 1, 2018. This transition is also aligned with efforts to promote integration between primary care and dental services. If the transition is accepted, 82% of dental patients will be covered by CareOregon. Currently Delta

Dental (ODS) insures 5%, with Third Party and Self Pay making up 16% combined.

Questions and comments raised by CHC members:

Inform only; No vote required.

Monthly Budget Report
(See Document - Monthly Dashboard-June 2018)

Mark Lewis, Interim Director of Business Operations, provided an abbreviated report of the June Monthly Dashboard. The year end report will be presented at the September meeting. Primary Care average billable visits were at 489 for June and Dental average billable visits were at 299. The numbers are lower than last month due to data being stuck in the workday software program. Student Health Centers' average billable visits were at 29. This number is down due to the summer, and are anticipated to increase substantially once school begins. The percentage of uninsured visits are above target for Primary Care and Dental, in part due to checking in with clients two days before their visit. The DMAP/Medicaid Payer Mix for Primary Care is down due to the redetermination of medicaid eligibility. Primary Care member assignments for CareOregon are at 34, 686 or 86.4% of total clients; for For Providence, they are 5,477 or 13.6% of total clients.

Questions and comments raised by CHC members:

- Wendy asked what PC member assignments meant. Marc explained that PC means primary care and that the roster tracks the number of clients that medical insurance providers assign to Multnomah County.
- Pedro wondered what the "commercial line" referred to on the Payer Mix chart. Mark shared that Multnomah County takes all insurance, and we do not decline service based on what insurance a client has. Insurance providers besides CareOregon and Providence fall into the category of "commercial".

No other questions or comments were raised by CHC members.

Motion by Jon to accept the Budget Report
Seconded by Pedro
6 aye; 0 nay; 0 abstain
Motion carries

HRSA Needs Assessment

(See Document - HRSA BPHC Health Center Program)

Marc Harris, Grants Development Administrator, explained that HRSA requires health centers to conduct a needs assessment and identify what is different about this grant cycle. The grant cycle is every three years. We have just finished our third year and plan to re-submit a competitive grant for our service area, or Service Area Competition (SAC). We are increasing emphasis on compliance and collaboration that includes local hospitals. We plan to focus efforts on HRSA clinical priorities that includes diabetes, depression, child weight and body mass. We are also emphasizing new clinical performance measures for services provided to the homeless population. Marc reviewed the data sources for the Needs Assessment and the Service Area and Target Population.

- The Target Population are people living on incomes that are less than 200% of the Federal Poverty Level. A Service Area color-coded map shows sections where the highest percentage of this population resides, and dots indicate the locations of the health center.
- Marc reviewed several service area demographics that compared target populations between the FY16 SAC and the FY19SAC, by race, and by socioeconomic status. Across the total service area, 39% of low income people are Health Center clients.

Marc reported that we are aligned well with what HRSA focuses on as the most significant causes of morbidity, mortality and health behaviors that impact the quality of life. Clinical performance measures will seek to impact Health Disparities and their different levels.

Marc reviewed demographic and healthcare needs data of the homeless population. HRSA tells us how many clients we need to serve, and our benchmark is 95-100% for funding of that goal. Removing Community Oral Health from our scope, new FQHCs that came on board, and people losing coverage had an impact. We are eligible for more funding due to our 3-year patient growth trend.

Questions or comments raised by CHC members:

- *Wendy asked what HP2020 stood for. Marc shared that HP2020 is Healthy People by 2020, a benchmark set by the federal government.*
- *Wendy asked whether the homeless population data included families. Marc replied that the data was based on a "point-in-time" count by individuals, not by families or people in shelters.*
- *Pedro asked whether the grant included health centers and Student Health Centers. Marc confirmed that all 22 sites are folded into the Needs Assessment and the grant application which includes health centers, Student Health Centers, and the dental clinics.*

Motion by Wendy to accept the HRSA Needs Assessment Report
Seconded by Fabiola
6 aye; 0 nay; 0 abstain
Motion carries

HRSA Grant Submission
(See Document - Grant Opportunity)

Vanetta Abdellatif, Director of Integrated Clinical Services and interim Co-Director of the Health Department reported that the re-application for the 3-year HRSA grant is a continuation of existing services. 10% of Multnomah County residents are uninsured and approximately 4200 experience homelessness. 35% of Multnomah County's population live on incomes below 200% of the Federal Poverty Level (about 263,700 people). The grant seeks $9,642,194 in funds for a period of January 1, 2019 through December 21, 2021. Vanetta and Hasan Bader reviewed the Budget scope and the service positions that the funding would support. Hasan explained that Direct Charges are costs that are charged to the grant, such as salaries, salaries related to expenses, and contractual services. Indirect Charges cover some of the costs for central services.

No other questions or comments were raised by CHC members.

Motion by Iris to accept the HRSA Grant Submission Report
Seconded by Jon
6 aye; 0 nay; 0 abstain
Motion carries

Vice-Chair, Sue Burns arrives...

Correction SFD Policy & National HC Week Update
(See Document - Community Health Center Services Fee Policy)

Adrienne Daniels, ICS Deputy Director, reported that the Services Fee Policy passed by the CHC in June requires clarification and correction to remove ambiguity. In the section Sliding Fee Discount Schedules the following has been added: If the total costs of the visit is lower than the flat fee, clients in tiers 2-4 will pay the total visit cost. Within the Sliding Fee Discount Schedules grid the following was added: Enabling services includes (after insurance billing) case management (not performed by nurses),

eligibility assistance, outreach, transportation, and translation services. Other visits include telemedicine, flu vaccine-only, clinical pharmacy, and targeted case management in maternal, child and family health programs. This section clarifies what nurses can bill for.

Questions and comments raised by CHC members:

- Iris wondered how this could go awry for clients. Wendy asked how staff were being trained. Adrienne replied that staff and EPIC are working to make sure the accurate fee is being allocated.

No other questions or comments were raised by CHC members.

Adrienne then reported on the upcoming National Health Center Week event planned for August 31 at the North Portland Health Center. Posters have been emailed to the health centers and fliers were passed out to the CHC members. The theme is health center heroes. The communication team designed a comic book style poster. There will be a Tai Chi demo, CSA groups will share information about their program, and various community groups will provide information about their services. Elected officials planning to attend are Senator Lew Frederick and staff from Congressman Earl Blumenauer's office. There will also be free food, super hero capes and family-friendly activities. Linda Niksich added that volunteers are still needed to help shepherd guests and share information about the health center. CHC members should contact Linda if they need transportation.

Questions and comments raised by CHC members:

- Pedro asked whether there will be vaccines available. Linda replied that that is not part of the program.
- Jon asked whether posters were up at the health centers. Linda shared that each health center had been emailed the poster and they should have been printed and posted. Let her know if posters are not visible.

No other questions or comments were raised by CHC members.

Motion by Wendy to accept the Correction SFD Policy Report & National HC Week Update
Seconded by Sue
7 aye; 0 nay; 0 abstain
Motion carries

Memorandum of Agreement

(See Document - Co-Applicant Agreement for the Operation of the Community Health Center)

Adrienne Daniels, ICS Deputy Director, reviewed the document and explained that at the last HRSA visit there were four areas that were out of compliance. Three of those areas have action plans and implemented corrections to move the Community Health Center into compliance. The final area is the need for a more robust and legal document called a Co-Applicant Agreement that clarifies and specifies the roles of responsibilities of the CHC and County Commissioners in governing the Community Health Center. The document before the CHC tonight has been vetted by county attorneys and the hired expert legal advisors at Feldesman Tucker. The roles and responsibilities have always existed but as an internal policy rather than as a legal document with enough detail to satisfy HRSA requirements.

Questions and comments raised by CHC members:

- Wendy understood that the CHC has authority to dismiss the CEO, but wondered what the succession plan was? Adrienne directed attention section 1.3.1 on page three that outlines the process of selection. Wendy thought the actual selection of a temporary successor needed to be detailed. Linda added that the By-Laws will outline the responsibility to implement a succession plan for the Director/CEO. It can specify an interim role until the position is filled. The Bylaws can go with the Co-Applicant Agreement as an addendum. Vanetta thought Wendy's point was an important point. The Co-Applicant Agreement codifies the governing of the Community Health Center. The process has been an enlightening experience to see what portions of the county need educating and working through these details. She suggested following up with the legal teams to determine best practice on the question of an interim position.
- Iris asked if there were examples of when re-education needed to happen and whether codifying the policy restricted what the CHC can do. Vanetta explained that every time there is a new county commissioner, there is a need for a thorough orientation about the FQHC and the role of the CHC.
- Iris wondered if the CHC could be boxed in. Vanetta shared the Co-Applicant Agreement just clarify roles. Adrienne added that this was a mandate from HRSA

No other questions or comments were raised by CHC members.

Motion by Wendy to accept the Memorandum of Agreement
Seconded by Sue
7 aye; 0 nay; 0 abstain
Motion carries

ICS/Strategic Plan Updates
Vanetta Abdellatif, ICS Director and Co-Interim Health Department Director, provided an ICS/Strategic Plan update as they relate to the ICS Values. Patient Centered: Sellwood News Seasons raised $846 with their "Bag it Forward" program for Student Health Centers. They plan to use the funds to pay for food and snacks for the Youth Advisory Council. Engaged and Expert Workforce: Sue and David are traveling to Orlando for the NACHC CHI conference to represent the CHC and learn about board development and the CHC movement. Fiscally Sound and Accountable: K-8 middle school Student Health Centers are being phased out. Commissioner Stegmann is interested in developments for a Student Health Center at Reynolds High School. PAC has changed their hours to accommodate more after-five pm needs and have gotten phone response time down to 1 minute and the abandoned rate is now 5%.

No questions or comments raised by CHC members:

Motion by Iris to accept the ICS Strategic Plan Update.
Seconded by Sue
7 aye; 0 nay; 0 abstain.
Motion carries

Council Business: Committee Reports

Nominating Committee Update:

- Tara said the committee met on July 17. There were three applicants to review. The one applicant who was invited to move forward withdrew their interest.

- Reminder to guests that they must attend 3 meetings to be eligible for CHC membership. Interested parties should contact Tara or Linda for more information on board membership.

  No questions or comments were raised by CHC members.

Executive Committee Update:

- Tara reported the committee met on July 23rd. The Dental Director presented the dental insurer report. The committee also considered who to honor at the National Health Center event. They selected Speaker Tina Kotek. The committee also craft the agenda for tonight's meeting.

No questions or comments were raised by CHC members.

Bylaws Committee Update:

- Tara reported that the final edits will be done by the end of August in time for a September vote.

No questions or comments were raised by CHC members.

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

Meeting Evaluation:

- Food was delicious
- Thanked guests

Meeting Adjourned at 7:44 pm.

Signed: _____ **Date:** 9/10/2018

~~Tara Marshall~~, **Chair**

VCQ

Community Health Council
Public Meeting Agenda

Monday, August 13, 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 (Member-at-Large); Sue Burns (Vice-Chair); Jon Cole (Member-at-Large); Robyn Ellis; Iris Hodge; Tara Marshall (Chair); Pedro Sandoval Prieto (Secretary/Treasurer); Wendy Shumway

Item	Process/Who	Time	Desired Outcome
Call to Order/Welcome	• Chair, Tara Marshall	6:00-6:05 (5 min)	Review meeting processes
Minutes **VOTE REQUIRED**	• Review and approve July CHC Minutes	6:05-6:10 (5 min)	Council votes to approve and Chair signs for the record
Capital Dental to CareOregon Dental **Inform Only**	• Dental Director, Len Barozzini	6:10-6:20 (10 min)	Council discussion
Monthly Budget Report **VOTE REQUIRED**	• Interim Director of Business Operations, Mark Lewis	6:20-6:30 (10 min)	Council discussion and vote to accept report
HRSA Needs Assessment **VOTE REQUIRED**	• Grants Development Administrator, Marc Harris	6:30-6:45 (15 min)	Council discussion and vote to accept report

HRSA Grant Submission **VOTE REQUIRED**	• Co-Interim Health Department Director and ICS Director, Vanetta Abdellatif	6:45-7:00 (15 min)	Council discussion and vote to approve
BREAK	• All	7:00-7:10 (10 min)	Meet and greet
Correction SFD Policy & National HC Week Update **VOTE REQUIRED**	• ICS Deputy Director, Adrienne Daniels	7:10-7:25 (15 min)	Council discussion and vote to approve policy correction and to accept report
Memorandum of Agreement **VOTE REQUIRED**	• ICS Deputy Director, Adrienne Daniels	7:25-7:40 (15 min)	Council discussion and vote to approve
ICS/Strategic Plan Updates **VOTE REQUIRED**	• Co-Interim Health Department Director and ICS Director, Vanetta Abdellatif	7:40-7:50 (10 min)	Vote to accept report
Council Business Committee Reports **VOTE REQUIRED**	• Chair, Tara Marshall	7:50-7:55 (5 min)	Vote to accept reports
Meeting Evaluation	• Chair, Tara Marshall	7:55-8:00 (5 min)	Discuss what went well and what needs improvement
Adjourn Meeting	• Chair, Tara Marshall	8:00	**Goodnight!**

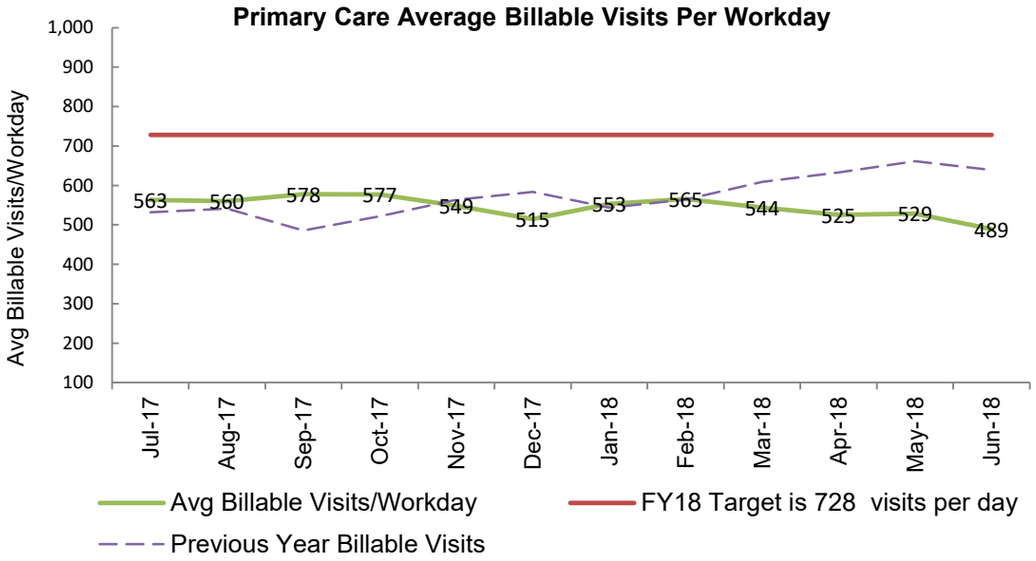
Multnomah County Health Department

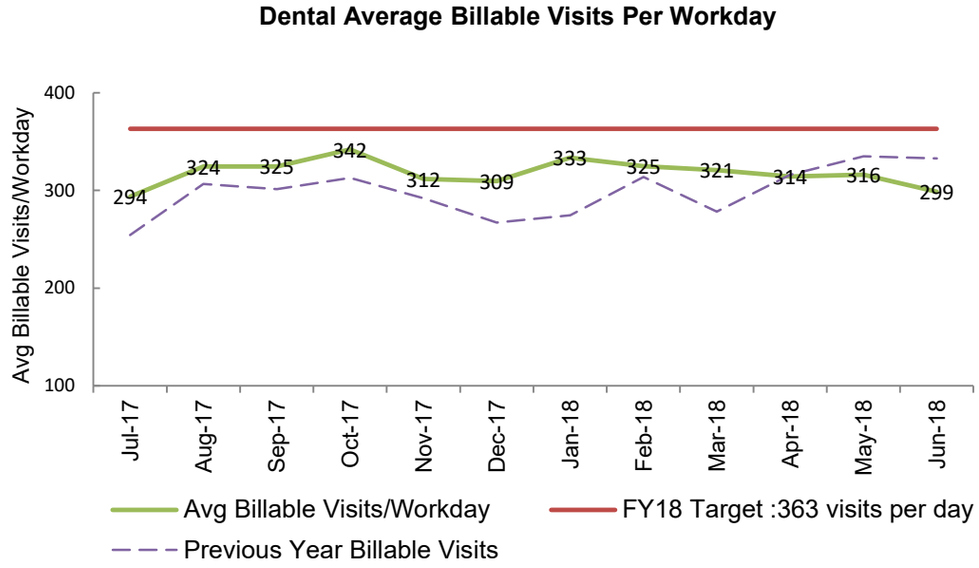
Monthly Dashboard

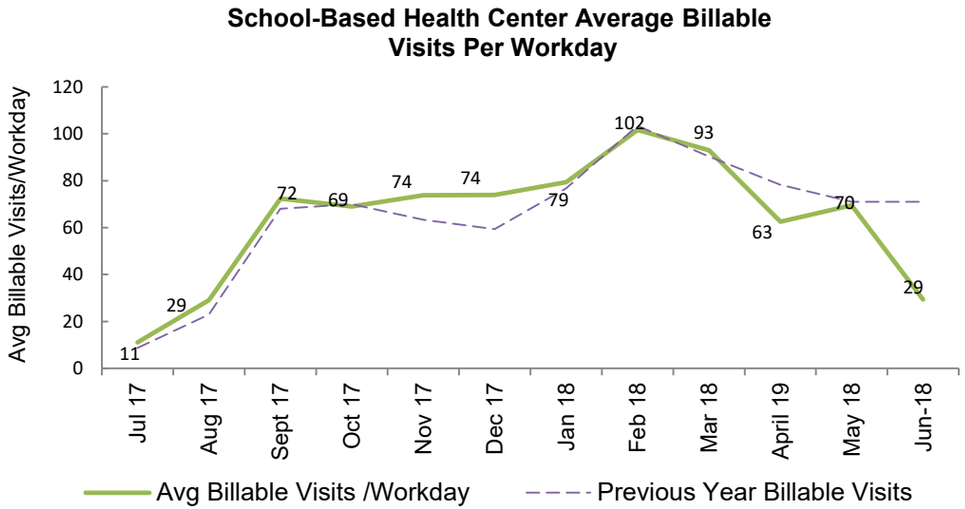
June 2018

Prepared by: Papa Diallo

Multnomah County Health Department
Weekly Billable Visits Per Department



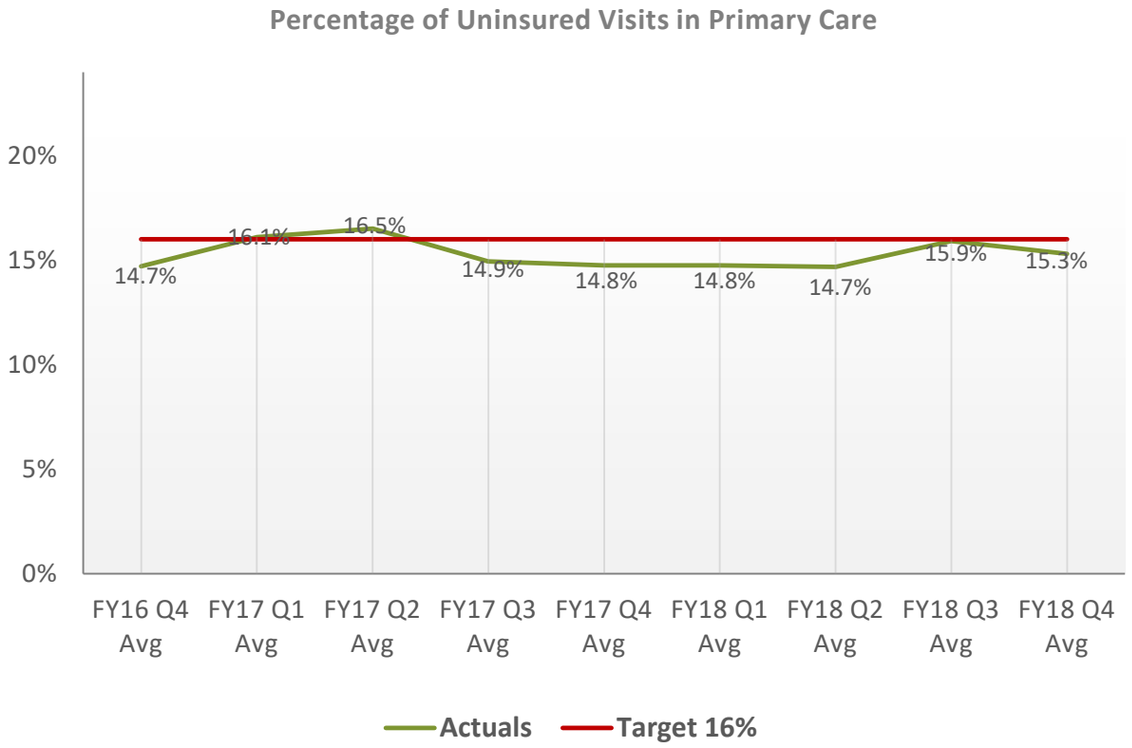


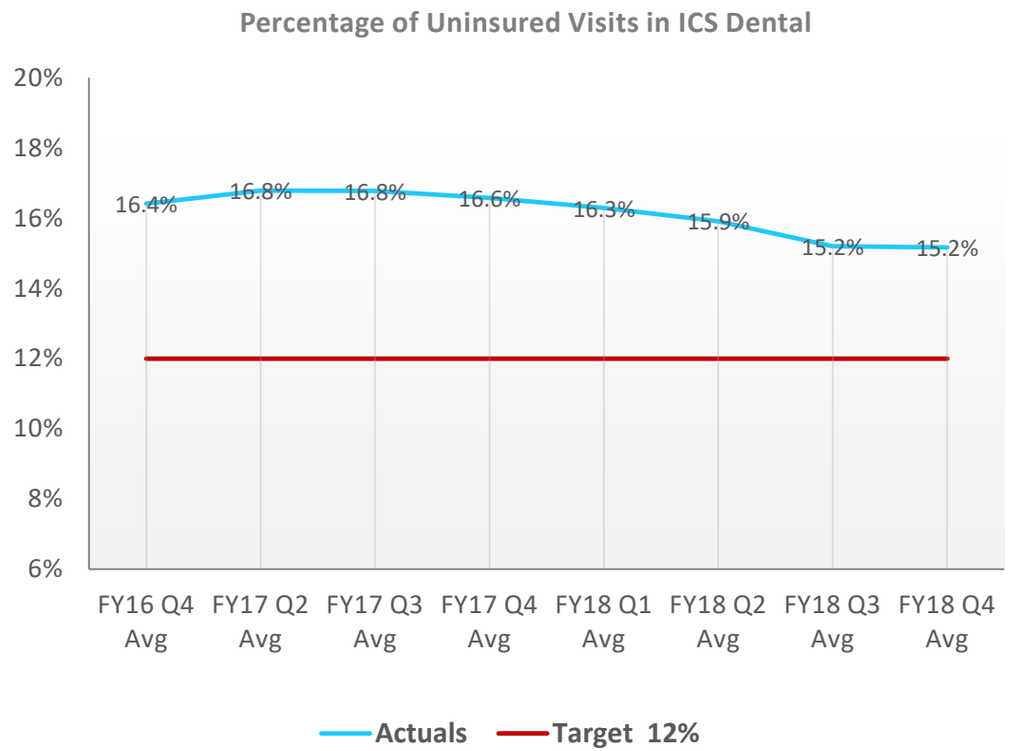


Notes: Primary Care and Dental visit counts are based on an average of days worked.
School Based Health Clinic visit counts are based on average days clinics are open and school is in session.

Multnomah County Health Department

Monthly Percentage of Uninsured Visits for ICS Primary Care Health Center

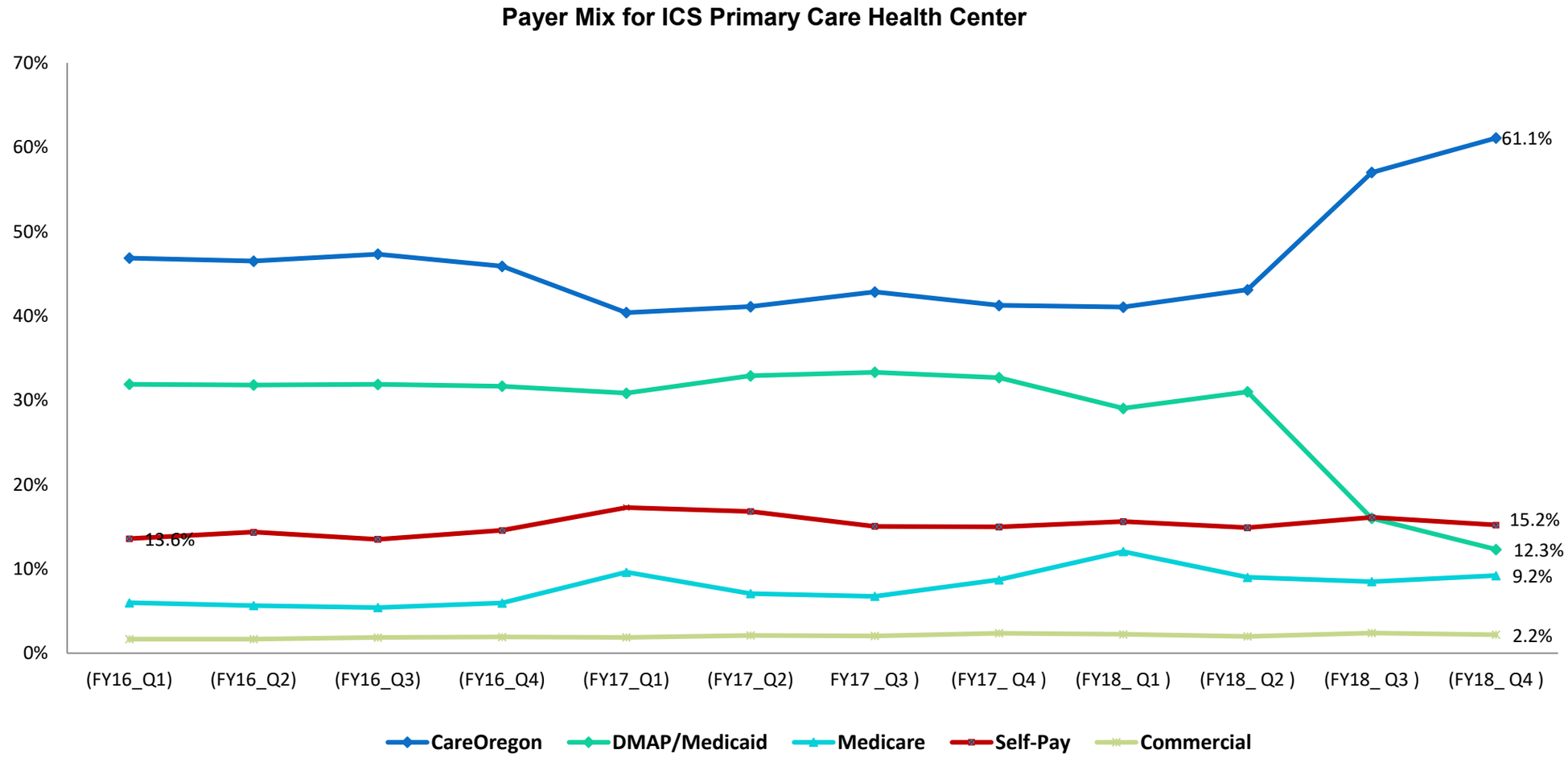




Comments:
ICS Dental data shows a slight change between run dates with the amount of uninsured patients declining with each new week.
The reason for this is the Dental Clinics try to check insurance coverage two days prior to the appointment. If they are unable to establish insurance coverage a client 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

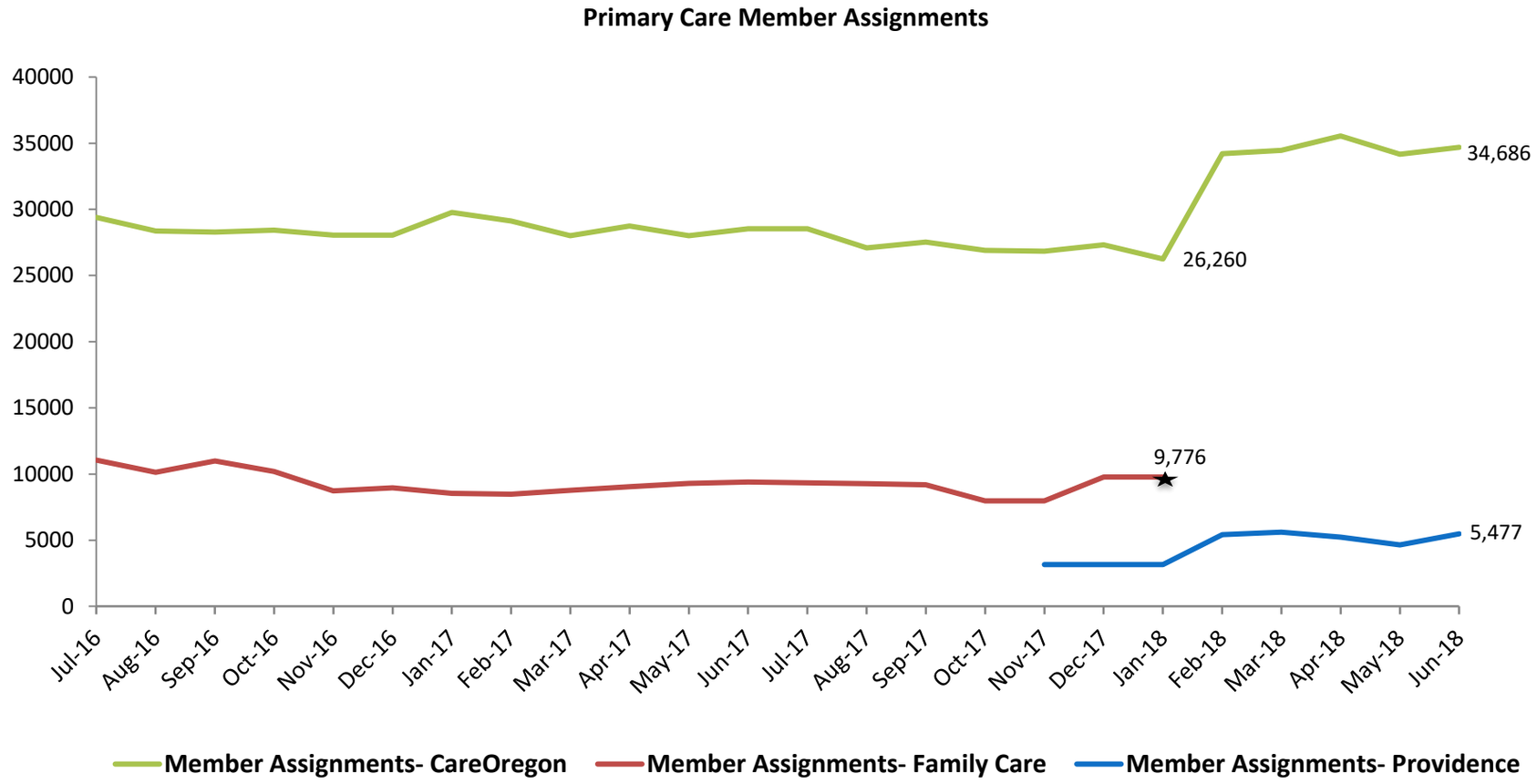
Monthly Percentage of Visits by Payer for ICS Primary Care Health Center



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

Multnomah County Health Department

MCHD Primary Care CareOregon OHP & Family Care Member Assignments



	Current Month	Previous Month
CareOregon	86.4%	88.05%
Providence	13.6%	11.95%
Total Clients	**100%**	**100%**

Notes:
CareOregon FY18 average:30,293
FamilyCare FY18 average :9,039
Providence FY18 average :4,482

Presentation Summary

Strengthening our Partnership with CareOregon Dental

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

Date of Presentation: July 23, 2018	Program / Area: ICS/Dental
Presenters: Vanetta Abdellatif, Len Barozzini	
Project Title/Scope Change and Brief Description • Evaluating our current payor mix in Dental~Determining how best to foster integration between Primary Care and Dental	
Describe the current situation: • HealthShare CCO is reducing the number of Dental Care Organizations (DCO's) it will administer in Multnomah County. Capitol Dental Care (CDC) will be eliminated, which is a plan MCHD Dental currently is contracted with. The expected transition of patients from CDC to CareOregon is to be October 1, 2018.	
Why is this project, process, system being implemented now? • HealthShare believes patient care and coordination is improved with less DCO's, and by administering DCO's that have a Primary care component	

Briefly describe the history of the project so far *(be sure to note any actions taken to address diverse client needs and cultures; to ensure fair representation in review and planning)*
• We are considering recommending to HealthShare to have Capitol Dental Care patients currently assigned to MCDH be *reassigned* to CareOregon Dental (COD) in order for Dental to be able to continue to serve these patients. In addition, we are considering severing our contract with ODS (Delta Dental Patients), in order to strengthen our ongoing relationship with CareOregon, by way of easier care coordination, integration and referral to specialists. Delta Dental Patients would be assisted with transferring to CareOregon in order for care to be continued at MCHD.
• Current State of Dental patients payors
  ○ CareOregon 67%
  ○ Capitol 12% (Will no longer be available at MCHD)	

Presentation Summary

○ Delta 5% ○ Self Pay 12% ○ Misc. 4%
List any limits or parameters for the Council's scope of influence and decision-making • n/a
Briefly describe the outcome of a "YES" vote by the Council *(be sure to also note any financial outcomes)* • Ease of patient care coordination, including specialty referral, metrics enhancement, integration with Primary Care, and ease of scheduling/billing with one payor for dental (or two payors for Dental if we opt to retain Delta).
Briefly describe the outcome of a "NO" vote or inaction by the Council *(be sure to also note any financial outcomes)* • Continued reliance on payors not as engaged with county leaders, nor as invested with outcomes that improve patient care at a holistic level via integration
Which specific stakeholders or representative groups have been involved so far? • HealthShare • CareOregon • Capitol Dental Care
Who are the area or subject matter experts for this project? *(& brief description of qualifications)* • Vanetta Abdellatif, ED of ICS, and co-interim ED of HD • Len Barozzini, dental director: partnership with external payor sources
What have been the recommendations so far? • Reaching out to HealthShare to reassign Capitol patients to CareOregon
How was this material, project, process, or system selected from all the possible options? • Careful review of current status, payor mix, and external partners engaged with patient care, including overall coordination of care, and emphasis on integration for primary care, and dental

Council Notes:

Presentation Summary

426 SW Stark St. 9th Fl. Portland OR 97204 Phone: 503-988-9492

Multnomah County Health Department

Dashboard_Payor Mix Epic Clinic Only Visits by Payor Mix FY18 Jun-2018

7/11/2018 James Donder x88904

Report Criteria
Departments: All Dental (excludes SCOH)
Service Dates:06/01/2018 to 06/30/2018
Service Provider: Dentist, Dental Hygienist
Totals: **DistinctCount** of **Encounter #s**
Datasource: Epic (CLARITY database)

Payors and associated Payor IDs
Capital Dental - 1012, 4770, 4771, 4772
CareOregon Dental - 1000, 4399, 5686, 5687
Delta Dental (ODS) - 1018, 9900
Third Party - all other Payor IDs not listed above
Self Pay - Payor ID is "null" in patient encounter

ALL DENTAL CLINICS	Jun-2018
CareOregon Dental	67%
Capital Dental	12%
Delta Dental (ODS)	5%
Third Party	4%
Self Pay	12%

EAST COUNTY DENTAL	Jun-2018
CareOregon Dental	68%
Capital Dental	10%
Delta Dental (ODS)	4%
Third Party	4%
Self Pay	13%

MID-COUNTY DENTAL	Jun-2018
CareOregon Dental	70%
Capital Dental	11%
Delta Dental (ODS)	6%
Third Party	4%
Self Pay	10%

NORTHEAST DENTAL	Jun-2018
CareOregon Dental	67%
Capital Dental	11%
Delta Dental (ODS)	4%
Third Party	6%
Self Pay	12%

ODEGAARD DENTAL	Jun-2018
CareOregon Dental	62%
Capital Dental	16%
Delta Dental (ODS)	8%
Third Party	5%
Self Pay	9%

ROCKWOOD DENTAL	Jun-2018
CareOregon Dental	73%
Capital Dental	10%
Delta Dental (ODS)	5%
Third Party	3%
Self Pay	9%

SOUTHEAST DENTAL	Jun-2018
CareOregon Dental	61%
Capital Dental	16%
Delta Dental (ODS)	6%
Third Party	3%
Self Pay	13%

HRSA BPHC

Health Center Program

FY19 Service Area Competition (SAC) Overview

What's different from FY16 SAC

Emphasis on compliance

- **FY16 SAC:** Project Narrative must "Demonstrate compliance with Health Center Program Requirements."

- **FY19 SAC:** Narrative questions, forms, and attachments will be used, **in whole or in part, in HRSA's assessment of compliance**. An applicant with one area of noncompliance will result in HRSA awarding a **1-year project period and may impact your ability to receive funding**.
- Competing continuation applicants will be awarded a **1-year project period if there are any HCP requirements related conditions at the time of award**."
- Competing continuation applicants **will not receive priority points if there are any conditions** related to HCP requirements at the time of application.

Collaboration section changes

- FY19 asks descriptions of collaboration to include coordination **efforts to reduce non-urgent use of hospital emergency departments.**
- **FY19 does not ask for** description of collaboration with State and local health departments, free clinics, other federally supported award recipients (e.g. Ryan White programs, Title V Maternal and Child Health programs), private provider group serving low income/uninsured patients, evidence-based home visiting programs, additional programs serving target population, neighborhood revitalization initiatives (if applicable),etc.
- **FY19 asks for letters from/with all local hospitals**, not just critical access hospitals
- FY19 does not ask for letter from State health department

Evaluative measures section changes

- FY19 Project Narrative must describe how the health center will focus efforts on the following HRSA **clinical priorities** to achieve goals cited in the Clinical Performance Measures form and improve health status of patient population:
    a) Diabetes
    b) Depression Screening and Follow-Up
    c) Child Weight Assessment and Counseling
    d) Body Mass Index
- FY19 has **new requirement for a clinical performance measure specific to any special populations** served by the Health Center (e.g. Healthcare for the Homeless)

Other changes

- FY19 does not ask about **ACA or insurance enrollment**
- FY19 has a question about the use of **telehealth**
- The **Colorectal Cancer Screening** performance measure has been revised to align with the Centers for Medicare & Medicaid Services electronic-specified clinical quality measures.

Needs Assessment

Data sources

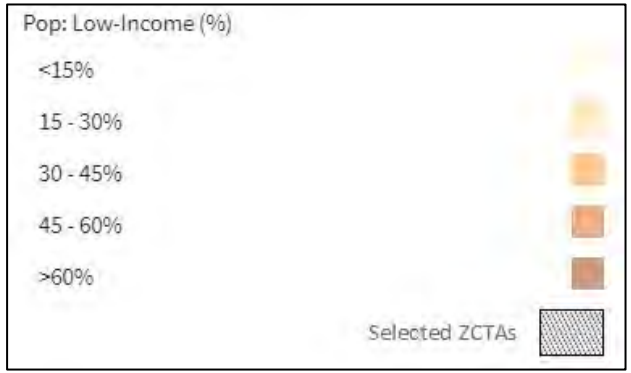
Main data sources include:

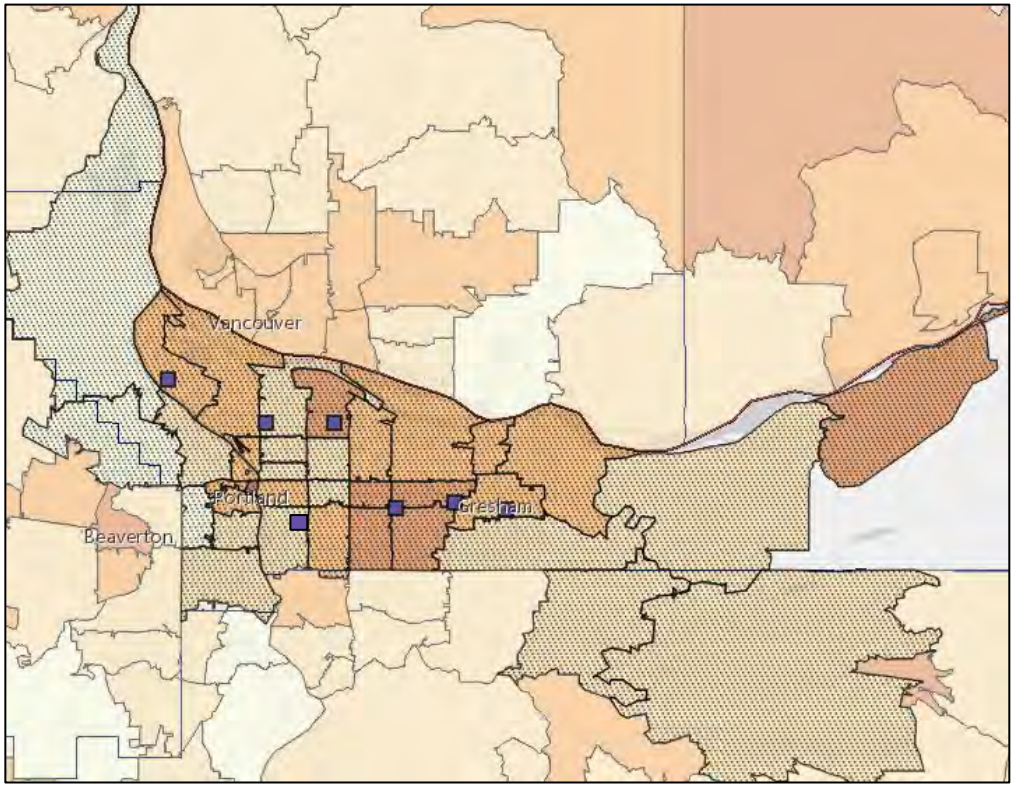
- U.S. Census Bureau's American Community Survey (population size and demographics)
- Behavioral Risk Factor Surveillance Survey
- Point-in-Time Count of Homelessness
- Communicable disease data
- Mortality data
- Pregnancy Risk Assessment Monitoring System
- Existing reports: Healthy Columbia Willamette 2016 Community Health Needs Assessment, MCHD 2014 Report Card on Racial and Ethnic Disparities, MCHD 2014 Maternal, Child, & Family Health Data Book
- UDS Mapper

Service Area & Target Population

Service Area - Density of target population

HCP Target population = people living on incomes that are less than 200% of the Federal Poverty Level.





Service Area Demographics

Service area and target population over time

	FY16 SAC	FY19 SAC	% Change
Total service area pop.	811,922	862,052	6.2%
Target population (<200% FPL)	275,365	280,656	1.9%
% of total population that is <200% FPL (target population)	33.9%	33.1%	---
Homeless population	3,801	4,177	9.9%

Service Area Demographics

Target population compared to total population - race

	Total Population (Multnomah County)	Target Population (Multnomah County < 200% FPL)
Asian	7.6%	6.9%
Black/African American	4.9%	11.5%
Latinx	10.7%	20.4%
Multiracial	4.3%	6.4%
Native American/Alaska Native	0.5%	1.7%
Pacific Islander	0.6%	1.1%
White non-Latinx	71.3%	54.1%

Service Area Demographics

Target population compared to total population - socioeconomic

	Below 100% FPL	Below 200% FPL	Covered by Medicaid	Uninsured
Target population	48.7%	100%	61.0%	18.6%
Total population	16.1%	33.1%	20.2%	9.9%

Service Area - Health Center Utilization

- In most zip codes where MCHD Health Centers are located, 40-60% of the low income population is a Health Center client (not necessarily MCHD).
- Across the total service area, 39% of low income people are Health Center clients.
- 12% of adults in the service area have delayed or not sought care due to cost.
- 19% of adults in the service area say they do not have a usual source of care.

Health status

Most significant causes of morbidity & mortality

Top ranked conditions based on: racial/ethnic disparity, gender disparity, worsening trend, worse county rate compared to state, high proportion of population affected, and severe health consequence.

Health Behaviors

- Alcohol use in teens
- Binge drinking in teens & adults
- Current cigarette smoking in teens & adults
- Dental visits in adults*
- Fruit/vegetable consumption in teens & adults
- Marijuana use in teens
- Physical activity in teens
- Flu shots in adults
- Pneumonia vaccine for 65+
- Usual source of health care and could not afford to see doctor

Morbidity

- Breast cancer incidence
- Chlamydia incidence
- Chronic hepatitis C incidence*
- Depression in adults
- Gonorrhea incidence*
- Hypertension in adults
- High cholesterol in adults
- Lung, trachea, bronchus cancer incidence
- Obesity/overweight in teens and adults
- Ovarian cancer incidence*

Mortality

- Alcohol-induced
- Alzheimer's disease
- Breast cancer among females
- Chronic lower respiratory disease*
- Colorectal cancer*
- Diabetes
- Drug-induced
- Heart disease
- Lung, trachea, bronchus cancer
- Non-transport accidents
- Suicide

*Not in the 4-county region top list

Health Disparities

Perinatal health

Prenatal care

-Mult. Co. is behind Oregon and HP2020 goal
-Disparities for populations of color, lower educational attainment, and OHP coverage

Low birth weight

-Mult. Co. does not meet HP2020 goal
-Disparities for Asians/PI, Blacks/AA, lower educational attainment, and OHP coverage

Preventable health issues

Unhealthy weight

-Latinos, Black/AA, Native American populations in Mult. Co. do not meet HP2020 goal.
-Nutrition/Physical activity disparities for Native Americans, Asians/Pacific Islanders, and Blacks/AA
-Food security disparity for Blacks/AA

Tobacco use

-Only Asians/Pacific Islanders meet HP2020 goal
-Disparately high use among Blacks/AA, Native Americans
-OHP clients more likely to smoke during pregnancy

Colorectal cancer screening

-Disparities for OHP clients, Asians, Latinos

PAP test

-Disparities for OHP clients and Asians

Immunizations

-More exemptions claimed than in Clackamas or Washington counties

Chronic disease

Asthma

-Higher in Mult. Co. and Oregon than U.S.
-Disparities for OHP, Native Americans, Blacks/AA

High cholesterol/heart disease

-Disparities for Blacks/AA and Native Americans

Hypertension

-Disparities for OHP clients, Blacks/AA, Native Americans

Diabetes

-Disparities for Blacks/AA, Native Americans, Asians/PI

HIV

-Disparity for Blacks/AA

Depression

-High in Mult. Co. Disparity for OHP clients

Oral Health

-OHP clients less likely to have had dental visit

Healthcare for the Homeless

Population Experiencing Homelessness

Demographics

- Native Americans, Blacks/African Americans, and Pacific Islanders are disproportionately represented
- The most commonly reported geographic area to sleep was SE Portland (22%), followed by downtown (20%)

Healthcare Needs

- 61% have at least one disabling condition (57% in 2015)
- 18% are adults with serious mental illness
- 15% are adults with substance use disorder
- 0.6% are adults who are HIV-positive
- 11% have a chronic health condition
- 15% have a physical disability

Award Eligibility & Targets

Funding by patients served

	FY16	FY19
Amount requested	$8,505,221	$9,642,194
Proposed pts. served	72,000	69,652
# of projected pts. listed in SAAT	71,600	73,318
Corresponding funding level	No reduction (95-100% of SAAT pts.)	No reduction (95-100% of SAAT pts.)

There is a **funding priority** for competing continuation applicants (a favorable adjustment of combined review scores:

- **Program Compliance** (5 points) - If you are a competing continuation and do NOT have a current 1-year project period or an active condition related to HCP requirements at the time of application
- **Patient Trend** (5 points) - If you are a competing continuation applicant that meets program compliance AND you have a positive or neutral 3-year patient growth trend.

Presentation Summary

Grant Opportunity

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

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

Date of Presentation: August 13, 2018	Program / Service Area: Health Center Program		
Presenters: Vanetta Abdellatif			
This funding will support:	X Current Operations	☐ Expanded services or capacity	☐ New services

Project Title and Brief Description:

- Health Center Program, Service Area Competition
- The Multnomah County Health Department (MCHD) has been receiving Health Center Program (Section 330) funds since 1980. As part of this award, MCHD receives Community Health Center and Healthcare for the Homeless funding. Health Center Program funds are

used to operate the Department's seven Community Health Centers, 10 student health centers, seven dental clinics, seven pharmacies, and HIV Health Services Center.
- No new or different services will be proposed in this year's competitive renewal; requested funding is for the continuation of existing services.

What need is this addressing?
- MCHD's Community Health Centers provide comprehensive primary care, dental, and behavioral health services for the 35% of Multnomah County's population that lives on incomes below 200% of the Federal Poverty Level (about 263,700 people).
- 10% of Multnomah County's population is uninsured, and around 4,200 people experience homelessness.

What is the expected impact of this project? (# of patients, visits, staff, health outcomes, etc)
- The patient goal for the project period will be set at 69,653, requiring MCHD to serve a minimum of that many patients annually by 2020.
- Goals for clinical and financial performance measures will also be set to track and improve health outcomes for patients.
- Grant funds support salaries for Health Center Program staff including: Administrative Analysts, Administrative Specialists, Business Process Consultants, Clerical Unit Coordinators, Clinical Services Specialists, Community Health Nurses, Community Health Specialists, Data Analysts, Dental Assistants, Dental Hygienists, Eligibility Specialists, Finance Specialists, Finance Technicians, Laboratory Technicians, Licensed Practical Nurses, Medical Assistants, Nurse Practitioners, Nurse Practitioner Manager, Nursing Supervisors, Office Assistants, Operations Supervisors, Physicians, Physician Assistants, Program Coordinators, Program Specialists, Program Technicians, and Project Managers.

What is the total amount requested: $9,642,194
A budget will be provided to the Community Health Council prior to the meeting.

Expected Award Date and project/funding period: January 1, 2019 – December 31, 2021

Briefly describe the outcome of a "YES" vote by the Council *(be sure to also note any financial outcomes)*
Upon a "yes" vote, MCHD will submit an application to renew its Health Center Program funding to continue operating its current service sites.

Presentation Summary

Briefly describe the outcome of a "NO" vote or inaction by the Council *(be sure to also note any financial outcomes)* Upon a "no" vote, MCHD will not submit an application to renew its Health Center Program and funding for MCHD's programming will be lost.
Related Change in Scopes Requests: *Not applicable*

OMB No.: 4040-0006. Expiration Date: 01/31/2020

DEPARTMENT OF HEALTH AND HUMAN SERVICES	FOR HRSA USE ONLY	
Health Resources and Services Administration	Grant Number	Application Tracking
FORM SF-424A: BUDGET INFORMATION		

Budget Information

SECTION A - BUDGET SUMMARY

Grant Program Function or Activity (a)	Catalog of Federal Domestic Assistance Number (b)	Estimated Unobligated Funds		New or Revised Budget		
		Federal (c)	Non-Federal (d)	Federal (e)	Non-Federal (f)	Total (g)
1. CHC	93.224	$ -	$ -	$ 7,505,484	$ 124,662,028	$ 132,167,512
2. HCH	93.224	$ -	$ -	$ 2,136,710	$ 6,299,514	$ 8,436,224
TOTALS				$ 9,642,194	$ 130,961,542	$ 140,603,736

SECTION B - BUDGET CATEGORIES

6. Object Class Categories	Federal	Non-Federal	Total
a. Personnel	$ 5,060,050	$ 50,190,806	$ 55,250,856
b. Fringe Benefits	$ 3,376,282	$ 33,476,133	$ 36,852,415
c. Travel	$ -	$ 141,634	$ 141,634
d. Equipment	$ -	$ 495,900	$ 495,900
e. Supplies	$ -	$ 12,611,792	$ 12,611,792
f. Contractual	$ 142,040	$ 4,707,989	$ 4,850,029
g. Construction	$ -	$ -	$ -
h. Other	$ 827,604	$ 27,140,464	$ 27,968,068
i. Total Direct Charges *(sum of 6a - 6h)*	$ 9,405,976	$ 128,764,718	$ 138,170,694
j. Indirect Charges	$ 236,217	$ 2,196,825	$ 2,433,042
k. TOTALS *(sum of 6i and 6j)*	$ 9,642,194	$ 130,961,542	$ 140,603,736

SECTION C - NON-FEDERAL RESOURCES

Grant Program Function or Activity	Applicant	State	Local	Other	Program Income	Total
CHC 93.224	$ 10,823,304	$ 5,788,099	$ 411,792	$ 35,585,768	$ 72,108,993	$ 124,717,956
HCH 93.224	$ 2,113,062	$ -	$ -	$ 1,031,717	$ 3,098,807	$ 6,243,586
TOTAL	12,936,366	5,788,099	411,792	$ 36,617,485	$ 75,207,800	$ 130,961,542

SECTION D - FORECASTED CASH NEEDS (Optional)

	1st Quarter	2nd Quarter	3rd Quarter	4th Quarter	Total for 1st Year
Federal					
NonFederal					
TOTAL					

SECTION E - BUDGET ESTIMATES OF FEDERAL FUNDS NEEDED FOR BALANCE OF THE PROJECT

	FUTURE FUNDING PERIODS (Years)			
(a) Grant Program	First	Second	Third	Fourth
CHC 93.224			N/A	N/A
HCH 93.224			N/A	N/A
			N/A	N/A
			N/A	N/A
TOTAL	$ -	$0	N/A	N/A

SECTION F - OTHER BUDGET INFORMATION

Direct Charges:	See narrative
Indirect Charges	See narrative
Remarks	

Title:	**Community Health Center Services Fee Policy**		
Policy #:	**AGN.10.03**		
Section:	Agency Wide Clinical	Chapter:	**Fiscal**
Approval Date:	06/11/2018	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. The remaining balance will be collected or billed at the end of the appointment.
Nominal Fee	The nominal fee is the amount requested 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	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. 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).
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; loyalties; 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. If the total cost of the visit is lower than the flat fee, clients in tiers 2-4 will pay the total visit cost.

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 > 133% to 167%	Tier 4 > 167% to 200%	Tier 5 > 200%
Medical Care (Including in-house lab fees)	$35	$45	$55	$65	No Discount (Pay Full Fee, $75 deposit)
Dental Care (Including lab fees)	$45	$55	$65	$75	No Discount (Pay Full Fee, $85 deposit)
Mental Health Care/ Behavioral Health Care*	$0	$0	$0	$0	No Discount (Pay Full Fee, $5 deposit)
Enabling & Other Services**	$0	$0	$0	$0	No Discount (Pay Full Fee if 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)
In house LAB Only Visit	$0	$18	$19	$20	No Discount (Pay Full)
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(after insurance billing) case management (not performed by nurses), eligibility assistance, outreach, transportation, and translation services. Other visits include telemedicine, flu vaccine-only, clinical pharmacy, and targeted 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 (per visit)	$0	$45	$55	$65	No Discount (Pay Full Fee, $75 deposit)	No Discount (Pay Full Fee, $75 deposit)
Ryan White Services (max	$0	No More than 5% of Annual Income			No More than 7% of Annual Income	No More than 10% of Annual Income

out-of-pocket)				

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-cays, 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 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 seperate 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)
Level 1	30	$4	$6	$8	$10	$12
	90	$10	$12	$14	$16	$18
Level 2	30	$10	$12	$14	$16	$18
Level 3	30	$15	$20	$25	$30	$35

(Non-formulary)						

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 with household incomes under 200% (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 (not performed by nurses), eligibility assistance, transportation and translation
- Clinical pharmacist visits
- Family planning visits for enrolled clients
- Flu vaccine visits
-

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

Co-Applicant Agreement for the Operation of the Community Health Center

This Co-Applicant Agreement for the Operation of the Community Health Center (the "Agreement") is entered into by and between Multnomah County (the "County") and the Multnomah County Community Health Council (the "Council") (individually a "Party" and the "Parties").

Recitals

WHEREAS, since 1977, the County has been awarded Federal grant support from the Health Resources and Services Administration ("HRSA") within the United Department of Health and Human Services ("DHHS"), pursuant to Section 330 of the Public Health Service Act ("Section 330"), to operate a community health center project (hereinafter the "Community Health Center");

WHEREAS, the Council was established in 1980, serves as the co-applicant governing body for the Community Health Center, and supports the Division of Integrated Clinical Services' vision of *Integrated. Compassionate. Whole person health*;

WHEREAS, the Council meets the size, selection, and composition requirements, and exercises certain governance authorities proscribed by Section 330, the implementing regulations set forth at 42 C.F.R. Part 51c, and related HRSA policies, including but not limited to the Community Health Center Program Compliance Manual (the "Compliance Manual");

WHEREAS, consistent with the County Division of Integrated Clinical Services, the mission of the Community Health Center is to provide services that improve the health and wellness for individuals, families, and communities; and

WHEREAS, the Parties wish to set forth in this Agreement their respective responsibilities with respect to governance and operation of the Community Health Center.

Agreement

NOW THEREFORE, the County and the Council agree as follows with respect to their responsibilities for the Community Health Center:

1. Health Council

1.1 Composition of the Governing Body.

The composition of the Council shall comply with the Council's Bylaws, which shall be consistent with the requirements of Section 330, its implementing regulations, and applicable HRSA policies, including but not limited to the Compliance Manual.

1.2 Authorities and Responsibilities of the Council.

The Council shall hold monthly meetings where a quorum is present and shall exercise

the authorities and responsibilities described in the Council's Bylaws and described below:

1.2.1 Adopting health care policies including the scope and availability of services to be provided by the Community Health Center, the mode of delivery of services, the location and hours of operation, quality-of-care audit procedures, and the Community Health Center's quality plan;

1.2.2 Evaluating the Community Health Center's activities, including service utilization patterns, productivity, patient satisfaction, achievement in health center project objectives, and development of a process for hearing and resolving patient complaints;

1.2.3 In consultation with the Community Health Center management team, evaluating the performance of the Community Health Center based on quality assurance/quality improvement assessments and other information received from the Community Health Center management;

1.2.4 Approving the Community Health Center's annual operating and capital budgets, which outline the proposed uses of both Section 330 and non-Federal resources and revenue, consistent with Section 2.1.1;

1.2.5 Approving the Section 330 grant application and other grant applications and formal requests to federal, state, local and private agencies related to the Community Health Center's Scope of Project, including but not limited to Change in Scope requests submitted to HRSA;

1.2.6 Selecting, evaluating and dismissing the Executive Director of the Community Health Center, consistent with Section 1.3;

1.2.7 Monitoring the financial status of the Community Health Center, including reviewing the results of the annual audit and ensuring appropriate follow-up actions are taken, consistent with Section 2.2.7;

1.2.8 Adopting a policy for eligibility for services, including a sliding fee discount schedule, related eligibility and verification policies and procedures, and other policies and procedures related to the Community Health Center's Sliding Fee Discount Program consistent with the requirements of Section 330, consistent with Section 2.1.4;

1.2.9 Assuring that the Community Health Center is operated in compliance with applicable federal, state and local laws and regulations, consistent with Section 3.1;

1.2.10 Approving any decisions to subaward or contract for a substantial portion of the Community Health Center's services; and

1.2.11 Exercising all other authorities and responsibilities, except those specified in Section 2.1 of this Agreement, which are required by Section 330, the implementing regulations, and HRSA policies, including but not limited to the Compliance Manual, to be vested in a Section 330-compliant governing board.

The Parties understand and agree that no other individual, entity, or committee shall reserve or have approval or veto power over the Council with regard to the above authorities.

1.3 Selection, Evaluation and Dismissal of the Executive Director.

1.3.1 Selection of an Executive Director. The County shall be responsible for recruiting candidates to fill any Community Health Center Executive Director vacancy. The Council may also propose candidates. The County shall consult with the Council on qualifications and the recruitment process for the Executive Director position. An equal number of representatives from both the County and the Council shall be included in the qualification, review, and interview process. The County shall present at least three (3) candidates to the Council for final selection The Council shall have the authority to either select or reject the Executive Director candidate(s) presented by the Search Committee. In the event that the Council rejects the candidate(s) presented, the Search Committee will prepare additional candidate slates until the Council approves a candidate.

1.3.2 Evaluation of the Executive Director. The Council will work with the County's MCHD Human Resources department to conduct an annual review of the Executive Director's performance. The Chair of the Board of County Commissioners or, if so designated by such Chair, the County Chief Operations Officer ("COO") shall conduct an independent evaluation of the Executive Director's performance as Director of Integrated Clinical Services and shall submit such report to the County's human resources department.

1.3.3 Dismissal of the Executive Director. Subject to Section 1.4.2, the Council shall have the authority to dismiss the Executive Director from the role as Executive Director of the Community Health Center, if such termination is warranted based on performance or pursuant to federal, state, or County personnel rules. The Executive Director shall be dismissed upon the vote of a majority of the voting Council Directors.

1.3.4 Duties of the Executive Director. The Executive Director will be the chief executive of the Community Health Center and will serve as the Director of Integrated Clinical Services. The Executive Director shall have responsibility for the general care, day-to-day management, supervision,

and direction of the Community Health Center's affairs in furtherance of established policies, procedures and programs. The Executive Director shall have the authority to approve the assignment of County personnel to the Community Health Center, to supervise such individuals, and to dismiss such personnel from their duties at the Community Health Center, in accordance with the personnel policies established by the County. The Executive Director or designee shall also have the authority to negotiate, execute and administer all contracts for goods and services as required for the operation of the Community Health Center subject to the rules and policies applicable to the County's procurement, purchasing and administration of contracts, and the budget approved for the Community Health Center. The Executive Director shall report to (i) the Council and (2) the Chair of the Board of County Commissioners or, if so designed by the Chair, the County Chief Operations Officer ("COO").

1.4 Employer-Employee Relations.

1.4.1 Subject to Section 1.3 of this Agreement regarding the selection, approval, evaluation and dismissal of the Community Health Center's Executive Director, the County shall have sole authority over employment matters and personnel policies and procedures applicable to the Community Health Center staff, including selection and dismissal procedures, salary and benefit scales, employee grievance procedures and processes, equal employment opportunity practices, labor disputes and other human resources issues.

1.4.2 The Community Health Center's Executive Director shall, at all times, be an employee of the County. Removal of the Executive Director by the Council pursuant to Section 1.3.3 of this Agreement may not constitute a termination of employment by the County. As the Executive Director's employer, the County shall have authority to terminate the Executive Director's employment if such termination is warranted pursuant to federal, state, or local law or rule, or County personnel rules. If the County seeks to terminate the Executive Director for a reason that is not warranted by federal, state, or local law or rule, or County personnel rules it may do so only with the Council's prior approval.

2. The County

2.1 Authorities and Responsibilities

The County, via the Board of County Commissioners, shall exercise certain responsibilities and authorities with respect to the Community Health Center. These authorities and responsibilities include:

2.1.1 Consistent with Section 1.2.4 of this Agreement, developing the Community Health Center's annual operating and capital budgets,

which will be prepared under the direction of the Community Health Center's management team and incorporated into the overall County's Health Department budget. In the event that the County proposes revisions to the budget that impact the portion of the budget applicable to the Community Health Center, such revisions shall be presented to and approved by the Council prior to final approval and implementation by the County.

2.1.2 Subject to Section 1.3 regarding the Executive Director, establishing personnel policies and procedures applicable to any County employee assigned to the Community Health Center, which policies and procedures include, but are not limited to, selection and dismissal policies and procedures, salary and benefit scales, position descriptions and classifications, and employee grievance policies and procedures, all of which shall meet all Oregon and federal employment requirements including, but not limited to, equal employment opportunity, drug free workplace, and non-discrimination.

2.1.3 Adopting policy for financial management practices and accounting systems, including a system to assure accountability for Community Health Center resources and assets, selection of an independent auditor and provision of an annual audit, long-range financial planning, and establishing purchasing policies and procedures consistent with DHHS administrative requirements set forth in 45 C.F.R. Part 75.

2.1.4 Consistent with the provisions of 1.2.8, supporting the Council in its development of policies for billing and collections activities, including a policy regarding determinations of eligibility for services; a schedule of charges; and a schedule of discounts off charges for services provided to uninsured and underinsured patients with annual incomes equal to or below 200% of the federal poverty level, a nominal fee policy for uninsured and underinsured patients with annual incomes less than or equal to 100% of the federal poverty level, related eligibility and verification policies and procedures, and other policies and procedures related to the Community Health Center's Sliding Fee Discount Program. The Council shall approve the policies for billing and collections activities as set forth in this Section.

2.2 Operational Responsibilities

The County shall fulfill the following obligations with respect to the Community Health Center:

2.2.1 Applying for and maintaining all licenses, permits, certifications, and approvals necessary and appropriate for the operation of the Community Health Center.

2.2.2 Receiving, managing and disbursing grant funds consistent with the budget approved in accordance with this Agreement. The County shall not be required to disburse funds for any expenditure not authorized by a budget approved in accordance with this Agreement. Consistent with Section 2.1.1, the County shall seek and obtain the Council's prior written approval before implementing any line item change in the portion of the Council's approved budget that is specific to the Community Health Center.

2.2.3 Maintaining the financial affairs of the Community Health Center, including capital and operating borrowing and controlling funds received for services provided by and all income otherwise generated by the Community Health Center, including fees, premiums, third-party reimbursements and other State and local operational funding (collectively, "Program Income"), as well as all Program Income greater than the amount budgeted to the Community Health Center ("Excess Program Income"). All Program Income and Excess Program Income shall be used as permitted under, and for such other purposes that are not specifically prohibited by, Section 330 and solely for uses that further the objectives of the Community Health Center's federally-approved program, consistent Section 330 and the policies and priorities applicable to the Community Health Center.

2.2.4 Supporting the Community Health Center through the County's Human Resources Department's recruitment and training resources and activities.

2.2.5 Developing management, reporting and internal control systems for the Community Health Center, in consultation with the Council, that are in accordance with sound financial management procedures, including:

2.2.5.1 The provision for an audit of the Community Health Center on an annual basis, consistent with the requirements of 45 C.F.R. Part 75 and the then current compliance supplement applicable to the consolidated Health Center Program (or any subsequent regulations that may replace and supersede 45 C.F.R. Part 75 and the applicable compliance supplement), to determine, at a minimum, the fiscal integrity of financial transactions and reports;

2.2.5.2 Implementing accounting procedures and controls in accordance with generally accepted accounting principles utilized in operating the Community Health Center, as well as the systems for the development, preparation, and safekeeping of records and books of account relating to the

business and financial affairs of the Community Health Center;

2.2.5.3 Maintaining the Community Health Center's business and financial records separate from records related to other County finances to ensure that revenues and expenditures of the Community Health Center may be properly allocated and accounted for, and that Community Health Center funds will be distinguished and accounted for separately from other funds of the County. All expenditures pertaining to the operation of the Community Health Center (including but not limited to, direct and indirect costs associated with staffing, operational systems, additional administrative support services, and overhead) shall be allocated as Community Health Center costs in accordance with the proportionate amount of time expended by the County's personnel in providing services to and on behalf of the Community Health Center or the proportionate amount of resources utilized by the Community Health Center; and

2.2.5.4 The preparation and submission of cost reports, supporting data, and other materials required in connection with reimbursement under Medicare, Medicaid, and other third party payment contracts and programs, in which the Community Health Center may from time to time participate.

2.2.6 Providing to patients of the Community Health Center access to the County's other programs, based on the County's established eligibility requirements for such programs.

2.2.7 Preparing regular financial statements of the Community Health Center's budgeted and actual revenues and expenses, and other financial status reports for the Council, and any other reports reasonably requested by the Council, to enable the Council to fulfill its responsibilities for the Community Health Center.

2.2.8 Submitting the required Section 330 grant-related information and reports to DHHS, including but not limited to the Uniform Data System ("UDS") data and the Federal Financial Report ("FFR").

2.2.9 Complying with the terms and conditions of the Section 330 grant.

3. Mutual Obligations

3.1 Compliance and Representatives.

The Parties shall have a mutual commitment and responsibility to work together to ensure that the Community Health Center provides care in compliance with all federal, state and local laws and regulations. The Executive Director shall ensure that both the County and Council communicate strategic priorities, maintain regular communication, and share information about the Community Health Center's operations.

The Council and County shall comply with County's code-of-conduct and harassment policies, including the health center project standards of conduct, which shall be drafted in a manner consistent with Chapter 13 of Compliance Manual. Consistent with 45 C.F.R. Part 75, the Parties further agree that no employee, officer, or agent of either Party may participate in the selection, award, or administration of a contract supported by the Section 330 grant award if he or she has a real or apparent conflict of interest.

3.2 Financial Responsibility and Expenses of the Parties.

Each Party agrees not to undertake expenditures in excess of overall available resources, to materially change or modify the adopted budget without their mutual agreement, or to otherwise take actions inconsistent with the financial management protocols developed hereunder.

3.3 Record Keeping and Reporting.

3.3.1 Each Party shall maintain records, reports, supporting documents and all other relevant books, papers and other documents so as to enable the Parties to meet all grant-related reporting requirements. Records shall be maintained for a period of four (4) years, or a period otherwise required by law, from the date this Agreement expires or is terminated. If an audit, litigation, or other action involving the records is started before the end of the period, the Parties agree to maintain the records until the end of the period or until the audit, litigation, or other action is completed, whichever is later. The Parties shall make available to each other, DHHS and the Comptroller General of the United States, or any of their duly authorized representatives, upon appropriate notice, such financial systems, records, reports, books, documents, and papers as may be necessary for audit, examination, excerpt, transcription, and copy purposes, for as long as such systems, records, reports, books, documents, and papers are retained.

3.3.2 The Parties agree that the County shall be the custodian of all health records established and maintained relating to diagnosis and treatment of patients served through the Community Health Center.

3.4 Legal Services.

The County shall provide the services of the County's employed or contracted counsel, as requested by the Council, to offer legal consultation for the operation of the Community Health Center. If the Council wishes to retain independent legal counsel, the Council will follow

County's policy to request such services.

3.5 Ownership of Property Acquired with Grant Funds.

The provisions of 45 C.F.R. §75.316, *et seq*. (and/or any subsequent regulations that replace and supersede 45 C.F.R. Part 75) apply to tangible property acquired under this Agreement. The Parties agree that the County shall be the title holder of all property purchased with Section 330 grant funds. The County shall further assure that all contracts executed by for the Community Health Center are consistent with procurement standards contained in 45 C.F.R. Part 75 (and/or any subsequent regulations that replace and supersede 45 C.F.R. Part 75).

4. Governing Law

4.1 Applicable Laws, Regulations and Policies.

This Agreement shall be governed and construed in accordance with, and both Parties shall comply with, applicable Federal and State laws, regulations, and policies, including but not limited to: Section 330 of the Public Health Service Act; implementing regulations at 42 C.F.R. Part 51c; the terms and conditions of Section 330 grants awarded to County; the legislative mandates issued by the Office of Federal Assistance Management (OFAM); HRSA policies and other guidance (including, but not limited to, Health Center Program Compliance Manual); the DHHS Grants Policy Statement in effect as of the date the Agreement is executed; and the DHHS Uniform Administrative Requirements, Cost Principles, and Audit Requirements for HHS Awards set forth in 45 C.F.R Part 75 (and/or any subsequent regulations that replace and supersede 45 C.F.R. Part 75).

4.2 Compliance with State and Local Law.

This Agreement is governed by the laws of the State of Oregon. Each Party covenants to comply with all applicable laws, ordinances and codes of the State of Oregon and local governments in the performance of the Agreement, including all licensing standards and applicable accreditation standards.

4.3 HRSA Communication.

County shall submit promptly to the Council HRSA communication, Notice of Grant Awards, directives and/or policies that are received from or issued by HRSA after execution of this Agreement and are pertinent to the Community Health Center.

5. Term

This Agreement shall remain in effect unless terminated at an earlier date in accordance with Section 6.

6. Termination

This Agreement shall terminate immediately upon the mutual approval of the Parties or upon the effective date of any termination in full of the County's Section 330 grant.

7. Dispute Resolution

The Parties will use their best efforts to carry out the terms of this Agreement in the spirit of cooperation. In the unlikely event of disagreement, the Parties shall first attempt to resolve any dispute arising under this Agreement by informal discussions. In the event the Parties are unable to resolve the dispute through informal negotiations within a reasonable period of time of the commencement of such discussions (not to exceed thirty days), the Parties shall attempt formal mediation, if they mutually agree to do so. If the Parties are unable to resolve the dispute, either Party may pursue any remedy available at law.

8. Notices

All notices permitted or required by this Agreement shall be deemed given when in writing and delivered personally or deposited in the United States Mail, first class postage prepaid, Certified and Return Receipt Requested, addressed to the other Party at the address set forth below, or such other address as the Party may designate in writing:

For the County:

For the Council: Chair
INSERT

9. Non-Severability

The provisions of this Agreement are not severable. In the event that any one or more provisions of this Agreement are deemed null, void, illegal or unenforceable, or should any part of this Agreement, as determined by DHHS or any other governmental authority, cause the County and the Council (as co-applicants) not to comply with Section 330, the Parties agree to attempt to amend this Agreement as shall reasonably necessary to achieve compliance. In the event that the Parties reach such agreement, this Agreement shall be construed in all respects as if such invalid or unenforceable provisions have been omitted. In the event that no such amendments or agreements for amendments can reasonably be made, this Agreement shall immediately terminate.

10. Waiver

No provision of this Agreement shall be waived by any act, omission or knowledge of a Party or its agents or employees except by an instrument in writing expressly waiving such provision and signed by a duly authorized officer of the waiving Party.

11. Third-Party Beneficiaries

None of the provisions of this Agreement shall be for the benefit of or enforceable by any thirty party, including, without limitation, any creditor or patient. No third party shall obtain any right under any provision of this Agreement or shall by reason of any provisions make any claim relating to any debt, liability, obligation or otherwise against any Party to this Agreement.

12. Entire Agreement

This Agreement represents the complete understanding of the Parties with respect to the subject matter herein and as such, supersedes any other agreements or understandings between the Parties, whether oral or written, relating to such subject matter, including but not limited to the 2015 policy, ICS.01.42, *Multnomah County Public Center Governance Staff Guidelines Community Health Council Board & Board of County Commissioners Co-Applicant Relationship*. No such other agreements or understandings may be enforced by either Party nor may they be employed for interpretation purposes in any dispute involving this Agreement.

13. Amendments and Modifications

Any amendment or modification to this Agreement shall be in writing and signed by both Parties. Modification or amendment of any provision(s) of this Agreement shall not affect the remaining provisions and, except for the specific provision(s) of this Agreement which thereby may be modified or amended, this Agreement shall remain in full force and effect as originally executed.

Notwithstanding anything set forth herein, in the event of a change in law or regulation, or upon the issuance of an order from a lawful authority, including but not limited to a court of law or a regulatory agency, that is binding upon a Party and will affect the provisions of this Agreement, the Parties shall meet and confer to amend this Agreement as necessary to incorporate any such change in law, regulation, or order, if a Party determines, in good faith and upon advice of counsel, that such amendment is necessary for purposes of compliance with such change in law or regulation or order.

14. Incorporation of Recitals

The Recitals are incorporated into this Agreement by this reference.

IN WITNESS WHEREOF, the Parties hereto have executed this Agreement.

Multnomah County	Multnomah County Community Health Council
By: _____	By: _____
Print: INSERT	Print: INSERT
Title: INSERT	Title: Board Chair
Date: _____	Date: _____

2018 NATIONAL HEALTH CENTER CELEBRATION

FOOD!

HEALTH

GAMES!

Celebrate our Health Heroes and join us at the reopening of our newly renovated North Portland Health Center.

TAI CHI DEMONSTRATION, CSA PARTNERSHIP, AND MORE!

Friday, August 31, 2018
from 2-4 pm
9000 N Lombard St.

Multnomah County Health Department

@MultCoHealth

Integrated. Compassionate. Whole person health.

HDComms-073118

CELEBRACIÓN NACIONAL DE LOS CENTROS DE SALUD 2018

¡COMIDA!

¡SALUD

¡JUEGOS!

¡DEMOSTRACIÓN DE TAI CHI, AGRICULTURA SOSTENIDA POR LA COMUNIDAD, Y MÁS!

Celebre a nuestros héroes de la salud y venga a la reapertura de nuestro recientemente renovado Centro de Salud Comunitario de North Portland.

Viernes, 31 de agosto, de 2018
de 2 a 4 pm
9000 N Lombard St.

Multnomah County Health Department

@MultCoHealth

Integrado. Compasivo. Salud integral de la persona.

HDComms-080818