Community Health Council

Community Health Council Board Meeting Minutes
Date: Monday, May 13th, 2019
Time: 6:00 PM-8:00 PM
Location: McCoy Building, 619 NW 6th Avenue, Room 150

Approved: **Recorded by:** Maurette Tollefsen
Attendance:

Board Members	Title	Y/N
Deborah Abney	Board Member	Y
David Aguayo	Treasurer	Y
Fabiola Arreola	Member-at-Large	Y
Jon Cole	Member-at-Large	N
Tamia Deary	Board Member	Y
Iris Hodge	Board Member	Y
Tara Marshall	Chair	Y
Susana Mendoza	Board Member	Y
Harold Odhiambo	Board Member	N
Pedro Sandoval Prieto	Secretary	Y
Wendy Shumway	Board Member	Y
Staff	**Title**	**Y/N**
Vanetta Abdellatif	ICS Director	Y
Hasan Bader	Finance Project Manager	Y
Judith Becher	Site Medical Director NEHC	Y
Shirley Bailey	Finance Technician Business Services	Y
Lucia Cabrejos	Interpreter, Passport to Languages	Y
Jan Carpenter	HSC Operations Supervisor	Y
Lisa Covarrubias	Senior Data Analyst Business Services	Y
Adrienne Daniels	ICS Deputy Director	Y
Fran Davison	Principal Management Auditor	Y
Paul DenOuden	HSC Site Medical Director	Y
Sonja Hendrix	Executive Specialist Business Services	Y
Amy Henninger	Deputy Medical Director	Y
Mark Lewis	Interim Director Business Operations	Y
Ritchie Longoria	Pharmacy and Lab Director	Y
Linda Niksich	Community Health Council Coordinator	Y
Dawn Shatzel	Quality Director	Y
Maurette Tollefsen	ICS Executive Specialist/Medical & Dental Directors	Y
Christian Thomson	Dental Operations Supervisor NE	Y
Katie Thornton	Senior Manager ICS	Y

Guests: No external guests attended the meeting.

Action Items:

- Mark to include a twelve month average cost per patient as part of UDS indicators on p.6 of the financials in future reports.
- Dawn Shatzel to change typo, "protocol" to "program" in Quality Management document.

Decisions:

- Approved the April 2019 Meeting Minutes
- Approved the FY20 Budget
- Approved the 2019 Quality Plan Update [?]
- Approved the New Policy HRSA LMR
- Approved three grant submissions: Oral Health, SBHC and IBHS
- Approved CHC Budget Testimony

The meeting was called to order at 6:10pm by Chair, Tara Marshall.

The Meeting Agreements were presented by Board Member, Wendy Shumway.

Noted that quorum was met with 9 members in attendance (7 needed for quorum).

April 2019 Meeting Minutes Review (HRSA Item-Vote Required)
(See document - 'April 2019 CHC Meeting Minutes')

Motion by Iris Hodge to approve the April 2019 Minutes.
Seconded by Wendy Shumway.
9 aye; 0 nay; 0 abstain
Motion carries

FY20 Budget Approval (HRSA Item-Vote required)
(See documents; '330 Application Forms 2019'& 'Budget Narrative')

- Hasan Bader, Finance Project Manager, presented the FY20 budget, together with Form SF-424A budget Information to be submitted to the DHSS, pursuant to MCHD's Federal grant application, which is required to be approved and voted on by CHC. Detailed copies of the FY20 budget and DHSS Form SF-424A were distributed.
  - The budget presentation is based on the proposed operating budget for FY 2019/20.
  - The SF-424A grant application covers two programs, Community Health Care (CHC) and Health Care for the Homeless (HCH). It is estimated that approximately 22% of total grant funds will be allocated to HCH.
  - The total FY20 estimated budget is $147,244,757, of which $137,602,568 are non-federal funds, resulting in a federal grant application of $9,642,194.
  - Hasan summarized the $9,642,194 federal grant budget category totals as: personnel, $5,167,532; fringe benefits, $3,345,914; contractual, $142,040; total direct charges (costs connected to specific services or products) $8,655,486 and indirect costs of $986,708. Hasan also presented a detailed narrative and

justification of each of the above categories.
- The remaining $137,602,568 non-federal revenue is resourced from: program income (visit revenue) $76,187,209; local grant support (state and other agencies) $6,388,749; other federal funding $3,574,352; pharmacy fees/PCPCH, (which include incentives) $42,932,511 and a general fund match (County) of $8,519,742.
- The budget presentations share the grant January start date, and a common fiscal year of July through June.
- **Question**: Wendy requested a definition of 'incentives' as it relates to the budget numbers.
- **Answer**: Hasan stated that if we meet or exceed our budgeted threshold numbers we derive additional 'incentive' dollars.
- **Question**: Tara asked whether there is any substantial difference in terms of numbers from the previous year.
- **Answer**: Hasan replied that there is no reportedly significant difference.

Motion by Wendy Shumway to approve the FY20 Budget.
Seconded by Tamia Deary.
9 aye; 0 nay; 0 abstain
Motion carries

Monthly Budget Report (HRSA Item-No Vote Required)
(See document, 'Weekly Billable Monthly Dashboard for March" and 'FQHC March Financial Statement')

- Mark Lewis, Interim Director of Business Operations, presented the March budget report. Copies of the March Dashboard, detailing March 2019 metrics were distributed.
  - Primary care billable visits stands at 482 for March, down from 505 for February. There was a perceptible decline in primary care visits for both February and March, far below our FY19 target figure of 732 visits per day.
  - Dental average billable visits per workday is up from 291 in February to 329 in March and is trending upwards towards the FY19 target figure of 365 visits per day.
  - School-based health center average visits per day declined from 80 in February to 73 in March.
  - Monthly percentage of uninsured visits in primary care dropped to 15%, the target being 13.85%. There was a dramatic decline in uninsured ICS dental visits from a targeted 15% to 6.6% FY19 Q3 average.
  - Percentage of visits by payer for ICS primary care showed CareOregon to remain the largest payer at 59.4% (a slight increase from the previous month), the second largest being Self-Pay which remained steady at 15%. DMAP/Medicaid dropped marginally to 14.3% while Commercial Payers remained constant at an average of 2.3%.
  - OHP primary care member assignments increased to a total of 38,682 clients in March, of which 90.71% were CareOregon and 9.29% Providence.
  - Dental cost per visit in March was $286. It was $346 for late year 2018.

- Average medical costs per visit in March were $444, compared with $380 for the same period last year.
- Average cost per patient stands at $1,576 for March, a slight increase from $1,535 in February.
- David, Treasurer, informed the meeting that the 482 primary care visits per day were on average billable at $445 per visit, and that the 329 dental visits per day were billable at $286 per visit.
- Vanetta remarked that medical care costs are driven higher than dental costs due to the number of medical personnel involved in each visit (4-5 staff on average per medical visit, versus 2-3 per dental visit).
- Collection rates by payer indicated the following percentage totals for March: Medicaid 54%; Medicare 47%; Self-Pay 15%; Commercial (62%); CareOregon Medicare 48% and FPEP (Family Planning) 61%.
- Mark recommended that it might be beneficial to show, as well as the cost per patient, a twelve month average cost per patient as part of the key UDS Indicators on page 6 of the financials. It was agreed that this would be a useful tool.

Quality Plan Update (HRSA Item-Vote Required)
(See document 'Multnomah County Health Department/Integrated Clinical Services (ICS), 2019 Quality Management Plan')

- Dawn Shatzel, Quality Director, presented the ICS 2019 Quality Management Plan.
  - Dawn informed the meeting that the Health Center is required by HRSA regulations to have a Quality Plan, which must be reviewed and approved annually.
  - Dawn stated that the Quality Plan has been revised to include the addition of a Community Health Council (CHC) Quality Committee. This Committee will convene at least quarterly and is responsible primarily for analyzing aggregate quality performance data, monitoring performance improvement efforts for effectiveness, and patient safety. Three CHC Board Members (Iris Hodge, "D"eb Abney and Wendy Shumway) serve on the CHC Quality Committee, and working in collaboration with Leadership, will aid in developing the draft Annual Quality Plan for review and approval by the full Board.
  - The Quality Plan is a reference guide used in monitoring health center performance. It also outlines program goals, a work plan and reporting schedule.
  - The CHC receives periodic reports as listed in the Quality Program Reports Table in order to fulfill their monitoring requirements.
  - Dawn stated that one enhancement this year, in seeking to improve diabetic and hypertension disease management, is the addition of a new Diabetes Education Management Program. All clients with A1C >9 will automatically be referred to the program.
  - Dawn informed the meeting that the work plan has also been changed to objectively improve culturally responsive care. A monthly cultural spotlight will be developed by the Health Equity/Health Promotion Specialist to inform all primary care staff about the unique cultural needs of patients. This will

commence in April and will be ongoing on a monthly basis.
- It was pointed out that there was an incorrect use of the word "protocol" instead of "program" within the document. It was agreed that Dawn would edit and correct the document, but that the Secretary was authorized to sign the Quality Management Plan should it be approved.

Motion by Iris, to approve the Quality Plan Update.
Seconded by Tamia.
9 aye; 0 nay; 0 abstain
Motion carries

Break for 10 minutes...

The Council Members and Staff extended birthday wishes to Tamia and Iris.

HRSA Appropriations Act and Legislative Mandate Review Policy (HRSA Item-Vote Required)
(See 'Health Resources & Services Administration Consolidated Appropriations Act and Legislative Mandate Review Policy')

- Adrienne Daniels, ICS Deputy Director presented the Health Resources & Services Administration Consolidated Appropriations Act and Legislative Mandate Review Policy for approval. This policy will be reviewed by the state annually, and the board will renew only if edits are required, at a minimum of every three years.
  - Adrienne informed the meeting that the purpose of this policy is to outline the requirements and adherence of the Multnomah County Community Health Center to the Consolidated Appropriations Act(s) and related applicable laws and regulations.
  - The legislative mandate review is a HRSA process which seeks to ensure that grant funding requirements, restrictions and permissions are only used to support approved funding activities.
  - Adrienne stated that HRSA seeks adherence to it's laws and regulations as it relates specifically to the following: salary limitation; gun control; anti-lobbying; acknowledgement of Federal funding; restriction on abortions (with exceptions); ban on funding human embryo research; limitation on the use of funds for the promotion of legalization of controlled substances; restriction of pornography on computer networks; restriction on funding ACORN (Association of Community Organizations for Reform Now); restriction on distribution of sterile needles; confidentiality agreements. A detailed policy statement relating to specific restrictions regarding each of the above items was handed out to the Board for review.
  - A general discussion ensued around questions such as nicotine classification as a controlled substance, abortions and sterile needle distribution. Adrienne informed the Board that abortions have never been performed by the Community Health Center and that harm reduction is an important consideration in distribution of sterile needles, but that no Federal grant money is used as part of any such program.
  - David asked if they could create a regularly scheduled review for the LMR. It

was agreed that the board would be able to review changes, per the policy, as soon as they become available during the appropriations process.

Motion by Fabiola Arreola to approve the HRSA Appropriations Act.
Seconded by Deborah Abney.
9 aye; 0 nay; 0 abstain
Motion carries

ICS/Strategic Updates and Three Grant Submissions: Oral Health, SBHC and IBHS (HRSA Items-Votes Required)
(See 'HRSA Grant Opportunities Presentation Summaries for: Oral Health Infrastructure; School-Based Health Center Mental Health Expansion; Integrated Behavioral Health Services Supplemental Funding')

- Vanetta Abdellatif, ICS Director, Presented the ICS strategic update.
  - Vanetta provided a brief review of Board representatives' April 9th trip to the Capital to attend OPCA's April Peer Network Gathering. This proved to be a fast paced day during which CHC Board members attended a total of 8 meetings with individual legislators. The day's agenda was a valuable opportunity to meet and converse with legislators about priorities relating to health centers.
  - Wendy commented that the day was very fruitful and that the Board members enjoyed the free flowing conversation with legislators. Unfortunately the capital is in the midst of considerable construction which hindered their ability to meet with many more legislators in person.
  - Vanetta informed the Board that ICS' move, of approximately 500 people, into the new McCoy Building at 619 NW 6th Avenue went smoothly and is complete.

  - **Oregon Health Authority School-Based Health Center Mental Health Expansion Grant:**
  - Vanetta presented a summary of the Oregon Health Authority School-Based Health Center mental health expansion grant. MCHD is seeking a grant in the amount of $575,587 in order to continue to provide a qualified mental health provider, equipped to provide on-site mental health services at school-based health centers, as well as a YouthAdvisory Council (YAC) coordinator who will implement a Youth Participatory Action and SHC-focused project.
  - This grant will directly impact mental and behavioral health accessibility in SHC's at David Douglas, Roosevelt, Madison, Centennial and, once open in the Fall of 2019, Reynolds. The addition of a full time YAC Coordinator will support youth at Centennial, David Douglas and Jefferson.
  - The funds will also, in part, be used to refurbish the facilities, including paint, signage and new furniture, in order to make them more inviting places for youth to visit.
  - It is MCHD's objective to greatly improve behavioral outcomes at these SHC's, particularly in the areas of obesity, mental health and substance abuse.
  - **Question**: Iris asked whether funding for this project comes from any other source.
  - **Answer**: Vanetta responded that additional funding for this project comes from

Medicaid (approximately 50%) and the local County general fund. Additional dollars are also derived from mental health providers. Approximately 30% is provided by Federal grants.

Motion by Iris Hodge to approve the Oregon Health Authority School-Based Health Center Mental Health Expansion Grants.
Seconded by Wendy Shumway.
9 aye; 0 nay; 0 abstain
Motion carries

- **HRSA Oral Health Infrastructure Grant**
- Vanetta presented a summary of the HRSA Oral Health Infrastructure grant.
- MCHD is submitting a one-time $300,000 funding application to support minor alteration and renovations, as well as to purchase equipment, in order to begin to provide dental services at North Portland Health Center.
- North Portland Health Center is one of only two MCHD health centers that does not offer co-located dental services, the closest current access point for dental patients being Northeast Health Center.
- The funding will support all work and equipment needed to begin operating three dental exam rooms at North Portland Health Center.

Motion by Iris Hodge to approve the HRSA Oral Health Infrastructure Grant.
Seconded by Wendy Shumway.
9 aye; 0 nay; 0 abstain

- **HRSA FY19 Integrated Behavioral Health Services Supplemental Funding**
- Vanetta presented a summary of the HRSA FY19 Integrated Behavioral Health Services Supplemental Funding.
- MCHD is submitting a proposal to add 0.8 FTE (a total of $145,000)in order to provide behavioral health support services to patients receiving Medication Assisted Treatment for opioid-use disorder in the HIV Health Services Center, as well as 0.25 FTE of project management time to support clinical workflow and practice transformation.
- MCHD has been successful in treating clients with Medication Assisted Treatment and there is a great need for these services. Behavioral health support is key to addressing these patients' complex needs and contributes greatly to successful outcomes.

Motion by Pedro Sandoval Prieto to approve the HRSA FY19 Integrated Behavioral Health Services Supplemental Funding.
Seconded by David Aguayo.
9 aye; 0 nay; 0 abstain

Council Business: Committee Updates and Budget Testimony (HRSA Item-Vote Required)
(See 'FY20 Budget Testimony to the Board of County Commissioners')

- Tara Marshall, Chair, detailed her upcoming budget testimony presentation to

the Board of County Commissioners.

- Tara outlined the Committee's recommendations to be presented to the Board of County Commissioners for the fiscal year 2020 budget. The report states that most importantly it is imperative that the County not risk its FQHC status, secondly that services are provided well into the future and thirdly support continues for Student Health Centers.
- Tara stated that these are stressful times, particularly in regards to funding issues and having to make hard decisions, particularly around staff reductions, in light of a challenging budget season. Tara added that CHC recognizes that this inevitable causes stress among clinic staff.
- Tara's testimony to the Board of Commissioners places emphasis an appreciation for the partnership between the CHC and the Board and the extremely important work that is being done on behalf of the most vulnerable residents of Multnomah County.

Motion by David Aguayo to approve the FY20 Budget Testimony to the Board of County Commissioners.
Seconded by Fabiola Arreola.
9 aye; 0 nay; 0 abstain

- Finance Committee Update
  - David Aguayo, Treasurer, presented a brief Finance Committee update.
  - David informed the Board that on May 7th he and Susana met with MCHD finance staff to review the FY20 budget prior to the monthly CHC meeting. David stated that this had been a valuable opportunity to ask detailed questions about the budget.
  - David stated that at this meeting he had made further recommendation that the Finance Committee be granted more time to review proposed budgets in future and that monthly financial statements be forwarded to the Board in a more timely manner.

Meeting Evaluation:

- There was general agreement that the new facilities far outweighed the old building and that Room 150 worked very well for the purposes of the CHC Board Meeting.

Questions and comments raised by CHC members:

- The question of the Annual Board Retreat, to be held in the Fall, was raised. It was generally agreed that Fridays tend to be favorable for ~~most members~~ the planning Committee. The Committee tasked with arranging the Board Retreat will begin to make plans. Wendy and Pedro volunteered to assist in any way they can.

Meeting Adjourned at 7:55pm.

Signed: Pedro Sandoval Prieto **Date:** 6-10-2019

Community Health Council
Public Meeting Agenda

Monday, May 13th, 2019
6:00-8:00 pm
McCoy Building: 619 NW 6th Avenue, Room 150

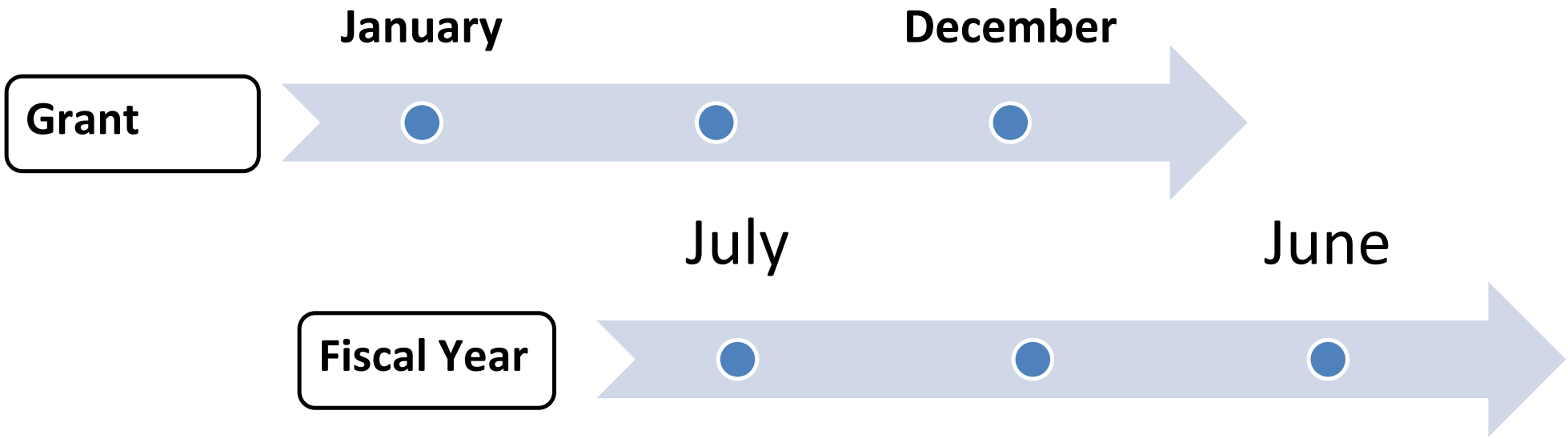
Integrated Clinical Services Mission: "Providing services that improve health and wellness for individuals, families, and our communities."

Our Meeting Process Focuses on the Governance of Community Health Centers -Use Meeting 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 "D"eb Abney; Dave Aguayo; Fabiola Arreola (Member-at-Large); Jon Cole (Member-at-Large); Tamia Deary; Iris Hodge; Tara Marshall (Chair); Susana Mendoza; Harold Odhiambo; Pedro Sandoval Prieto (Secretary); Wendy Shumway

Item	Process/Who	Time	Desired Outcome
Call to Order/Welcome	• Chair, Tara Marshall • Introductions/Ice Breaker	6:00-6:10 (10 min)	Review processes and introduce ourselves with an icebreaker question
Minutes **VOTE REQUIRED**	• Review and approve April Minutes	6:10-6:15 (5 min)	Council votes to approve and Secretary signs for the record
FY20 Budget Approval **VOTE REQUIRED**	• Finance Project Manager, Hasan Bader	6:15-6:35 (20 min)	Council Discussion and Vote
Monthly Budget Report	• Interim Director Business Operations, Mark Lewis	6:35-6:50 (15 min)	Council receives report

2019 Quality Plan Update **VOTE REQUIRED**	• Quality Director, Dawn Shatzel	6:50-7:05 (15 min)	Council Discussion and Vote
BREAK	• All	7:05-7:15 (10 min)	Meet and greet
New Policy HRSA LMR **VOTE REQUIRED**	• ICS Deputy Director, Adrienne Daniels	7:15-7:30 (15 min)	Council Discussion and Vote
ICS/Strategic Updates & Three Grant Submissions; Oral Health, SBHC, and IBHS **VOTE REQUIRED**	• ICS Director, Vanetta Abdellatif	7:30-7:45 (15 min)	Council receives updates Council Discussion and Vote on Grant Submissions
<u>Council Business</u> Committee Updates & Budget Testimony **VOTE REQUIRED**	• Executive Committee Update; Chair, Tara Marshall • Finance Committee Update; Treasurer, David Aguayo • Budget Testimony; Chair, Tara Marshall	7:45-7:55 (10 min)	Council receives update from Exec Council receives update from Finance Council Discussion and vote to approve Budget Testimony
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!**

Budget Timeline



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	$ 132,258,977	$ 139,764,461
2. HCH	93.224	$ -	$ -	$ 2,136,710	$ 5,343,586	$ 7,480,296
TOTALS				$ 9,642,194	$ 137,602,563	$ 147,244,757

SECTION B - BUDGET CATEGORIES

6. Object Class Categories	Federal	Non-Federal	Total
a. Personnel	$ 5,167,532	$ 51,530,838	$ 56,698,370
b. Fringe Benefits	$ 3,345,914	$ 34,898,247	$ 38,244,161
c. Travel	$ -	$ 146,674	$ 146,674
d. Equipment	$ -	$ 609,000	$ 609,000
e. Supplies	$ -	$ 15,547,052	$ 15,547,052
f. Contractual	$ 142,040	$ 5,351,646	$ 5,493,686
g. Construction	$ -	$ -	$ -
h. Other	$ -	$ 28,241,328	$ 28,241,328
i. Total Direct Charges *(sum of 6a - 6h)*	$ 8,655,486	$ 136,324,785	$ 144,980,271
j. Indirect Charges	$ 986,708	$ 1,277,778	$ 2,264,486
k. TOTALS *(sum of 6i and 6j)*	$ 9,642,194	$ 137,602,563	$ 147,244,757

SECTION C - NON-FEDERAL RESOURCES

Grant Program Function or Activity	Applicant	State	Local	Other	Program Income	Total
CHC 93.224	$ 7,502,807	$ 5,437,807	$ 421,339	$ 45,907,074	$ 72,989,950	$ 132,258,977
HCH 93.224	$ 1,016,935	$ -	$ -	$ 1,129,392	$ 3,197,259	$ 5,343,586
TOTAL	8,519,742	5,437,807	421,339	$ 47,036,466	$ 76,187,209	$ 137,602,563

	BUDGET NARRATIVE AND JUSTIFICATION				
	Section II: Program Budget Details				
			Grant Year 19		
			Federal Request	**Non-Federal Recources**	**Total Budget**
A.	**PERSONNEL**		**5,167,532**	**51,530,838**	**56,698,370**
	Salaries (Combined Personnel By Pos.)				
B.	**FRINGE BENEFITS**		**3,345,914**	**34,898,247**	**38,244,161**
	Salary related expenses: FICA (7.65%), Retirement PERS (23.46%), PERS Bond (7.65%), and Transit tax (0.76%) for a total of 39.52% of pay. Retirement for employees hired after August 03 is (16.74%) with a total espense of 32.80% of pay.		1,836,698	19,910,481	**21,747,179**
	Salary related insurance benefits: Includes workers compensation, liability, unemployment, long term/short term disability, retiree medical, and benefits administration for a total of 6.85% of base pay. Flat rate insurance benefits budgeted at $16,614 per full-time employee. For Local 88 three-quarter time employees, it is $12,461. For half-time employees, the rate is $9,483 per employee.		1,509,216	14,987,766	**16,496,982**
C.	**TRAVEL & TRAINING**		-	**146,674**	**146,674**
D.	**EQUIPMENT**		-	**609,000**	**609,000**
	Pharmacy/Lab Equipment		-	609,000	**609,000**
E.	**SUPPLIES**		-	**15,547,052**	**15,547,052**
	Drugs		-	12,817,907	**12,817,907**
	Medical & Dental Supplies		-	1,927,592	**1,927,592**
	Office Supplies		-	801,553	**801,553**
F.	**CONTRACTUAL**		**142,040**	**5,351,646**	**5,493,686**
	Patient Care				
	Primary Care Contracts				
	Contracted lab services with EPIC Imaging, Quest Diagnostics, OR Health Divisiton, Blood Lead Testin Svcs, OHSU Radiology Svcs.		-	724,097	**724,097**
	MH Family Partners and Peer Support Svcs: NAMI		-	645,614	**645,614**
	MH Consultation for Children: Morrison Center		-	184,896	**184,896**
	MH Caring Community Coordination: Centennial SD		-	169,460	**169,460**

	Primary Care MH Services: CODA Contract to provide substance abuse treatment to enable patients to access and remain in Primary Care, access drug therapies and includes supportive counseling.		142,040	-	**142,040**
	Healthstream & e-Learning Platforms		-	120,000	**120,000**
	OHSU Nurse Practioner Contract		-	97,000	**97,000**
	OHSU contract for OBGYN Services		-	81,000	**81,000**
	MH ORCHWA Project		-	69,000	**69,000**
	In-service and Consultation: Honorarium for provider speakers and workshop facilitation		-	67,866	**67,866**
	Transportation: Client bus tickets - TriMet		-	66,909	**66,909**
	After Hours RN medical advice - Fonemed		-	62,000	**62,000**
	Behavioral Health and Psychiatric consultation to juveniles involved in the juvenile justice treatment programs		-	60,500	**60,500**
	MH Consultation for Children: NAMI		-	56,000	**56,000**
	On-Call Pharmacist		-	52,200	**52,200**
	MH A&D Outpatient Services: NAMI		-	50,000	**50,000**
	MH Consumer Leadership: Latino Network		-	50,000	**50,000**
	Quality Improvement Projects		-	32,000	**32,000**
	Psychiatrric Svcs for Youth and Young Adults: Cascadia		-	13,500	**13,500**
	Shredding Svcs: AccuShred Confidential Shredding		-	6,000	**6,000**
	Dental Contracts				
	Contracted lab services with EPIC Imaging, Stae X-ray licensing, Artisan Lab Services, and Matheson lab		-	123,170	**123,170**
	Staffing Svcs: Dental proffesional staffing for on-call coverage		-	113,000	**113,000**
	In-service and other consultation: workshop facilitation and honorarium		-	8,000	**8,000**
	CPR Training: Portland Community College		-	7,000	**7,000**
	Shredding Svcs: AccuShred Confidential Shredding		-	6,100	**6,100**
	Dental Waste Removal		-	5,500	**5,500**
	Field Services				

	Healthy Birth Initiative Services		-	821,157	**821,157**
	Community Groups support		-	142,000	**142,000**
	Client Incentives and Support		-	99,716	**99,716**
	Nurse Family Partnership Support: staff training through Nurse Family Support program		-	58,777	**58,777**
	MH Services and Consulting for HBI Clients		-	27,600	**27,600**
	MH Services For Immigrant and Refugee families		-	15,000	**15,000**
	Non-Patient Care				
	Contracts with IRCO, Optimal, Pssport to Language, Linguava, and Teleport for phone, in-person, sign lanuage, and document interpretation and translation		-	947,202	**947,202**
	Software Fees Maintenance: Pharmacy Interactive voice response system and pharmacy switch fees		-	187,048	**187,048**
	Laundry: Contacts for Lab Jackets, gowns, and coats with Alsco, SafetyClean, etc		-	83,037	**83,037**
	Child and Elder care for community involvement groups during meetings and support		-	38,664	**38,664**
	Lab & X-ray Calibration and Repair: Contract with CHR, CLIA, and API Proficiency Testing		-	26,999	**26,999**
	Courier Svcs		-	17,432	**17,432**
	Transportation - Clients		-	10,720	**10,720**
G.	**CONSTRUCTION**		-	**-**	**-**
H.	**OTHER**		-	**20,415,518**	**20,415,518**
	INTERNAL SERVICES				

	Data Processing: All data processing or information technology services provided by the County's Information Technology division. Services include PC and software maintenance and replacement, network and data center services, Help Desk and network security services, SAP support, and department-specific application development		-	9,902,082	**9,902,082**
	Building Occupancy: Routine building costs, including space, utilities, maintenance, lease payments, and debt service		-	5,608,049	**5,608,049**
	Telecom: County-supplied telecommunications services including desktop digital and analog phones; long distance charges; and fax machine, alarm; and costs for County-issued mobile devices and associated data plans		-	838,068	**838,068**
	Dist/Postage: U.S. postage and mail distribution for interoffice mail and U. S. mail		-	608,256	**608,256**
	Motor Pool - County Fleet		-	122,717	**122,717**
	OTHER				
	On-Call and Temporary		-	1,570,155	**1,570,155**
	Premium: Language, shift and lead incentives		-	807,311	**807,311**
	Education & Training: registration and attendance at professional conferences and conventions, tuition and fees, course materials, out-of-town travel and per diem, lodging, provider's continuing education, Primary Care conference, etc		-	525,866	**525,866**
	Repairs and Maint: Estimated County Facilities requests for repairs and maintenance to buildings, clinics, and offices that are not Capital in nature		-	143,598	**143,598**

	Dues & Subscriptions: Membership to regional and national organizations and access to professional websites. This includes NACHC, Northwest Regional Primary Care Association, Oregon Primary Care Association, UpToDate, Online Management System, and several professional journals		-	136,205	**136,205**
	Printing: ICON copier lease, forms, business cards, and all printing, photocopying, binding, graphics, and photography services		-	86,971	**86,971**
	Rentals: This includes space rental for meetings and workshops.		-	45,120	**45,120**
	Communications: moving/adding/changing telephone services, videoconferencing stations, internet service (purchased outside the County network) and employee reimbursement for personal mobile phone usage		-	21,120	**21,120**
I.	**TOTAL DIRECT CHARGES**		**8,655,486**	**128,498,975**	**137,154,461**
J.	**INDIRECT CHARGES**		**986,708**	**9,103,588**	**10,090,296**
K.	**TOTAL COSTS**		**9,642,194**	**137,602,563**	**147,244,757**
	REVENUE		**9,642,194**	**137,602,563**	**147,244,757**
	FEDERAL FUNDS REQUESTED		**9,642,194**	**-**	**9,642,194**
	PROGRAM INCOME		**-**	**76,187,209**	**76,187,209**
	LOCAL GRANT SUPPORT		**-**	**6,388,749**	**6,388,749**
	OTHER FEDERAL FUNDING		**-**	**3,574,352**	**3,574,352**
	OTHER - PHARMACY FEES / PCPCH		**-**	**42,932,511**	**42,932,511**
	GENERAL FUND MATCH (Applicant)		**-**	**8,519,742**	**8,519,742**

OMB No.: 0915-0285

Department of Health and Human Services Health Services and Resources Administration Form 3: Income Analysis	For HRSA Use Only	
	Grant Number:	Application Tracking Number

Part 1: Patient Service Revenue - Program Income						
Line #	Payer Category	Patients By Primary Medical Insurance	Billable Visits	Income Per Visit	Projected Income	Prior FY Income
		(a)	(b)	(c)	(d)	
1	Medicaid	52,617	226,252	312.27	70,651,712	63,671,574
2	Medicare	5,943	25,554	128.90	3,293,910	2,574,328
3	Other Public	-			-	-
4	Private	2,944	12,160	118.90	1,445,824	947,389
5	Self Pay	8,137	38,002	20.94	795,763	819,185
6	Total (lines 1-5)	69,641	301,968	N/A	76,187,209	68,012,476
Part 2: Other Income - Other Federal, State, Local and Other Income						
7	Other Federal				3,574,352	3,979,941
8	State Government				5,437,807	5,870,912
9	Local Government				421,339	466,792
10	Private Grants/Contracts				529,603	319,302
11	Contributions				-	-
12	Other - Pharmacy Fees / PCPCH				42,932,511	30,371,930
13	Applicant (County General Fund)				8,519,742	11,387,750
14	Total Other (lines 7-13)				61,415,354	52,396,627
Total Non-Federal (Non-section 330) Income (Program Income Plus Other)						
15	Total Non-Federal (lines 6 + 14)				137,602,563	120,409,103
Comments/Explanatory Notes (if applicable)						

Federally-Supported Personnel Justification Table

Multnomah County Health Department Budget Justification

The table below is required for each staff position supported in whole or in part by federal Section 330 grant funds.

POSITION TITLE	FTE APPLIED TO FEDERAL GRANT FUNDS	TOTAL FEDERAL SUPPORT REQUESTED
Business Process Consultant	1.0	84,575
Clerical Unit Coordinator	0.7	42,930
Clinic Medical Assistant	12.7	609,464
Clinical Services Specialist	0.8	63,903
Community Health Nurse	10.4	943,636
Community Health Specialist 2	1.4	75,445
Dental Assistant/Efda	1.6	78,127
Dental Hygienist	1.0	87,298
Eligibility Specialist	2.7	149,136
Executive Specialist	1.0	56,009
Finance Specialist 1	1.0	56,547
Finance Technician	0.5	21,083
Licensed Comm Practical Nurse	4.3	276,140
Nurse Practitioner	3.2	418,222
Nurse Practitioner Manager	0.6	88,114
Office Assistant 2	10.8	488,705
Office Assistant/Sr	0.7	31,088
Operations Process Specialist	0.9	60,147
Operations Supervisor	1.0	69,727
Physician	3.3	710,657
Physician Assistant	0.8	96,439
Program Communications Specialist	0.5	36,575
Program Coordinator	1.0	66,787
Program Specialist	2.0	119,262
Program Specialist/Sr	2.4	204,906
Program Technician	0.9	43,156
Project Manager - Represented	2.0	189,454
Grand Total	**68.8**	**$5,167,532**

HRSA GRANT BUDGET
Grant # H80CS00149
Grant Year 19

PERSONNEL	**$ 5,167,532**
Salaries for health center 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, a Nurse Practitioner Manager, Nursing Supervisors, Office Assistants, Operations Supervisors, Physicians, Physician Assistants, Program Coordinators, Program Specialists, Program Technicians and Project Managers.	
FRINGE BENEFITS	**$ 3,345,914**
Fringe benefit costs include percentage-based and flat rate fringe benefits; the projected costs are driven by standard County benefit plans, which vary slightly by union bargaining unit. Percentage-based include retirement and various other charges. Flat rate benefits include medical and dental insurance.	
CONTRACTUAL	**$ 142,040**
Contract to provide substance abuse treatment to enable patients to	
TOTAL DIRECT CHARGES	**$ 8,655,486**
"Direct" charges are costs connected to specific services or products	
INDIRECT CHARGES	**$ 986,708**
Department's indirect rate at 12.16% of Personnel Expenses (Salary and	
TOTAL COSTS	**$ 9,642,194**

A. INTRODUCTION

The following budget presentation covers two programs:
- Community Health Center/330
- Health Care for the Homeless

All presentations share the grant January start date, and a common fiscal year of July through June.

The budget presentation consists of three sections:
- General budget information & justification common to all programs
- Budget presentations, detailing budget information
- Federal 424a form and other tabular budget information

B. SOURCE OF BUDGETARY INFORMATION

Multnomah County operates on a July 1 - June 30 fiscal year. The County adopted its FY 2018/2019 operating budget. This operating budget includes appropriations and corresponding revenue estimates for the entire scope of the project.

The budget presentation is based on the proposed operating budget for FY 2019/2020. In keeping with past practice, we have not assumed a cost-of-living adjustment for the final six months (July 2020 through December 2020) of the grant application period.

C. COST ALLOCATION

The source document for cost allocation is the recently proposed FY 2019/2020 operational budget for the Health Department.

The **CHC and HCH Programs** include the following:
- All Primary Care Clinics
- All School-Based Health Centers
- The Field Nursing Program
- The Dental Program
- The Mental Health and Substance Abuse Services Program
- The Eligibility Outreach Program and other Enabling Services
- The HIV Treatment Program
- Information and Referral Program.

D. INDIRECT COSTS

The County has established federally approved indirect rates for FY 2019-2020. The Central Services cost allocation plan identifies and distributes the cost of services provided by central County support organizations (e.g. Budget Office, County Auditor). The Departmental Administration rate is based on administrative costs incurred within the Health Department. Indirect rates are assessed on personnel actual charges. Only costs not charged directly to grants are included in the departmental rate. Internal

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County services (e.g. IT, Phones, Facilities) are charged directly to grants, when applicable, and are not part of the County indirect rates. Indirect rates are not applied to County General Fund expenditures.

As a local government, these rates are not negotiated with DHHS. A letter of exemption from the cognizant federal agency, Department of Health and Human Services, is attached to the application. These rates are, however, subject to audit.

E. EMPLOYEE COSTS

Base Pay

General staff positions (clerical assistant, health assistant, nutritionist, hygienist, etc.) are represented by the American Federation of State, County and Municipal Employees (AFSCME Local 88). Nursing staff are represented by the Oregon Nurses Association (ONA). Physicians have joined AFSCME and they are represented by Local 88. Rates of pay for these groups are determined through collective bargaining.

Dentists and managerial employees are not represented. Pay increases are awarded through local ordinance, enacted by the Board of County Commissioners.

Fringe Benefits

Employees assigned to these programs receive the same benefit package as County employees in general. Benefits costs consist of three components:

- **Salary Related Expenses** are budgeted at 39.52% of the base pay. This includes PERS retirement (23.46%), PERS Bond (7.65%), FICA (7.65%), and Tri-Met transit tax (0.76%). PERS retirement for employees hired after August '03 is (16.74%) with a total expense of 32.80% of base pay.
- **Salary-Related Insurance Benefits** are budgeted at 6.85% of the base pay. This includes workers compensation insurance (0.50%), liability insurance (2.25%), unemployment insurance (0.25%), long term disability insurance (0.75%), retiree medical insurance (2.0%), and benefits administration (1.10%).
- **Flat-Rate Insurance Benefits** are budgeted at $16,614 for full-time employees (0.8 – 1.0 FTE). For Local 88 three-quarter time employees, it is $12,614 and $9,483 for other part-time employees (0.5 FTE – 0.79 FTE). This covers medical and dental insurance, life insurance (non-represented employees only), and health promotion. Employees have a health insurance co-payment that varies depending on the type of coverage and family size.

F. PROJECT REVENUES

Schedule of State, Local, and Other Funding

1-	**Other Federal Grants (Income Analysis – Form 3)**	**3,574,352**
	Other Federal Ryan White I	**1,293,679**
	Other Federal Healthy Start	**892,500**

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	Other Federal Ryan White IIIb - Early Intervention	**811,628**
	Other Federal Ryan White IV AIDS Healthcare	**368,765**
	Other Federal Community MH Block Grant	**182,780**
	Other Federal Maternal Infant Early Childhood Home Visit	**25,000**
2-	**State (Income Analysis – Form 3)**	**5,437,807**
	State MH Grant	**2,733,346**
	State School Based Clinics	**766,648**
	State FFS Insurance Rcpts	**659,431**
	State OR Department of Education- Youth Development Division	**396,697**
	State Oregon Youth Authority	**234,711**
	State Oregon Health Authority Ryan White	**115,006**
	State Child & Adolescent	**100,000**
	State OHA HIV Care Assistance	**98,601**
	State Babies First	**88,802**
	State Family Planning	**87,588**
	State Refugee Screening	**85,000**
	State AIDS Drug Assistance Program/CareAssist	**58,477**
	State Vocational Rehab - Early Assessment & Support Alliance	**13,500**
3-	**Local Government (Income Analysis – Form 3)**	**421,339**
	School-Based MH Expansion - PPS SUN Comm	**177,010**
	Portland Public School - Head Start	**146,829**
	School-Based MH Expansion - Centennial	**75,000**
	School-Based MH Expansion - Parkrose	**22,500**
4-	**Private Grants (Income Analysis – Form 3)**	**529,603**
	Gilead FOCUS	**293,010**
	CareOregon Dental PC Coordination	**142,070**
	Local UW AIDS Educ Training Center	**81,400**
	OHSU HIV Counseling - Russell St.	**13,123**
5-	**Other Medicaid/Medicare (Income Analysis – Form 3)**	**42,932,511**
	Other Medicare Pharmacy FFS	**15,836,447**
	Other Medicaid Pharmacy FFS - CareOregon	**12,251,104**
	Other Medicaid Quality & Incentive Pay - CareOregon	**8,418,534**
	Other Child Mental Health Services	**5,480,760**
	Other Medicaid Pharmacy FFS	**682,114**
	Other Patient Fees Pharmacy	**263,552**
6-	**Applicant - CGF (Income Analysis - Form 3)**	**8,519,742**

County General Fund (Applicant Funding)

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The Portland metropolitan economy remains remarkably strong, growing above its historical growth rate since mid-2012. As of December 2017, the 3.7% unemployment rate in Multnomah County was at historical lows. At the state level, Oregon's unemployment rate matched the U.S. rate at 4.1% in January.

Property tax is the single largest discretionary source of revenue in the General Fund, accounting for 60% of ongoing revenues. General Fund growth, therefore, is particularly sensitive to taxable value growth and compression. The FY 2019 budget assumes the following rates of growth (as measured from the FY 2018 Adopted budget) for each revenue source:

• Property Tax – An increase of 4.4%
• Business Income Tax – An increase of 0.6%
• Motor Vehicle Rental Tax – A decrease of 0.4%
• Recording Fees/CAFFA Grant – A decrease of 7.1%
• US Marshal Jail Bed Rental – An increase of 6.2%

Total direct resources, or "revenues," for FY 2019 are $1.70 billion vs. $1.73 billion in FY 2018 (excluding service reimbursements and cash transfers between funds). Intergovernmental revenues are the County's single largest revenue category at $602.5 million or 35.4%. This reflects a $54.4 million or 9.9% increase from FY 2018.

Taxes constitute the next largest revenue source (28.2%) and include property tax, business income tax, motor vehicle rental tax, transient lodging tax, and county gas tax. For FY 2019, tax collections are anticipated to increase 2.6% from $466.7 million in FY 2018 to $478.9 million.

The County's General Fund expenditures are forecast to grow at roughly 4.2% to 4.9% annually through FY 2023, a rate of growth that takes into account inflation, employee compensation, and long-term fixed costs. Department expenditures for all funds, excluding cash transfers, contingencies, and unappropriated balances, total $1.88 billion in FY 2019 vs. $1.86 billion in FY 2018.

Other Healthcare Funding

Multnomah County has joined with hospital systems, health plans, and Clackamas and Washington Counties to initiate CCO formation. This partnership, titled Health Share of Oregon (HSO), launched services as a CCO on September 1, 2012. Care Oregon operates under the umbrella of this new HSO. In addition to HSO, an existing managed care plan called Family Care, Inc. began operating as a CCO on August 1, 2012. Family Care, Inc ceased Medicaid operations in February 2018.

MCHD is a central part of both HSO. HSO operates on a global budget with the goal to create a regionally integrated, patient-centered, community care system that improves quality, cost, and health status for high-cost/high-acuity Medicaid and dual-eligible adults.

Multnomah County serves a large number of Care Oregon clients. Care Oregon is a non-profit, health plan that serve State of Oregon Health Plan clients. The County is Care Oregon's largest primary care provider. Services provided to Care Oregon clients are reimbursed on a fee-for-service basis. In Nov 2017, Providence Health Plan started assigning medicaid clients to Multnomah County Health Department.

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In addition to creating CCOs, Oregon is also implementing health insurance reforms. Beginning October 1, 2013, uninsured and underinsured Oregon residents started applying for Oregon Health Plan (OHP) and other affordable insurance options through a State-run insurance exchange called Cover Oregon. Cover Oregon is an online marketplace. OHP/Medicaid eligibility expanded from 110% FPL to 138% FPL based on ACA recommendations. Insurance premium tax credits will provide significant subsidies for the cost of insurance for persons with incomes below 400% FPL. Coverage from Cover Oregon insurance plans started on January 1, 2014.

Starting October 1, 2014, Multnomah County Health Department joined a pilot program in Oregon called Alternative Payment Method (APM). Under this method, the Department is paid a monthly rate per assigned Primary Care members. Dental Services are not part of this pilot program and continue to receive FQHC reimbursement rate for eligible visits.

The APM rate applies to Care Oregon and Providence assigned clients. In FY 2018, the number of Care Oregon clients assigned to Multnomah County averaged 30,293 clients per month. The number of Providence clients assigned to the Health Department averaged 4,482 clients per month.

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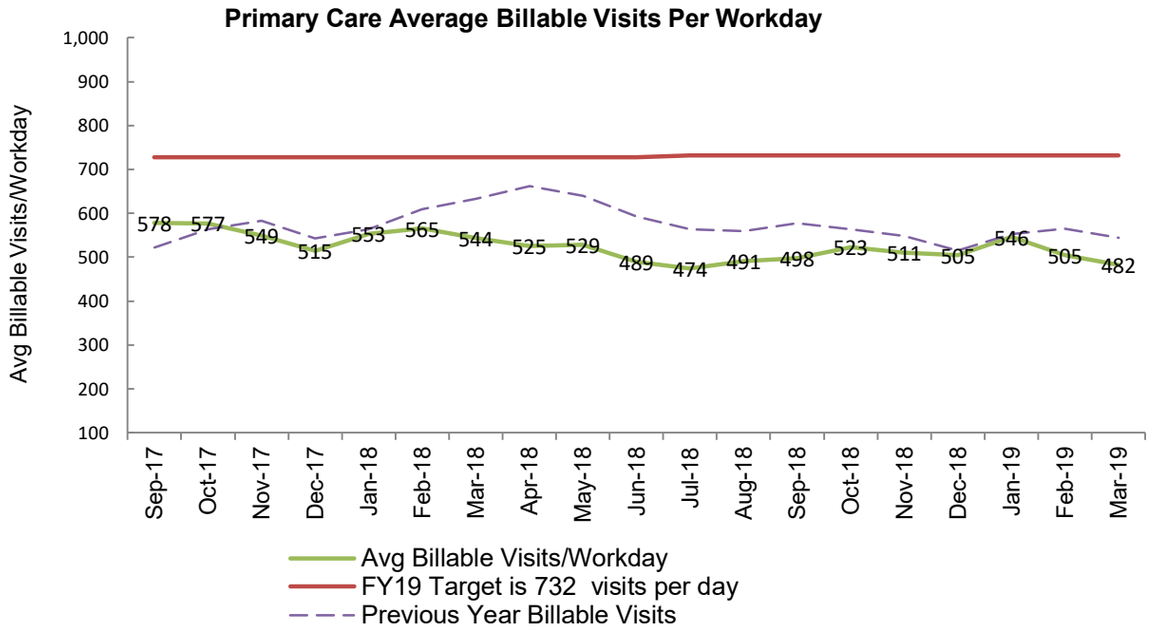
Multnomah County - Federally Qualified Health Center

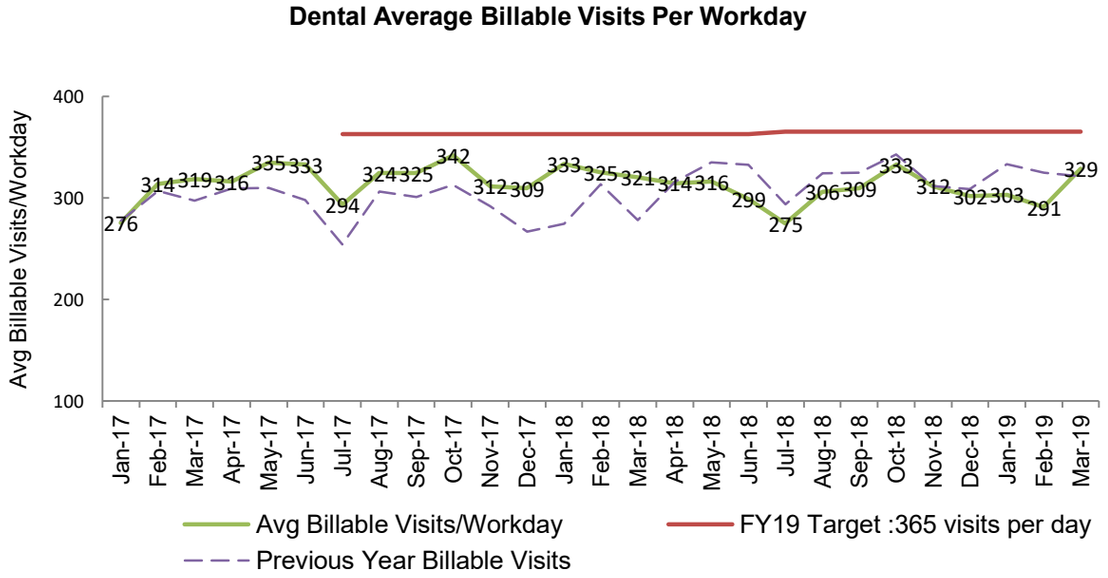
Monthly Dashboard

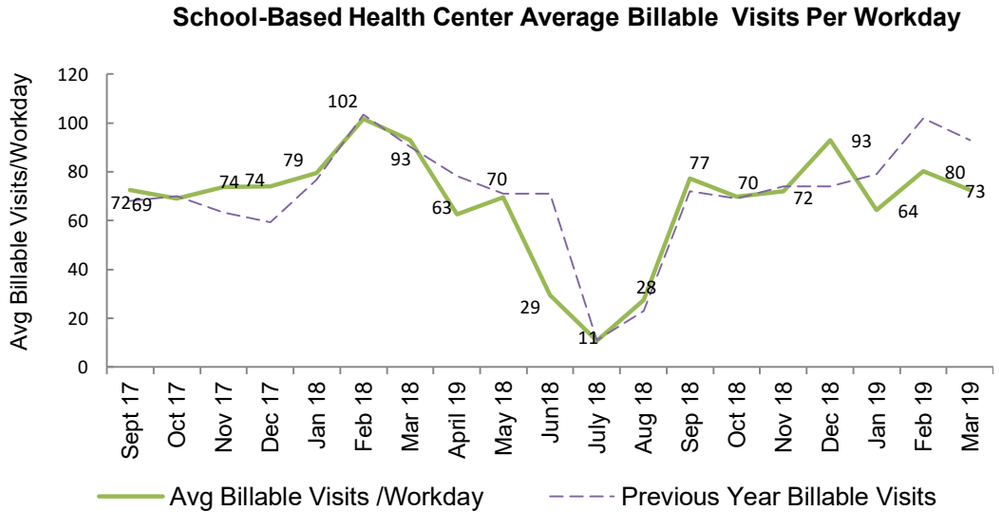
March 2019

Prepared by: Larry Mingo

FQHC Weekly Billable Visits Per Department



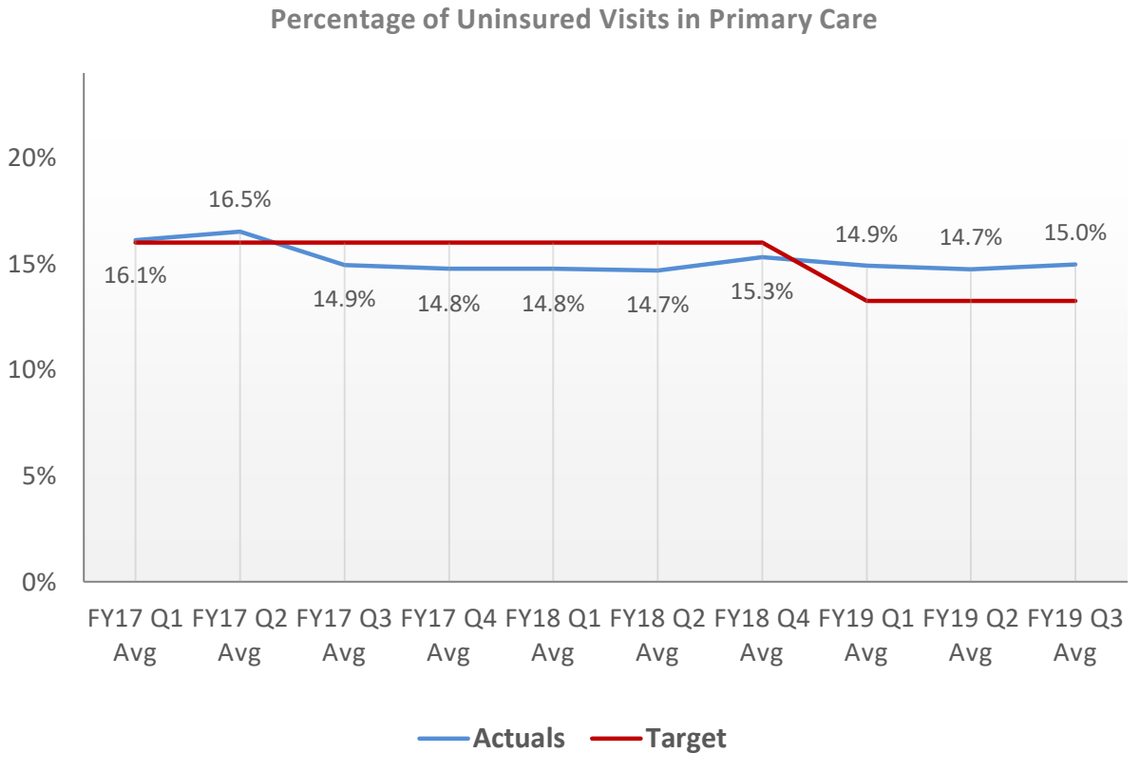


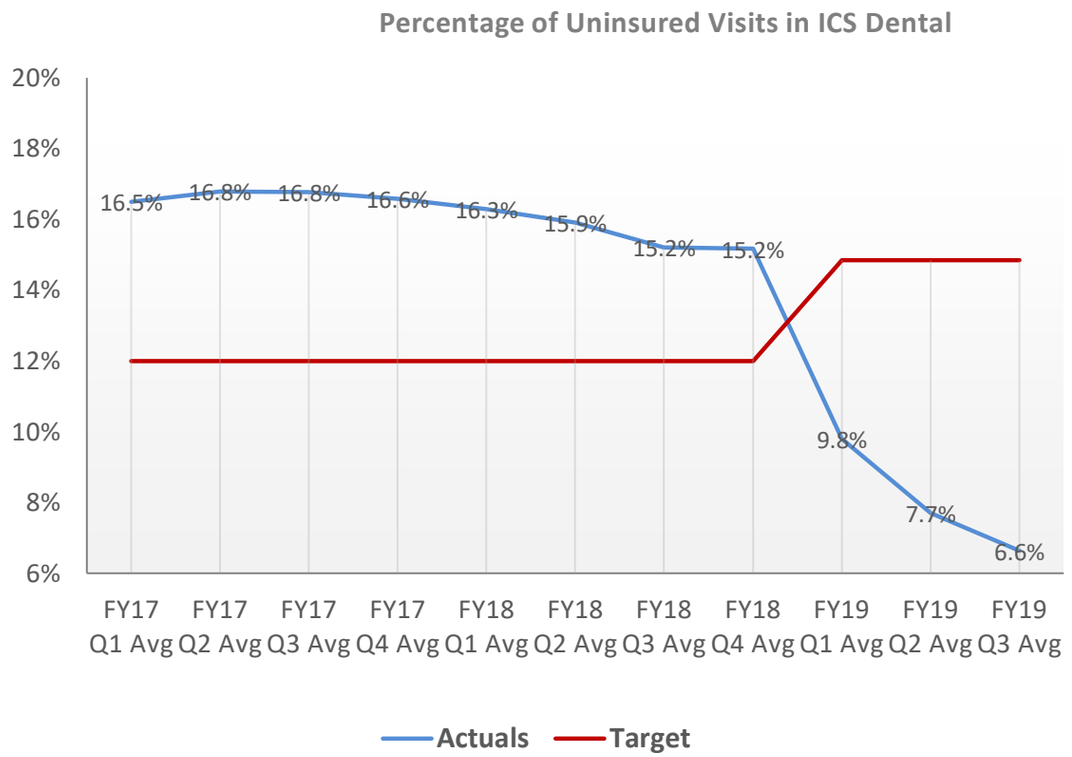


* SBHC clinics are closed during the month July except Parkrose SBHC

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.

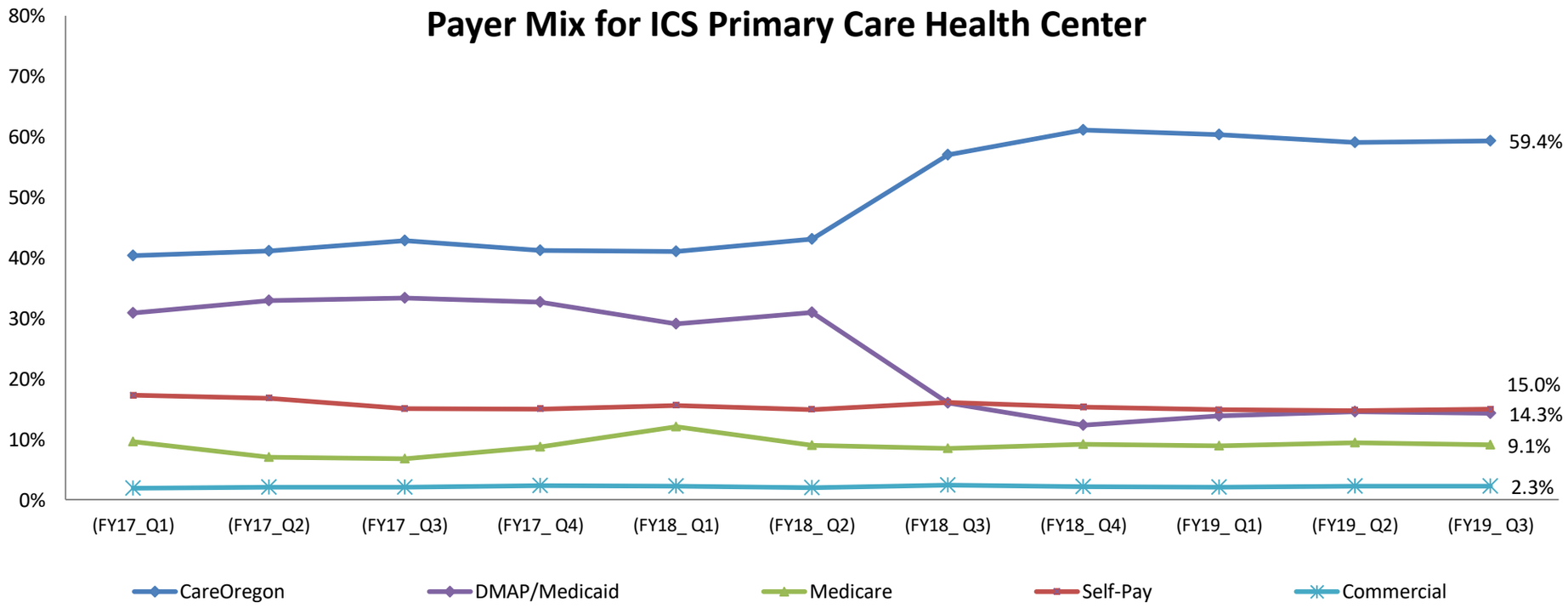
Monthly Percentage of Uninsured Visits for FQHC Centers





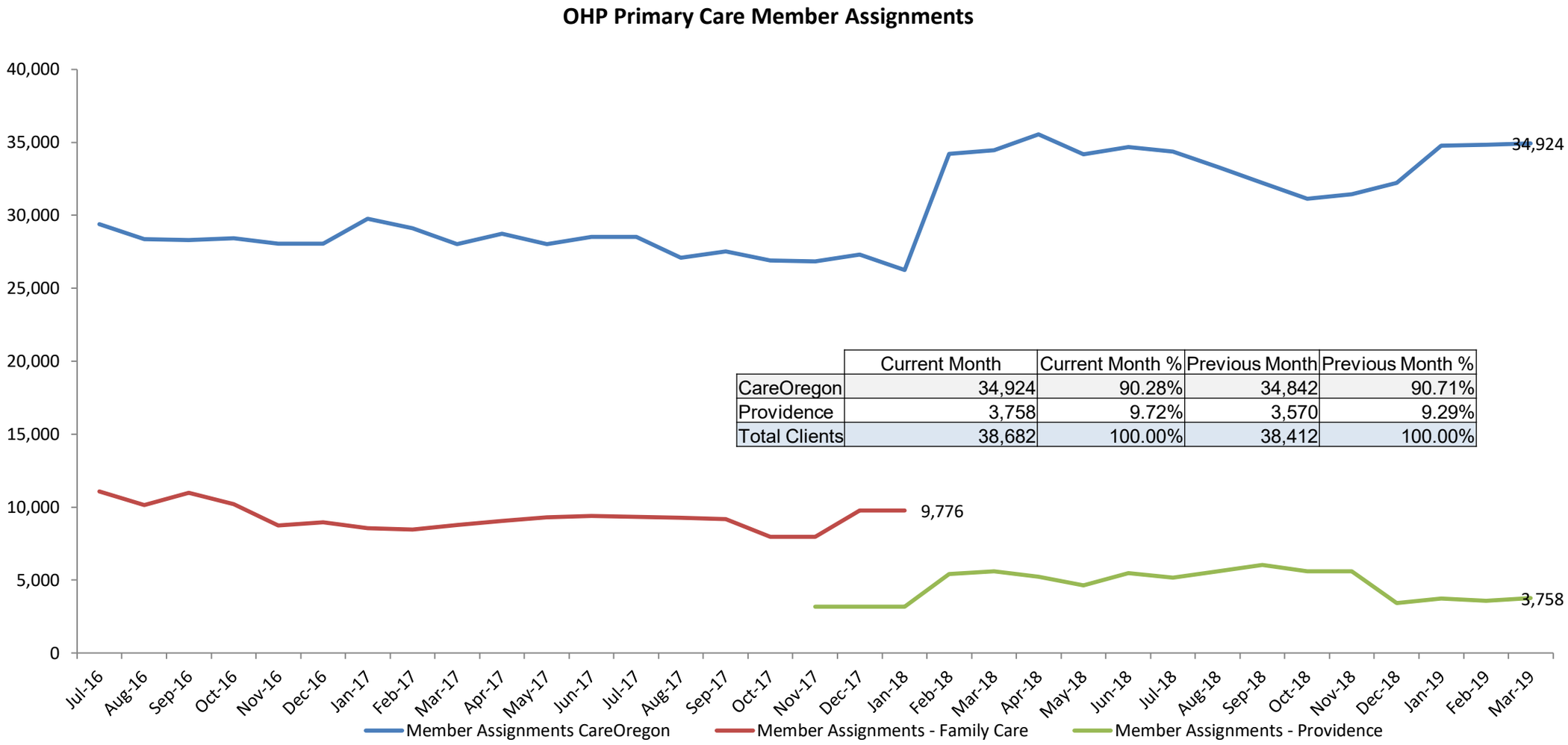
Comments:
Primary Care target % of Uninsured Visits for FY18: 16%; for FY19: 13.25%
Dental target % of Uninsured Visits for FY18: 12%; for FY19: 14.85%

FQHC Monthly Percentage of Visits by Payer for ICS Primary Care Health Centers



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

FQHC Primary Care Member Assignments



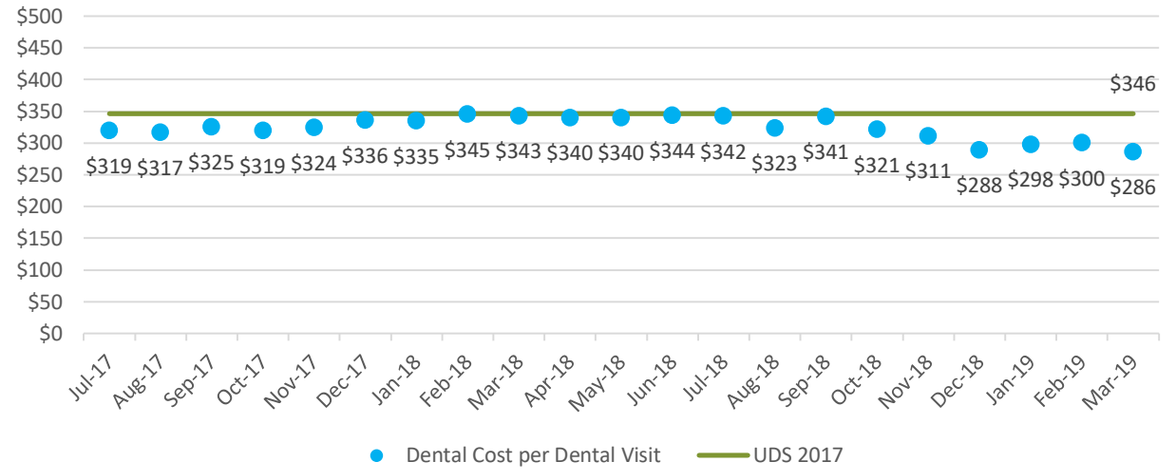
	Current Month	Current Month %	Previous Month	Previous Month %
CareOregon	34,924	90.28%	34,842	90.71%
Providence	3,758	9.72%	3,570	9.29%
Total Clients	38,682	100.00%	38,412	100.00%

CareOregon FY19 average: 33,245

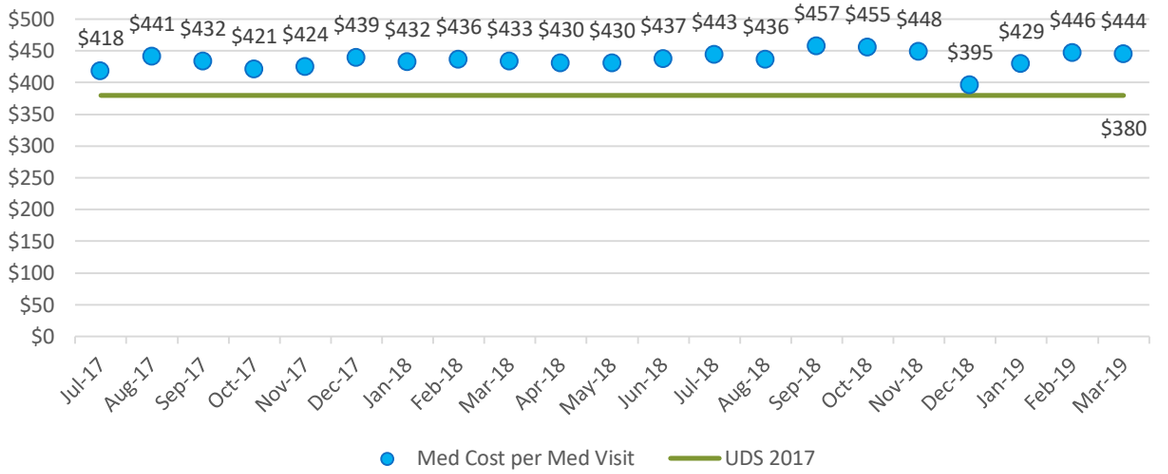
Providence FY19 average: 4,721

Key UDS Indicators
Jul 2017 – Mar 2019

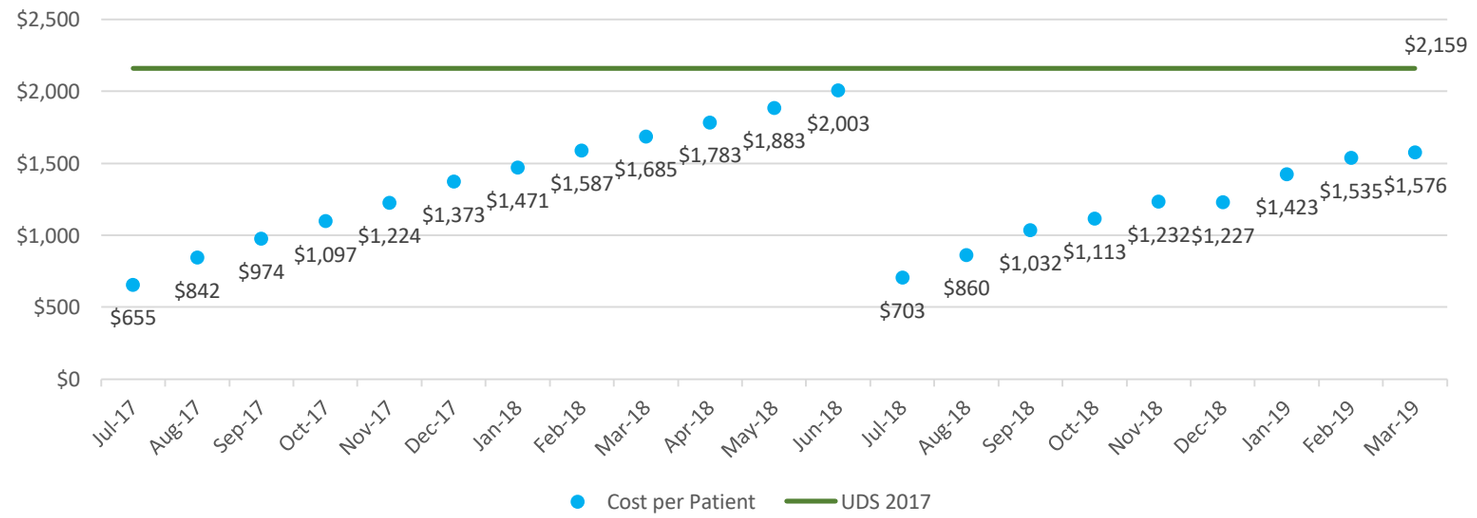
Dental Cost Per Dental Visit



Med Cost per Med Visit

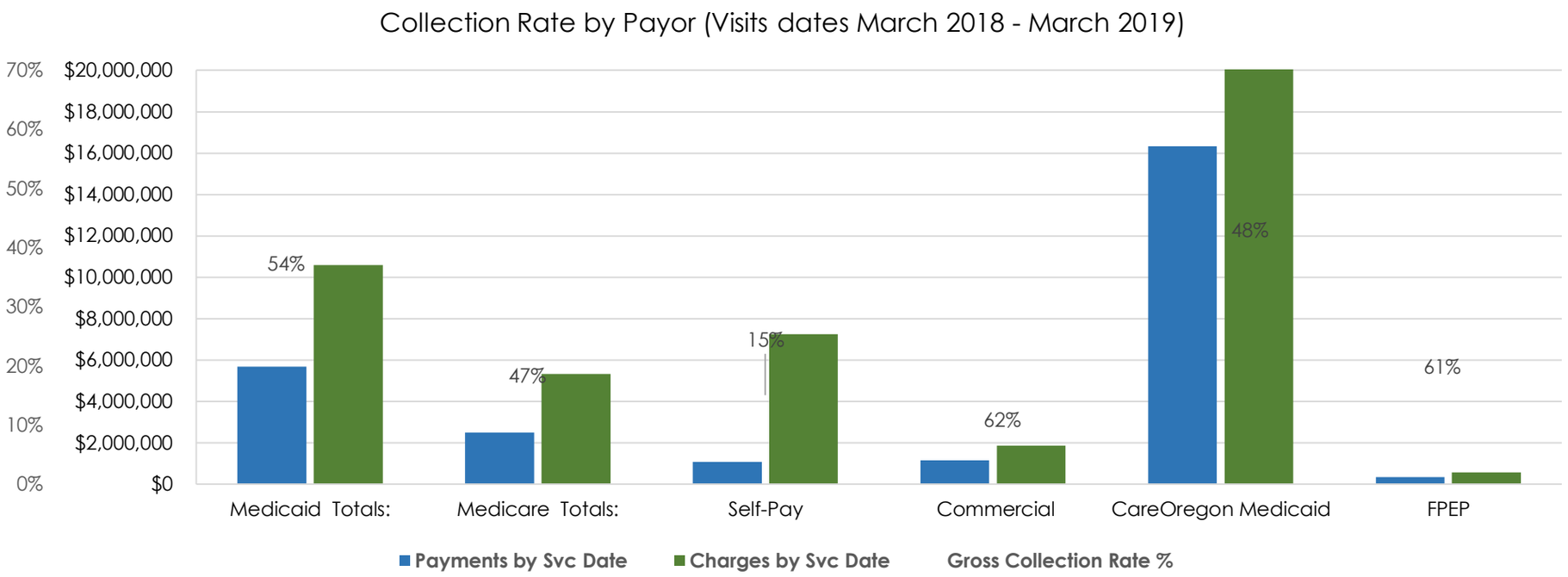


Cost Per Patient



FQHC Gross Collection Rate by Payer
March 2018 – March 2019

	Medicaid Totals:	Medicare Totals:	Self-Pay	Commercial	CareOregon Medicaid	FPEP
Payments by Svc Date	$5,692,272	$2,498,318	$1,092,901	$1,150,215	$16,337,688	$345,604
Charges by Svc Date	$10,587,936	$5,323,355	$7,242,186	$1,856,706	$34,326,767	$570,184
Gross Collection Rate %	54%	47%	15%	62%	48%	61%



Multnomah County Health Department
Federally Qualified Health Center Financial Statement
For Period Ending March 2019

Community Health Centers - Page 1

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

Behavioral Health:

General Fund: The general fund is the primary operating fund for the County, and is used to account for and report all financial resources not accounted for and reported in another fund. All County departments have some part of their operations either reported in or supported by the general fund.

Grants – BPHC: The Bureau of Primary Health Care grant revenue is isolated here. This grant is sometimes known as the Primary Care 330 (PC 330) grant.

Grants – Incentives: External agreements that are determined by meeting certain metrics.

Grants – All Other:

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

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

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

Personnel: Costs of salaries and benefits.

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

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

Community Health Centers - Page 2

Internal Services

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

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

Community Health Centers - Page 3

March Target: 75%

	Adopted Budget	Revised Budget	Budget Variance	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18
Revenue									
Behavioral Health	$ 5,394,614	$ 5,394,614	$ -	$ 395,899	$ 395,357	$ 386,929	$ 392,315	$ 315,304	$ 239,775
General Fund	$ 10,510,645	$ 10,497,645	$ (13,000)	$ 880,918	$ 882,684	$ 992,021	$ 924,144	$ 894,914	$ 996,625
Grants - BPHC	$ 9,967,847	$ 9,967,847	$ -	$ -	$ -	$ 1,710,117	$ 781,367	$ 935,417	$ 865,926
Grants - Incentives	$ 7,326,480	$ 7,326,480	$ -	$ -	$ 1,068,109	$ 2,340,693	$ 498,640	$ 1,500	$ 4,354,540
Grants - All Other	$ 9,392,798	$ 9,415,223	$ 22,425	$ 384,509	$ 370,555	$ 862,642	$ 1,015,074	$ 620,246	$ 995,304
Health Center Fees	$ 96,332,757	$ 96,332,757	$ -	$ 7,807,405	$ 9,042,004	$ 8,052,219	$ 7,717,611	$ 9,970,501	$ 5,744,877
Self Pay Client Fees	$ 1,127,294	$ 1,127,294	$ -	$ 86,553	$ 100,907	$ 76,035	$ 105,026	$ 98,354	$ 87,054
Total	$ 140,052,435	$ 140,061,860	$ 9,425	$ 9,555,284	$ 11,859,615	$ 14,420,656	$ 11,434,177	$ 12,836,236	$ 13,284,101
Expense									
Personnel	$ 94,202,326	$ 94,257,953	$ 55,627	$ 7,027,910	$ 7,335,971	$ 7,174,182	$ 8,172,851	$ 8,042,358	$ 7,623,316
Contracts	$ 4,994,483	$ 4,952,788	$ (41,695)	$ 234,197	$ 178,587	$ 897,067	$ 217,171	$ 762,433	$ (74,025)
Materials and Services	$ 13,978,032	$ 13,973,151	$ (4,881)	$ 1,065,843	$ 1,191,908	$ 1,327,446	$ 1,512,088	$ 1,558,757	$ 861,177
Internal Services	$ 26,381,694	$ 26,382,068	$ 374	$ 1,167,854	$ 2,089,623	$ 2,117,172	$ 2,425,022	$ 2,054,471	$ 2,095,802
Capital Outlay	$ 495,900	$ 495,900	$ -	$ -	$ -	$ 17,730	$ 10,116	$ -	$ -
Total	$ 140,052,435	$ 140,061,860	$ 9,425	$ 9,495,803	$ 10,796,090	$ 11,533,597	$ 12,337,248	$ 12,418,019	$ 10,506,270
Surplus/(Deficit)	$ -	$ -	$ -	$ 59,481	$ 1,063,526	$ 2,887,058	$ (903,071)	$ 418,217	$ 2,777,831

Note: Financial Statement for Fiscal Year 2019 (July 2018 - June 2019). Columns are blank/zero until the month is closed.

Community Health Centers - Page 4

March Target: 75%

	Adopted Budget	Revised Budget	Budget Variance	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Year to Date Total	% YTD
Revenue											
Behavioral Health	$ 5,394,614	$ 5,394,614	$ -	$ 370,276	$ 370,761	$ 289,214	$ -	$ -	$ -	$ 3,155,830	58%
General Fund	$ 10,510,645	$ 10,497,645	$ (13,000)	$ 1,013,762	$ 1,021,983	$ 877,232	$ -	$ -	$ -	$ 8,484,283	81%
Grants - BPHC	$ 9,967,847	$ 9,967,847	$ -	$ 797,522	$ 482,291	$ 887,434	$ -	$ -	$ -	$ 6,460,074	65%
Grants - Incentives	$ 7,326,480	$ 7,326,480	$ -	$ 88,722	$ 56,797	$ 164,067	$ -	$ -	$ -	$ 8,573,067	117%
Grants - All Other	$ 9,392,798	$ 9,415,223	$ 22,425	$ 512,554	$ 915,062	$ 937,668	$ -	$ -	$ -	$ 6,613,614	70%
Health Center Fees	$ 96,332,757	$ 96,332,757	$ -	$ 9,078,057	$ 6,345,850	$ 8,515,158	$ -	$ -	$ -	$ 72,273,682	75%
Self Pay Client Fees	$ 1,127,294	$ 1,127,294	$ -	$ 94,935	$ 72,148	$ 84,277	$ -	$ -	$ -	$ 805,288	71%
Total	$ 140,052,435	$ 140,061,860	$ 9,425	$ 11,955,828	$ 9,264,892	$ 11,755,050	$ -	$ -	$ -	$ 106,365,839	76%
Expense											
Personnel	$ 94,202,326	$ 94,257,953	$ 55,627	$ 7,811,373	$ 7,174,182	$ 7,258,404	$ -	$ -	$ -	$ 67,620,546	72%
Contracts	$ 4,994,483	$ 4,952,788	$ (41,695)	$ 359,308	$ 401,713	$ 513,048	$ -	$ -	$ -	$ 3,489,499	70%
Materials and Services	$ 13,978,032	$ 13,973,151	$ (4,881)	$ 1,698,999	$ 1,258,877	$ 1,602,225	$ -	$ -	$ -	$ 12,077,320	86%
Internal Services	$ 26,381,694	$ 26,382,068	$ 374	$ 1,704,422	$ 2,101,871	$ 2,101,509	$ -	$ -	$ -	$ 17,857,746	68%
Capital Outlay	$ 495,900	$ 495,900	$ -	$ -	$ 5,303	$ -	$ -	$ -	$ -	$ 33,149	7%
Total	$ 140,052,435	$ 140,061,860	$ 9,425	$ 11,574,102	$ 10,941,946	$ 11,475,186	$ -	$ -	$ -	$ 101,078,261	72%
Surplus/(Deficit)	$ -	$ -	$ -	$ 381,726	$ (1,677,054)	$ 279,864	$ -	$ -	$ -	$ 5,287,578	

Note: Financial Statement for Fiscal Year 2019 (July 2018 - June 2019). Columns are blank/zero until the month is closed.

Multnomah County Health Department

Multnomah County Health Department
Integrated Clinical Services (ICS)
2019 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 and Workplan
- 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 Commision

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 2019 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.

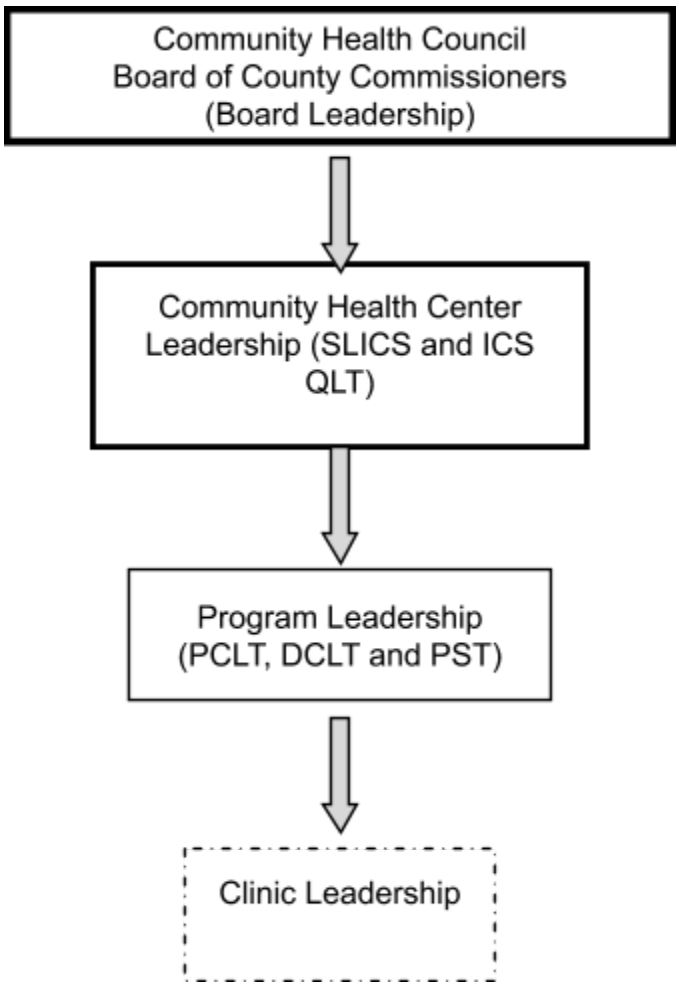
3. **Clinical Systems Information / Health Information Services:** Clinical Systems Information includes information technology infrastructure, hardware and software applications, and support. Health Information Services encompasses the practices and policies to ensure client/patient confidentiality,

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 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
- Quality Committee: At least quarterly

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
- Interim Primary Care Clinical Deputy Director

The Integrated Clinical Services Quality Leadership Team (ICS QLT) provides a forum for coordinated decision-making and implementation of quality across ICS. 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 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 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

- Interim Primary Care Clinical Deputy Director

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 the operations leaders from each dental care site. This team reviews productivity, and revenue, metrics status, and decides service delivery changes, project implementation, and plans initiative roll-outs. DCLT also reviews personnel in clinics to collaborate on how best to improve co-worker relations for a healthy and safe environment for all. 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
- Discuss personnel and other HR matters related to providers

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
- 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 Committee

The Quality Committee meets at least monthly and is responsible for reviewing quality initiative proposals which fall within the scope of the health center. The Quality committee will prioritize proposals/projects, commit resources, and will confirm deliverables and criteria for project end.

The committee is responsible for monitoring progress on initiatives, identifying key measures, creating and maintaining the Health Center Quality Work Plan and facilitating communication between quality staff, leadership and board.

Membership includes:

- ICS Quality Director
- Primary Care Operations Manager
- ICS Deputy Director
- Dental Manager
- Pharmacy Director
- HSRA Advisor

- Representation from the Medial Director's office
- Project Management Office (PMO) Supervisor
- Clinical Systems Information (CSI) Manager

Ad-hoc Members include:

- Integrated Clinical Services Director
- Primary Care Director
- Medical Director
- Dental Director
- Privacy Manager

Community Health Council (CHC) Quality Committee

The CHC Quality Committee meets at least quarterly and is responsible for defining, prioritizing, overseeing and monitoring the Health Center's performance improvement activities, including patient and environmental safety. The primary duties of the CHC Quality Committee include analyzing aggregate quality performance data, monitoring performance improvement efforts for effectiveness, and patient safety. The Quality Committee partners with Health Center leadership on developing the draft Annual Quality Plan for review and approval by the full board.

Membership includes:

- Up to three CHC Board Members

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

<u>Patient Satisfaction</u>

The Client Feedback and Awareness Program collects feedback through phone-based surveys, feedback provided by Care Oregon, 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 with in 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, analysis 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 2019/2020

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 2019. 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.	Improve culturally responsive care within patient interactions and delivery Increase EHR MyChart enrollment by 5% from .	• Annual survey to assess improved culturally responsive service delivery. • Current average is 21%. Goal it is to increase to 26%.
Dental	Engaged patients will experience improved health care and have increased satisfaction.	Increase patient satisfaction scores by 5% in 2019 patient satisfaction survey for questions asked Trainings to providers and clinics to increase scores when consistent shortcomings are identified.	Measurement will be conducted to: • 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	Providing high quality patient services that are	MCHD clients are surveyed for client satisfaction.

	pharmacies due to expected high level quality of care and customer service.	meaningful and viewed as helpful by the client.	Targeted measures: ● Pharmacy staff providing desired and useful information in an understandable way at >90%.
Disease Management			
	Goals	**Objectives**	**Measurements**
Medical	Clients will attain the best quality of life supported by their health care team.	Provide patient centered care utilizing all members of the care team to simplify disease management and promote preventive care outreach and management.	50% of the teams in each clinic will utilize team specific clinical performance dashboards to drive local improvement for processes and health outcomes. 100% of all nurses will utilize the new Diabetes Education Program.
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 50% treatment plans completed within a 12 month period Opioid prescribing will be maintained at 2018 levels (approximately 1000 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 defined by HealthShare. The 2019 Goals are: ● 71% of patients have controlled blood pressure in the past 12 months ● <23.1% of patients have A1C of 9% (lower is better)

2019 Work Plan

Patient Services			
	Objectives	**Activities**	**Timeline**
Medical	Improve culturally responsive care within patient interactions and delivery	Monthly cultural spotlight developed by the Health Equity/ Health Promotion Specialist in order to inform all primary care staff about the unique cultural needs of our patients. This information will also be aligned with the metrics monthly review.	First cultural spotlight will be shared with staff in April 2019 and monthly Thereafter.
	Increase EHR MyChart enrollment by 5%.	Outreach and lobby engagement with patients for	Outreach is taking place throughout the year. On site

		My Chart education and enrollment Bi-annually to patients.	engagement will occur June-Aug 2019
Dental	Increase patient satisfaction scores by 5%..	SBAR crafted for all staff to implement 4 specific activities to address PSS shortfalls (ie...specific questions to ask patients, visual aids during care)	Training of staff February, March, and April 2019 by Dental Director, and on site clinic leadership, and resurveying patients in May and June 2019 to review corrective action plan
Pharmacy	Improve Patient Pharmacy Experience through improved Pharmacy Software	Implementation of Pharmacy Software Management System	Implementation in Late Summer through Fall of 2019
	Improve Patient Pharmacy Experience through evaluation of feedback	Develop and Implement Pharmacy Specific Feedback Process for Patients/Clients of the Pharmacy	The Pharmacy Quality Committee will develop a Patient Feedback comment card available at the Pharmacy. Development Timeline January 2019 to August 2019. The Pharmacy Quality Committee will review Patient Feedback on an every other month basis from comment cards provided at the Pharmacy window and provide

			recommendations of suggested improvements to Leadership.
	MCHD health clinic clients choose in-house MCHD pharmacies	Providing high quality patient services that are meaningful and viewed as helpful by the client.	Pharmacy satisfaction survey completed in collaboration with ICS Quality Team on a yearly basis (Targeted measures: ● of pharmacy staff providing desired and useful information in an understandable way at >90%.
Disease Management			
	Objectives	**Activities**	**Timeline**
Medical	Improve diabetic and hypertension disease management for clients - Hypertension control - Diabetic Control	Outreach to clients who are due for a diabetes follow-up visit and lab work Review of DM lists at team meeting monthly to determine client centered needs to achieve glycemic control Referral to Diabetes Education Management Program for all appropriate clients with A1C >9	On a monthly basis- Preventative Care Medical Assistants to review lists of diabetics due for follow up visit and lab work, outreach and schedule clients who are due. At every visit blood pressure checked, if high MA will recheck blood pressure and inform provider if consistently elevated, provider to

		Referral to Clinical Pharmacist for collaborative drug management for clients with uncontrolled diabetes and/or hypertension	address elevated BP. Review DM lists at team meetings monthly and determine plan for 4-6 patients per month
	Improve preventative screening rate for all clients in the following areas - Colorectal cancer screening - Tobacco use and cessation - Depression screening	Review clinic performance rates of colorectal cancer screening, tobacco use and cessation, and depression screening and follow-up	On a monthly basis clinic care teams will review performance rates of colorectal cancer screening, tobacco use and cessation, and depression screening and follow-up Teams will develop a team-level PDSA and track their performance and adjust their PDSA depending on the results.
Dental	Emphasize Treatment completion	Using current dashboards to emphasize TC goals of 50% for all providers, and reiterating with staff monthly via staff meetings and email	Evaluate effectiveness of TC during bimonthly staff meetings, and at annual all staff meeting
	Recommend using non opioid alternatives for acute pain	Amend scheduled meds policy to require dentists to access statewide prescription monitoring program for every opioid prescribed, and	Ongoing, will evaluate the success of prescribing quarterly

		increase documentation required when prescribing	
Pharmacy	**Improve Disease management-Hypertension**	Clinical Pharmacist Collaborative Drug Therapy Management (CDTM)- the participation by a practitioner and a pharmacist in the management of drug therapy	Ongoing
	Improve Disease management-Type II Diabetes Mellitus	Clinical Pharmacist CDTM	Ongoing
	Improve Disease management-Hyperlipidemia & ASCVD Risk Reduction	Clinical Pharmacist CDTM	Ongoing
	Improve Disease management-Chronic Obstructive Pulmonary Disease (COPD)	Clinical Pharmacist CDTM	Ongoing

Review and Approval Tracking

Quality Management Plan-2019/2020

Community Health Council ● 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) ● Reviewed and approved annually ● Record of approval in meeting minutes	
Approval by SLICS (represented by ICS Director):	**Signature and Date:**

Title:	**Health Resources & Services Administration Consolidated Appropriations Act and Legislative Mandate Review Policy**		
Policy #:	ICS.01.##		
Section:	Integrated Clinical Services	Chapter:	**General**
Approval Date:		Approved by:	Vanetta Abdellatif, MPH ICS Director Tara Marshall, Chair, Community Health Council
Related Procedure(s):	Not Applicable		
Related Standing Order(s):	Not Applicable		
Applies to:	All programs and staff supported by the Consolidated Appropriations Act under the Community Health Center program		

PURPOSE

Multnomah County's Community Health Center is committed to high standards and compliance with all applicable laws and regulations. The purpose of this policy is to outline the requirements and adherence of the Multnomah County Community Health Center to the Consolidated Appropriations Act(s) and related applicable laws and regulations.

DEFINITIONS

Term	Definition
Co-Applicant Board	When the public agency's board cannot independently meet all applicable health center governance requirements, a separate "co-applicant" must be established whose governing board meets Public Health Service Act (PHS) section governance 330 requirements. The Health Department's Community Health Council (CHC) is the Co-Applicant Board for the Integrated Clinical Service's (ICS) Community Health Centers.
HRSA	The Health Resources and Services Administration. As a federally qualified health center (FQHC) and recipient of federal funds, ICS and the CHC must meet all HRSA Health Center Program Requirements.

Public Agency Status	HRSA's designation for health centers funded through a section 330 grant which include state, county, or local health departments. ICS Community Health Centers have a Public Agency Status.
Public Center	Defined by the Health Center Program's authorizing statute as a health center funded through a section of 330 grant to a public agency.
Consolidated Appropriations Act(s)	Defined as the most recent federal appropriations spending bill (omnibus) which provides designated funding for the Health Resources and Services Administration.
Legislative Mandate Review	A process to assure that grant funding requirements, restrictions, and permissions are only used to support approved funding activities.

POLICY STATEMENT

It is the policy of the Multnomah County Community Health Center (Federally Qualified Health Center) to comply with all applicable laws and regulations, including the Consolidated Appropriations Act(s) and associated legislative mandates. This policy supersedes provisions in any Community Health Center policy which may be in conflict with this policy.

In accordance with the requirements of the Consolidated Appropriations Act(s), grant funding received by the Community Health Center under the Health Resources and Services Administration Bureau of Primary Health Care from the most recently appropriated Consolidated Appropriations Act(s) will follow the below requirements:

1. Salary Limitation: None of the funds shall be used to pay the salary of an individual, through a grant or other extramural mechanism, at a rate in excess of Executive Level II of the Federal Executive pay scale.

2. Gun Control: None of the funds may be used, in whole or in part, to advocate or promote gun control.

3. Anti-Lobbying:

    a. No part of the funds including those transferred pursuant to section 4002 of Public Law 111-148 will be used, other than for normal and recognized executive legislative relationships, for publicity or propaganda purposes, for the preparation, distribution, or use of any kit, pamphlet, booklet, publication, electronic communication, radio, television, or video presentation designed to support or defeat the enactment of legislation before Congress or any State or

local legislature or legislative body, except in presentation to Congress or any State or local legislature itself, or designed to support or defeat any proposed or pending regulation, administrative action, or order issued by the executive branch of any State or local government itself.

b. No part of the funds or transferred pursuant to section 4002 of Public Law 111–148 shall be used to pay the salary or expenses of any grant or contract recipient, or agent acting for such recipient, related to any activity designed to influence the enactment of legislation, appropriations, regulation, administrative action, or Executive order proposed or pending before the Congress or any State government, State legislature or local legislature or legislative body, other than for normal and recognized executive-legislative relationships or participation by an agency or officer of a State, local or tribal government in policymaking and administrative processes within the executive branch of that government.

c. The prohibitions in subsections (a) and (b) shall include any activity to advocate or promote any proposed, pending or future Federal, State or local tax increase, or any proposed, pending, or future requirement or restriction on any legal consumer product, including its sale or marketing, including but not limited to the advocacy or promotion of gun control.

4. Acknowledgement of Federal Funding: When issuing statements, press releases, requests for proposals, bid solicitations and other documents describing projects or programs funded in whole or in part with Federal money, such documents shall clearly state – (1) the percentage of the total costs of the program or project which will be financed with Federal money; (2) the dollar amount of Federal funds for the project or program; and (3) percentage and dollar amount of the total costs of the project or program that will be financed by non-governmental sources.
5. Restriction on Abortions:
    a. None of the funds, and none of the funds in any trust fund to which funds are appropriated in this Act, shall be expended for any abortion;
    b. None of the funds, and none of the funds in any trust fund to which funds are appropriated in this Act, shall be expended for health benefits coverage that includes coverage of abortion;
    c. The term ‘‘health benefits coverage’’ means the package of services covered by a managed care provider or organization pursuant to a contract or other arrangement.
6. Exceptions to Restrictions on Abortions:
    a. The limitations established in the preceding section shall not apply to an abortion – (1) if the pregnancy is the result of an act of rape or incest; or (2) in the case where a woman suffers from a physical disorder, physical injury, or physical illness, including a life-endangering physical condition caused by or

arising from the pregnancy itself, that would, as certified by a physician, place the woman in danger of death unless an abortion is performed.

b. Nothing in the preceding section shall be construed as prohibiting the expenditure by a State, locality, entity, or private person of State, local, or private funds (other than a State's or locality's contribution of Medicaid matching funds).

c. Nothing in the preceding section shall be construed as restricting the ability of any managed care provider from offering abortion coverage or the ability of a State or locality to contract separately with such a provider for such coverage with State funds (other than a State's or locality's contribution of Medicaid matching funds).

d. (1) None of the funds may be made available to a Federal agency or program, or to a State or local government, if such agency, program, or government subjects any institutional or individual health care entity to discrimination on the basis that the health care entity does not provide, pay for, provide coverage of, or refer for abortions. (2) In this subsection, the term ''health care entity'' includes an individual physician or other health care professional, a hospital, a provider-sponsored organization, a health maintenance organization, a health insurance plan, or any other kind of health care facility, organization, or plan."

7. Ban on Funding Human Embryo Research:
    a. None of the funds made available in this Act may be used for – (1) the creation of a human embryo or embryos for research purposes; or (2) research in which a human embryo or embryos are destroyed, discarded, or knowingly subjected to risk of injury or death greater than that allowed for research on fetuses in utero under 45 CFR 46.204(b) and section 498(b) of the Public Health Service Act (42 U.S.C. 289g (b)).
    b. (b) For purposes of this section, the term ''human embryo or embryos'' includes any organism, not protected as a human subject under 45 CFR 46 as of the date of the enactment of this Act, that is derived by fertilization, parthenogenesis, cloning, or any other means from one or more human gametes or human diploid cells.

8. Limitation on the Use of Funds for the Promotion of Legalization of Controlled Substances:
    a. None of the funds may be used for any activity that promotes the legalization of any drug or other substance included in schedule I of the schedules of controlled substances established under section 202 of the Controlled Substances Act except for normal and recognized executive-congressional communications.
    b. The limitation in subsection (a) shall not apply when there is significant medical evidence of a therapeutic advantage to the use of such drug or other substance

or that federally sponsored clinical trials are being conducted to determine therapeutic advantage.

9. Restriction of Pornography on Computer Networks:
    a. None of the funds may be used to maintain or establish a computer network unless such network blocks the viewing, downloading, and exchanging of pornography.
    b. Nothing in subsection (a) shall limit the use of funds necessary for any federal, state, tribal, or local law enforcement agency or any other entity carrying out criminal investigations, prosecution, or adjudication activities.

10. Restriction on Funding ACORN: None of the funds may be provided to the Association of Community Organizations for Reform Now (ACORN), or any of its affiliates, subsidiaries, allied organizations, or successors.

11. Restriction on Distribution of Sterile Needles: No funds shall be used to purchase sterile needles or syringes for the hypodermic injection of any illegal drug: Provided, That such limitation does not apply to the use of funds for elements of a program other than making such purchases if the relevant State or local health department, in consultation with the Centers for Disease Control and Prevention, determines that the State or local jurisdiction, as applicable, is experiencing, or is at risk for, a significant increase in hepatitis infections or an HIV outbreak due to injection drug use, and such program is operating in accordance with State and local law.

12. Confidentiality Agreements:
    a. Multnomah County's Community Health Center shall not require its employees or contractors seeking to report fraud, waste, or abuse to sign internal confidentiality agreements or statements prohibiting or otherwise restricting such employees or contractors from lawfully reporting such waste, fraud, or abuse to a designated investigative or law enforcement representative of a Federal department or agency authorized to receive such information.
    b. The limitation in subsection (a) shall not contravene requirements applicable to Standard Form 312, Form 4414, or any other form issued by a Federal department or agency governing the nondisclosure of classified information.

Community Health Center administrative staff will review the Consolidated Appropriations Act at least once every 12 months. Required updates and changes to the policy will be presented to the Community Health Council for their review, at minimum, every three years. The Community Health Council will approve any updates and changes to the policy. If no changes are required to the policy, it will not be brought to the Community Health Council.

REFERENCES AND STANDARDS

Legislative Mandates in Grant Management for FY2019, Office of Federal Assistance Managements (OFAM), Division of Grants Policy (DGP)

H.R. 1625 - Consolidated Appropriations Act, 2018

PROCEDURES AND STANDING ORDERS

Not Applicable

RELATED DOCUMENTS

Name
Not Applicable.

POLICY REVIEW INFORMATION

Point of Contact:	Adrienne Daniels, Deputy Director, Integrated Clinical Services
Supersedes:	Not Applicable.

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: May 13, 2019	Program / Service Area: Health Center Program, Dental		
Presenters: Vanetta Abdellatif			
This funding will support:	□ Current Operations	□ Expanded services or capacity	X New services
Project Title and Brief Description: HRSA Oral Health Infrastructure grant ● HRSA has released an Oral Health Infrastructure funding opportunity that will provide one-time funding for infrastructure enhancements to provide new or enhance existing high quality, integrated oral health services in health centers. Infrastructure investments may include minor alteration and renovation, equipment purchases, health information technology, and training.			

- MCHD plans to submit an application to support minor alteration and renovations and purchase equipment to begin providing dental services at North Portland Health Center.
- The 2015 HRSA Health Infrastructure Investment Program grant allowed MCHD to renovate the North Portland Health Center, which included creating space for future provision of dental services through County General Fund match.

What need is this addressing?

- North Portland Health Center is one of only two MCHD health centers that does not offer co-located dental services (the other is La Clinica de Buena Salud).
- The closest current access point for dental services for patients at these two clinics is Northeast Health Center.
- Providing dental services at North Portland Health Center would accommodate patients in North/Northeast Portland, relieving some capacity at Northeast Health Center, creating a ripple effect of increased capacity across MCHD dental clinics.

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

- The funding will support all work and equipment needed to begin operating three dental exam rooms at North Portland Health Center.
- Increased access to integrated oral health services across MCHD's dental clinics. Once at full capacity, North Portland Health Center dental will be able to provide ~3,000 visits to ~2,000 patients annually.
- Improved oral health and related outcomes.

What is the total amount requested: $300,000. The budget includes the following:

- $251,962 in equipment (including x-ray equipment, compressors, cabinets for exam rooms, exam chairs, etc.)
- $48,038 in supply (including exam room supplies, dental lights, computers, etc.)

Expected Award Date and project/funding period: September 2019 – December 2021

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

A "yes" vote by the Council would mean MCHD will submit an Oral Health Infrastructure grant application to HRSA in request for up to $300,000 to equip three dental exam rooms in North

Presentation Summary

Portland Health Center. As a result, North Portland Health Center would begin providing dental services.
Briefly describe the outcome of a "NO" vote or inaction by the Council *(be sure to also note any financial outcomes)* A "no" vote by the council would mean that MCHD will not submit an Oral Health Infrastructure grant application to HRSA. As a result, MCHD would not have the possibility of being awarded up to $300,000 to purchase the necessary equipment to begin providing dental services at North Portland Health Center.
Related Change in Scopes Requests: *(only applicable in cases in which project will represent a change in the scope of health center services, sites, hours or target population)* Not applicable – Required preventive and additional dental services and the North Portland Health Center location is already in MCHD's scope. A scope change is not required for adding services at a location as long as both the services and location are already in scope.

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: May 13, 2019	Program / Service Area: Health Center Program		
Presenters: Vanetta Abdellatif			
This funding will support:	☐ Current Operations	X Expanded services or capacity	☐ New services
Project Title and Brief Description: HRSA FY19 Integrated Behavioral Health Services Supplemental Funding ● HRSA has released the Integrated Behavioral Health Services supplemental funding opportunity for existing health center grantees to increase access to high quality integrated			

behavioral health services, including prevention or treatment of mental health conditions and/or substance-use disorders, including opioid use disorder.

- Proposal must include addition of at least 0.5 FTE of a mental health or substance-use disorder services personnel.
- Applicants may request up to $145,000.
- MCHD plans to submit a proposal to add 0.8 FTE to provide behavioral health support services to patients receiving Medication Assisted Treatment for opioid-use disorder in the HIV Health Services Center; and 0.25 FTE of project management time to support clinical workflow and practice transformation.

What need is this addressing?

- Integrated behavioral health services can address mental health conditions and substance-use disorders that may manifest from a complex blend of psycho-physiological symptoms, co-morbid conditions, personal situations, and social determinants of health.
- MCHD has had successes treating clients with Medication Assisted Treatment and continues to see need for services. A key to this success is providing behavioral health support services to patients to address their complex needs.

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

- 0.8 FTE additional behavioral health staff; project management support
- 200 patients served by new staff annually
- Increased access to behavioral health support services for patients receiving Medication Assisted Treatment for opioid-use disorder

What is the total amount requested: $145,000
See attached budget.

Expected Award Date and project/funding period: September 1, 2019 – December 31, 2020

Briefly describe the outcome of a "YES" vote by the Council *(be sure to also note any financial outcomes)*
A "yes" vote would mean MCHD will submit an application for the Integrated Behavioral Health Services supplemental funding opportunity for up to $145,000 that will fund 0.8 FTE in personnel to provide behavioral health support services to patients receiving Medication Assisted Treatment for

Presentation Summary

opioid-use disorder in the HIV Health Services Center, as well as 0.25 FTE in project management support.
Briefly describe the outcome of a "NO" vote or inaction by the Council *(be sure to also note any financial outcomes)* A "no" vote would mean MCHD will not submit an application to the Integrated Behavioral Health Services supplemental funding opportunity, thereby foregoing the possibility of securing $145,000 to expand access to services.
Related Change in Scopes Requests: *(only applicable in cases in which project will represent a change in the scope of health center services, sites, hours or target population)* Not applicable

Proposed Budget

	Budgeted Amount	Comments (Note any supplemental or matching funds)	Total Budget
A. Personnel, Salaries and Fringe			
Licensed Clinical Social Worker (Clinical Services Specialist)	$99,921		
The position will work closely with providers administering Medication Assisted Treatment to patients in the HIV Health Services Center by providing behavioral health support services to patients.			
Project Manager	$30,019		
This position will work closely with staff to strengthen clinical workflows and practice transformation for integrated behavioral health services and Medication Assisted Treatment.			
Total Salaries, Wages and Fringe	**$129,940**		
Total Direct Costs	**$129,940**		
Indirect Costs			
The FY 2018 Multnomah County Cost Allocation Plan has set the Health Department's indirect rate at 11.59% of Personnel Expenses (Salary and Fringe Benefits). The rate includes 2.67% for Central Services and 8.92% for Departmental. The Cost Allocation Plan is federally-approved.			
Total Indirect Costs (11.59% of A)	**$15,060**		
Total Project Costs (Direct + Indirect)	**$145,000**		

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: May 13, 2019	Program / Service Area: Student Health Center Program		
Presenters: Vanetta Abdellatif			
This funding will support:	X Current Operations	□ Expanded services or capacity	□ New services
Project Title and Brief Description: **Oregon Health Authority School-Based Health Center Mental Health Expansion Grants** ● Funds mental health services in school-based health centers and their host schools.			

- **Capacity** funds are awarded to cover a) the salary of a Qualified Mental Health Provider who provides on-site services at school-based health centers, and b) any necessary capacity/infrastructure to collect data and report on the mental health encounter visits.
- **Youth-Led Projects** funds are awarded to support Youth Advisory Councils in implementing a Youth Participatory Action Research project and a SHC-focused project.

What need is this addressing?

- MCHD has used this funding since 2015 to support FTE for Mental Health Consultants and Behavioral Health Providers in its Student Health Centers.
- MCHD has also used this funding since 2015 to support the Youth Advisory Council (YAC) Coordinator.
- Receiving this money again for 2019-2021 would allow these services to continue.

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

- The project will fund mental health consultants and behavioral health consultants at the following SHCs: David Douglas, Roosevelt, Madison, Centennial, and, once open in Fall 2019, Reynolds.
- The project will also fund YAC Coordinator FTE to support youth at Centennial, David Douglas, and Jefferson
- Staff will work to improve behavioral health outcomes at these SHCs.

What is the total amount requested:
The total amount requested will be $575,587 total over 24 months. $515,805 will be used to support the following personnel and associated fringe benefits: mental health and behavioral health consultants and YAC Coordinator. $59,782 will support indirect costs @ 11.59% of personnel and fringe benefits.

Expected Award Date and project/funding period: Awards will be announced by June 30, 2019, and projects will run from July 1, 2019 through June 30, 2021.

Briefly describe the outcome of a "YES" vote by the Council *(be sure to also note any financial outcomes)*
In the event of a "Yes" vote, MCHD will submit an application to the School-Based Health Center Mental Health Expansion Grants. A successful application would mean continued funding for Mental

Presentation Summary

Health Consultants, Behavioral Health Providers, and Youth Advisory Council projects in Student Health Centers.
Briefly describe the outcome of a "NO" vote or inaction by the Council *(be sure to also note any financial outcomes)* In the event of a "No" vote, MCHD will not submit an application, meaning the loss of funding for Mental Health Consultants, Behavioral Health Providers, and Youth Advisory Council projects in Student Health Centers.
Related Change in Scopes Requests: *(only applicable in cases in which project will represent a change in the scope of health center services, sites, hours or target population)*

FY 20 Budget Testimony to the Board of County Commissioners
May 15, 2019

Good morning, Chair Kafoury and Commissioners.

Thank you for the opportunity to address you all this morning. My name is Tara Marshall and I am the Chair of the Community Health Council.

First I would like to thank, Chair Kafoury and Commissioners Meieran and Stegmann, for accepting our invitation to attend a CHC public meeting over the past year. I would like to extend an invitation for you all to return and those who have not met with us yet to please know that we look forward to meeting with you. Chair Kafoury, I would also like to thank you for your attendance at our March Executive Committee meeting to discuss the FY20 budget with us during the most challenging budget season we have seen so far for Multnomah County. My colleagues and I appreciate each Commissioner for your leadership and continued support of our Health Center, and our Mission; "to provide services that improve the health and wellness for individuals, families, and our communities". As the co-applicant governing body for the Health Center our partnership is very important to us and the clients we all are committed to serving.

As you are aware, the Council is a federally-mandated board. We share governance responsibility with you all, the Multnomah County Board of Commissioners. We appreciate our partnership with you to provide vital healthcare services to the people of Multnomah County. We look forward to having more conversations with you on how we can work together toward eliminating health disparities and promoting health equity among our patients and communities within Multnomah County.

Our basic responsibilities are:

- to preserve the mission,
- establish and monitor Health Center policy,
- ensure that Health Center finances are properly managed,

- select, evaluate and support the Director of Integrated Clinical Services,
- monitor and evaluate Health Center and Council performance,
- and plan for the long-range future of the Health Centers.

I am representing the Council today to provide testimony about the FY20 budget. I will share our perspective on how it affects services for the approximately 66,000 clients, who are among the most vulnerable residents of Multnomah County, that we serve each year.

The Community Health Council is made up of a majority of consumers of the health centers; meaning that the Council are mostly clinic patients.

We meet monthly to monitor the clinics' performance, compliance with health center policies and to ensure access for our community and patients in need.

Our focus is on our patients. We work closely with Vanetta Abdellatif, who leads the Health Centers, and have a good relationship with the County and are proud to serve.

The federal government requires that the Council shares responsibility to approve the health center's budget and regularly review financial performance. We approve the Health Center's budget annually and continue to monitor financial performance on a monthly basis.

I would like to share our recommendations for the fiscal year 2020 budget you are considering. There are three areas I want to highlight.

● **First** Help us maintain our Federally Qualified Health Center, or FQHC, status. We do not want to see the County risk its FQHC status and its ability to earn federal dollars. ***This is important for our community as FQHCs are essential to serving the most vulnerable people in our community.***

Federal funding requires that County health centers have a certain level of care within the clinic system. Due to continued population growth, the demand for quality, affordable health services in our schools and clinics is increasing while County General Fund contributions are constricted by another 3% this year. Compounded by rising income inequality and reduced access to affordable housing, these challenges make our services that much more important to our residents.

We agree with the Health Department's Community Budget Advisory Committee's (CBAC) recommendation to invest County dollars where they can be most impactful and also wish to continue to work towards reducing health disparities, promoting racial justice and transforming the health of our community, especially for those who have historically been underserved.

We are pleased that in the past, we have not been in danger of losing federal grant dollars. However, with the current Federal Administration in place, we are concerned about what that means for the future of our Health Centers. We continue to have very strong performance and provide excellent care to patients and work diligently to comply with the FQHC mandatory requirements.

If reductions in local resources deepen, we are concerned about the impact that would have on our FQHC status.

We urge you to try to maintain, as much as possible, current service levels and support the health center system. Our patients need us now more than ever in this uncertain health care climate. Our ability to provide care for the most vulnerable residents of Multnomah County is dependent upon our ability to continue receiving the federal dollars that require us to maintain our FQHC status. And now more than ever, we cannot afford to lose this money.

● **Second** Partner to ensure we provide these vital services, long into the future. Like the Board of County Commissioners, we are also concerned with getting the most out of our shrinking revenue dollars as expenses increase. We are supportive

of engaging an expert assessment and evaluation of health center's expenses and revenue projections over the next 5 years to assure the community that we will be here for the long haul.

We know that, Countywide, all departments are feeling the same pressure. But pressing on and maintaining current service levels will help drive revenue generation and ensure our staying power into the future.

• **Third** Supporting Student Health Centers. We agree with the Health Department's CBAC that opening a new Student Health Center at Reynolds High School is vital to the health of the youth living in East County. We urge the Board of County Commissioners to ensure funding for the transition of services from George and Chavez Middle Schools to the proposed Reynolds High School Student Health Services Center.

In closing I would like to invite each one of you to visit our monthly Community Health Council Board meeting. My co-applicant board colleagues and I look forward to continuing to build our partnership to improve access to quality health services, reduce health disparities, promote health equity, and transform the overall health of our patients and communities within Multnomah County.

On behalf of the Community Health Council and the people served in our county's health centers, I thank you for your leadership for our community.