Community Health Council

Community Health Council Board Meeting Minutes
Date: Monday, August 12th, 2019
Time: 6:00 PM
Location: Gladys McCoy Building, Conference Room 850

Approved: **Recorded by:** Jordana Sardo
Attendance:

Board Members	Title	Y/N
Deborah Abney	Board Member	Y
David Aguayo	Treasurer	Y
Fabiola Arreola	Vice Chair	Y
Jon Cole	Member-at-Large	Y
Iris Hodge	Board Member	Y
Tara Marshall	Chair	N
Susana Mendoza	Board Member	Y
Pedro Sandoval Prieto	Secretary	Y
Wendy Shumway	Board Member	Y
Tamia Deary	Board Member	Y
Harold Odhiambo	Board Member	Y
Staff	**Title**	**Y/N**
Vanetta Abdellatif	Integrated Clinical Services Director	Y
Lucia Cabrejos	Interpreter, Passport to Languages	Y
Adrienne Daniels	ICS Deputy Director	Y
Fran Davison	Senior Management Auditor	Y
Marc Harris	Public Health Operations & Development	Y
Mark Lewis	Senior Manager Business Operations	Y
Linda Niksich	Community Health Council Coordinator	Y
Jordana Sardo	Executive Specialist	Y
Tasha Wheatt-Delancy	Primary Care Services Director	Y
Christine Palermo	Dental Program Manager	Y
Robert Henriques	Site Medical Director North Portland	Y
Courtney Kappes	Program Supervisor, Dental School Community Dental	Y
Alex Lehr O'Connell	Senior Grants Management Specialist	Y

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Guests: Deb Williams (IT Health)

Action Items:

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Decisions:

- Approved the July 2019 Meeting Minutes

- Approved HRSA Grant Continuation Submission
- Approved Student Health Center Scope Changes; Switching NP Days, Moving Dental Hygiene Chair from Centennial to Reynolds, Increasing access to Behavioral Health Practitioner Days
- Approved Policy Updates/Renewals for ICS.04.18 and ICS.01.41
- Approved Tamia Deary for fulfilling unexpired Member at Large term

The meeting was called to order at 6:03 pm by Vice Chair, Fabiola Arreola.

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

Noted that quorum was met with 10 members in attendance (6 needed for quorum)

July 2019 Meeting Minutes Review (Vote required)
(See document - July 2019 CHC Meeting Minutes)

Motion by Tamia to approve the July 2019 Minutes
Seconded by Harold
9 aye; 0 nay; Abstain 1 (Iris)
Motion carried

HRSA Needs Assessment and Grant Continuation Submission (Vote Required)
(See document, "Presentation Summary, Grant Opportunity")

- Marc Harris, Strategy and Grant Development Lead requested approval to submit a continuation application for the HRSA Bureau of Primary Care Health Center Program grant. He provided an overview of the grant, the budget and community need
- The application contains information about 1)Environment/Needs assessment; 2) Organizational Capacity; 3)Telehealth; 4) Patient Capacity; 5)Supplemental Awards; 6) One-time funding awards; and 7) Clinical/Financial Performance Measures
- Environment/Needs assessment: Marc shared the charts, maps, and data sources used to measure community needs. A map of the Multnomah County service area showed we serve over 874,000k people and 96.2% of patients live within our service area. Changes within the target population are reported to HRSA, such as the two new LGBTQ+ health clinics, the partnership with the St Francis Dining Hall, and with Reynolds School District to open a school health center in the Fall. CCO 2.0 changes are coming but we're not sure what those are. Marc went over the most significant causes of morbidity and mortality and how our services address these things as well as the health disparities for people of color, those living on low incomes and experiencing homelessness.
- Organizational Capacity: no significant changes other than the growth of the CHC with 64% consumer representation. New systems include Workday and Wisdom.
- Telehealth: This portion explains how we use Telehealth to communicate with

patients through MyChart, and Telehealth carts at two student health centers.
- Patient capacity: This report reflects a decrease in patients since 2016,due to removing School Community Oral Health from the scope; workforce capacity, and hesitancy of patients to access care due to fear of government retribution.
- Supplemental Awards: Marc shared that we received AIMS funding to hire a Behavioral Health and Addictions Specialist. We maintained patient education groups on mental health and substance use and strengthened links with community providers, and standardized and integrated workflows.
- One time funding: Marc shared that Quality Improvement work included patient satisfaction surveys, emergency preparedness planning, and workflow training.

Questions and comments raised by CHC members:
- ***Question:*** Wendy wondered how visits per year were calculated?
- ***Answer:*** Vanetta explained that data systems are used to track that.
- ***Question:*** *Dave asked how big of a portion is carried over?*
- ***Answer:*** Marc replied *$142,000*

Motion by Jon to authorize Grant Continuation Submission
Seconded by Wendy
10 aye; 0 nay;
Motion carried

Monthly Budget Report: Mark Lewis Interim Director of Business Operations
(See document, "Monthly Dashboard - June 2019")

- Mark reviewed the monthly budget report.
- Percentage of uninsured dropped for Primary Care to 13.8%. The target is 13.25%
- Payer Mix remains unchanged
- FQHC member assignments increased to 38,900 clients
- UDS changes will continue. How this information is visually reflected will change
- There were no financials because they are closing the fiscal year

Questions and comments raised by CHC members:
- ***Question:*** Pedro wondered what the small line reflected on the FQHC Gross Collection Rate By Payer sheet
- ***Answer:*** Mark explained it reflected the Family Planning expansion project within school health centers. A medicaid waiver is used to to cover family planning services.

Student Health Centers Scope Changes (Vote Required)
(See document, "Changes in Scope for Student Health Centers: Increasing Access")

- Alexandra Lowell and Courtney Kappes requested authorization to increase access for Student Health Centers by changing access days to a nurse practitioner and

registered nurse; increase access to behavioral health; and moving dental hygiene services from Centennial School Health Center to the new Reyholds School Health Center in the winter of 2020.

- They reviewed a powerpoint describing how client need was the engine behind this request and an update on how plans for the Reynolds school health center were moving forward. They plan to open the school health center in February 2020.
- Courtney explained the history of the dental hygiene chair at Centennial and how the greater need and access at Reynolds makes moving the chair from Centennial to Reynolds a positive change. The hygiene chair need had not increased from one day/week since 2014 despite doing significant outreach.
- Alex emphasized that the switching of days did not impact access to care but was in response to budget cuts and spreading RNs based on need and demand. She noted that Madison will moving to Marshall because of renovation.
- Alex noted that there is an increase in behavior health service delivery. They are adding two days a week at Parkrose, Roosevelt and Reynolds, and a Behavioral Health intern at Roosevelt;

Questions and comments raised by CHC members:

- ***Question:*** Harold wondered how clients in areas with closed health center will get access to care at Reynolds high school?
- ***Answer:*** Alex explained that they did a transition plan, spoke with each family and worked with them to determine where to transfer their care. They used direct contact, social media, and saturated many channels to publicize change.
- ***Question:*** Dave wondered what the client retention rate was for closures or changes like this?
- ***Answer:*** Alex did not have an answer to that but offered to research and report back.
- ***Question:*** Iris notes that $2 billion dollars was just allocated to schools with some funds going to mental health support. She wondered if that money would be accessible for our school clinics.
- ***Answer:*** Alex shared we get money for mental health from the state general fund and while she thought there might be more funding available, she did not think the recent legislation would be available for us.
- ***Answer:*** Vanetta added that we should look into it. It could help fund specialty mental health providers. We want to advocate for mental health and behavioral health services.
- Some increase in service delivery with behavior health - add two days a week at Parkrose, Roosevelt and Reynolds; BH intern at Roosevelt;
- ***Question:*** Harold wondered if the behavioral health need at Roosevelt could be met with current services and did Alex anticipate the need increasing?
- ***Question:*** Iris also wondered about enough mental health services.
- ***Answer:*** Alex shared that all High School sites are open 5 days / week and when an NP isn't there an RN is there
- ***Question:*** Regarding the hygiene chair, Tamia asked whether a survey was done to determine why access was so low.
- ***Answer:*** Courtney shared that getting their teeth cleaned was not a significant part of oral health education

- ***Question:*** Tamia asked whether they are taught its importance?
- ***Answer:*** Courtney shared that they work with the school nurses so that students and families are aware of the chair. But they can't justify more days/week when the need is not there. Moving the chair to Reynolds nearly doubles the access because there are more students.
- ***Question:*** Harold asked what made Courtney think the outcome will be better?
- ***Answer:*** Courtney shared that transportation is a factor for other sites. Reynolds is excited about having us there. It's a better partnership.
- ***Question:*** Wendy asked whether Ride Care had been utilized?
- ***Answer:*** Courtney confirmed this and added that plans include transitioning students from Centennial to Reynolds;

Motion by Pedro to Switch days of access to Nurse Practitioner (NP) and registered nurse (CHN)
Seconded by Deb
10 aye; 0 nay;
Motion carried

Motion by Wendy to Increase access to behavioral health services
Seconded by Jon
10 aye; 0 nay;
Motion carried

Motion by Tamia to Move the dental hygiene services from Centennial SHC to the new SHC at Reynolds slated to open winter 2020
Seconded by Harold
10 aye; 0 nay;
Motion carried

Break for 10 minutes...

ICS Policy Renewals (Vote Required)

- ICS.04.18 - Adrienne Daniels explained the policy renewal. This policy describes interactions between providers, clients and staff, that clients be involved in their care planning, and sets expectations of patients, like showing up on time, and paying what you can. There are no changes to the Right and Responsibility section. The ask is for the Council to continue to support existing policy.

Questions and comments raised by CHC members:

- ***Question:*** Dave asked how often the policy is approved?
- ***Answer:*** Adrienne was not sure
- ***Answer:*** Vanetta shared that it used to be every two years, but now it gets renewed every three years

Motion by Iris to approve ICS Policy Renewals ICS.04.18

Seconded by Wendy
10 aye; 0 nay;
Motion carried

- ICS.01.41 - Adrienne Daniels explained that proposed changes were highlighted in yellow. This policy outlines the Council's responsibilities, defines the co-applicant agreement and describes its role.

Questions and comments raised by CHC members:

- ***Question:*** Susana wondered how do you know what to change?
- ***Answer:*** Adrienne replied that sometimes HRSA makes a decision such as what kinds of service can and cannot be delivered, and sometimes changes are driven by changes in demographics.
- ***Question:*** Pedro noted that every time HRSA comes, they always make changes. Is this one of theirs or yours?
- ***Answer:*** Adrienne replied this is not specific to HRSA, but policies, except the last one , are non-value added ones.
- **Comment:** Fabiola noted there is a typo on page two in the highlighted section. The word "and" is used twice.

Motion by Wendy to approve ICS Policy Renewals ICS.01.41
Seconded by Pedro
10 aye; 0 nay;
Motion carried

Board Development: HRSA Chapter 2 & Co-Applicant Agreement
This agenda item was moved to the next meeting. Vanetta noted that the board will review the compliance manual chapter by chapter and asked that all council members come prepared to engage in dialogue.

ICS Director's Update

- Many of CHC members were able to come to the wonderful National Health Center Week event. Health Centers celebrate their work, bring in elected officials to thank them and get support from them.
- There will be an ICS All Staff meeting in the afternoon of September 17. It will include all services in ICS.
- The Executive Committee voted to send Jon and Tamia to the NWRPCA in Seattle. This is a nice opportunity to do board development. She asked they show pictures and report when they get back.
- As Marc Harris presented on the grant application, CCO 2.0, coordinated care organization, is an experiment that Oregon is doing around Medicaid. Family Care is gone but there is a second CCO in our market that may impact how patients are assigned to us. We are keeping an eye on that because while that change in the

market does not impact the services we provide, Medicaid patients might not know that they will get moved. Patients might be considered "not engaged" if they have not seen a provider in a certain amount of time. It impacts how and where they will assign patients.

Questions and comments raised by CHC members:

Comment: Wendy has been to CCO 2.0 conferences and has brought up these issues and patients not knowing they are being reassigned.

Comment: Harold suggested writing to patients who have not been seen in a few years, reaching out to them to get them in.

Answer: Vanetta shared that we are actively doing that now. More to come.

Question: Tamia asked who is doing the outreach?

Answer: Vanetta shared that Community Health workers are talking with patients as well as panel managers and medical assistants;

Council Business

Committee Updates

Executive Committee Update:

- Hold the date on October 12, retreat. Usually all day 9am-4pm
- Jon and Tamia have been selected to attend the NWRPCA Fall Primary Care Conference in Seattle.

Vote to affirm Tamia Deary to complete term for Member-at-large vacancy

- Wendy, David - motion passes
- Need to recruit more people

No questions or comments were raised by CHC members.

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Add pronouns to name tents and turn in to Linda

- Updated for next month

No questions or comments were raised by CHC members.

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Meeting Evaluation/General updates:

- Fabiola did great job
- Shout out to R. Henriques
- Great room, but need fan for AC circulation

Meeting Adjourned at 7:49pm.

Signed: Pedro Sandoval Prieto **Date:** 9/9/19

Pedro Sandoval Prieto, Secretary

Community Health Council
Public Meeting Agenda

Monday, August 12, 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 (Treasurer); Fabiola Arreola (Vice-Chair); 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	• Vice Chair, Fabiola Arreola • Icebreaker/ Introductions	6:00-6:10 (10 min)	Call to order Review processes/ Introductions with Icebreaker
Minutes **VOTE REQUIRED**	• Review and approve the July Minutes	6:10-6:15 (5 min)	Council votes to approve and Secretary signs
HRSA Needs Assessment and Grant Continuation Submission **VOTE REQUIRED**	• Strategy and Grant Development Lead, Marc Harris • ICS Director, Vanetta Abdellatif	6:15-6:35 (20 min)	Council receives report Council Discussion and Vote
Monthly Budget Report	• Senior Manager Business Operations, Mark Lewis	6:35-6:45 (10 min)	Council receives report

Student Health Centers Scope Changes **VOTE REQUIRED**	• Student Health Center Manager, Alexandra Lowell and School Oral Health Program Supervisor, Coutney Kappes	6:45-7:00 (15 min)	Council Discussion and Vote
BREAK	• All	7:00-7:10 (10 min)	Meet and greet
ICS Policy Renewals **ICS.04.18** **ICS.01.41** **VOTES REQUIRED**	• ICS Deputy Director, Adrienne Daniels	7:10-7:25 (15 min)	Council discussion and vote
Board Development: HRSA Chapter 2 & Co-Applicant Agreement	• CHC Coordinator, Linda Niksich	7:25-7:35 (10 min)	Council receives training
ICS Director's Updates	• ICS Director, Vanetta Abdellatif	7:35-7:45 (10 min)	Council receives updates
<u>Council Business</u> **Committee Updates**	• Executive Committee Update; Vice Chair, Fabiola Arreola • Vote to affirm Tamia Deary to complete term for Member-at-Large vacancy • Add pronouns to name tents and turn-in to Linda	7:45-7:55 (10 min)	Council receives updates from Chair and Committees Council votes to affirm Executive Committee Recommendation Council writes preferred pronouns to name tents and turn- in to Linda
Meeting Evaluation	• Vice Chair, Fabiola Arreola	7:55-8:00 (5 min)	Council Discussion
Adjourn Meeting	• Vice Chair, Fabiola Arreola	8:00	**Goodnight!**

HRSA BPHC Health Center Program

FY 20 Budget Period Renewal

Presentation to the Community Health Council, August 12, 2019

FY 20 BPR Contents

1. Environment (Needs Assessment)
2. Organizational Capacity
3. Telehealth
4. Patient Capacity
5. Supplemental Awards
6. One-Time Funding Awards
7. Clinical/Financial Performance Measures

Needs Assessment

Needs Assessment Components

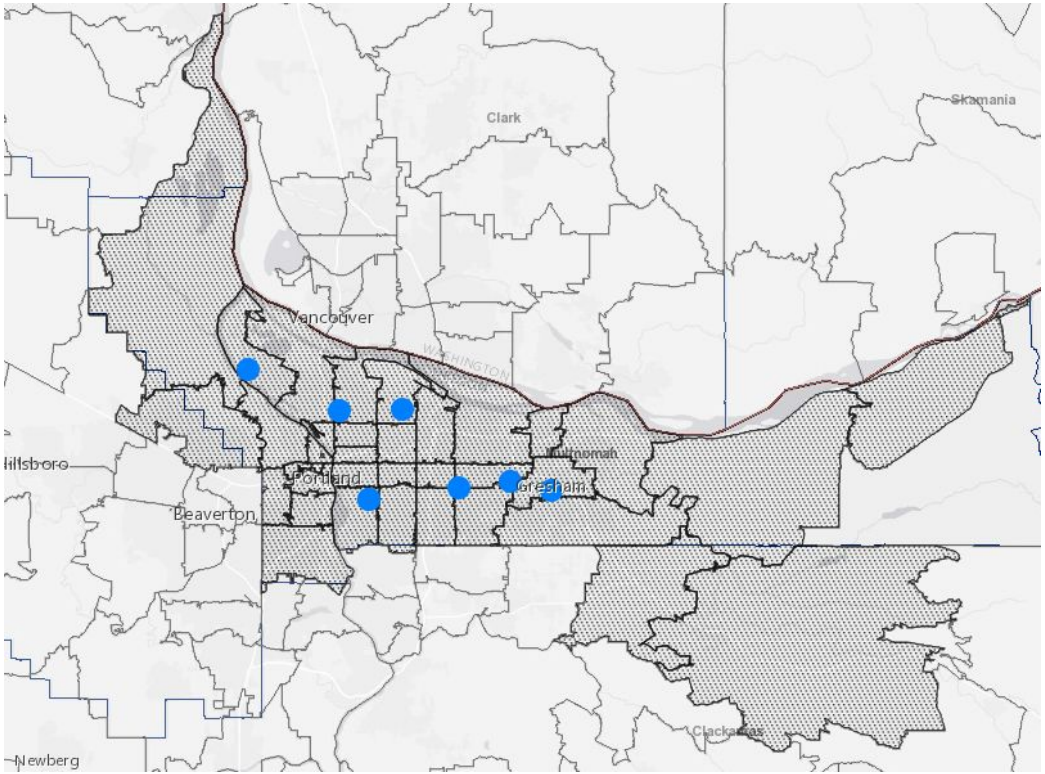
	SAC	BPR
Service Area description	Borders, size, % of patients	Major changes in Service Area demographics
Factors associated with access to health care	Geography, transportation, occupation, unemployment, income level, educational attainment, transient populations	Major changes in -health care providers -key community partnerships -insurance coverage
Population health status	-Most significant causes of morbidity & mortality -Health disparities	
Unique health care needs	E.g., cultural factors, housing status, etc.	Major changes in patient population needs

Data Sources

Main data sources include:

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

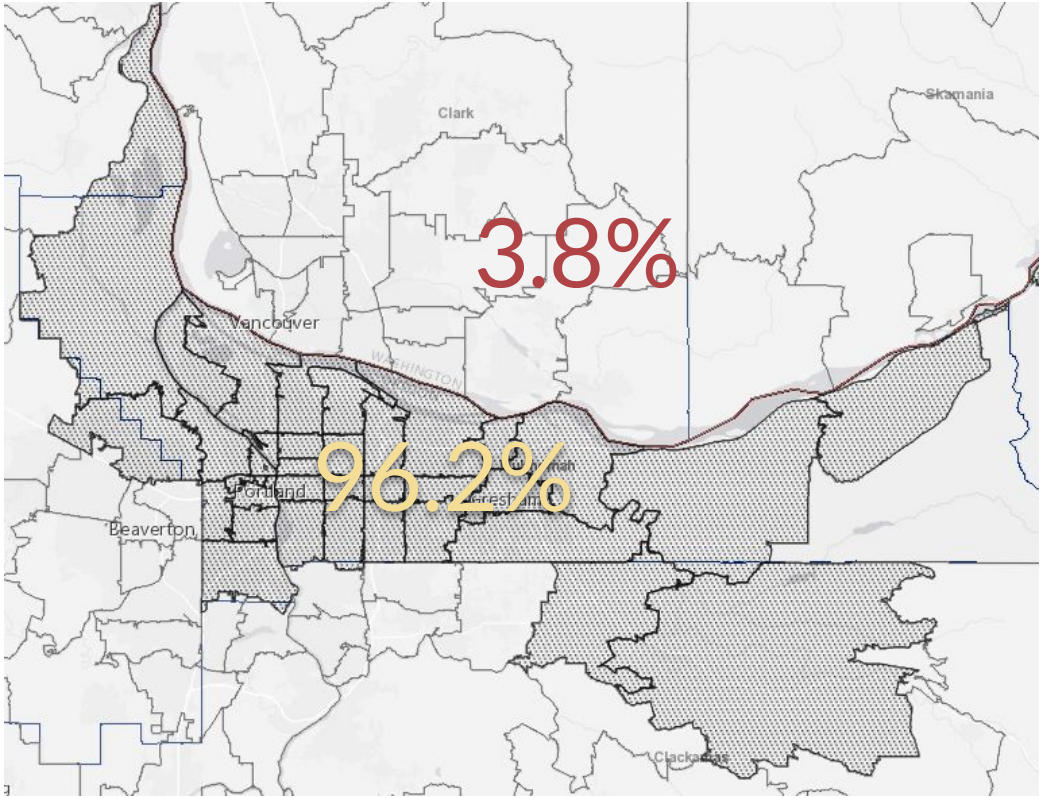
Service Area



The MCHD Health Center Program Service Area is slightly larger than the official Multnomah County jurisdiction.

Mult. Co.	Service Area
807,555	874,770

Service Area



At least 75% of MCHD HCP patients must live in the Service Area for continued eligibility/compliance.

If less than 95% of patients live outside the Service Area (but at least 75%), subject to reduction in funding.

2017 data reported in SAC showed 95% living outside Service Area. 2018 data show 96%.

Service Area & Target Population Sizes

	FY 19 SAC	FY 20 BPR	% Change
Total Service Area Pop.	862,052	874,770	1.5%
Target Pop. (<200% FPL)	280,656	275,967	-1.7%
% of Population that is <200% FPL (Target Population)	32.6%	31.5%	-3.4%
Population experiencing homelessness	4,177	4,015	-3.9%

Service Area Demographics – race/ethnicity

	Total Population	Target Population
Asian	7.9%	7.8%
Black/African American	4.9%	11.5%
Latinx	10.9%	19.6%
Multiracial	4.4%	6.9%
Native American/Alaska Native	0.6%	1.6%
Pacific Islander	0.5%	0.8%
White non-Latinx	70.6%	53.9%

Service Area Demographics – health insurance

	Total Population	Target Population
Uninsured	8.5%*	15.3%
Medicaid	13.4%	---
Public insurance	32.4%	56.9%

*UDS Mapper estimates 6.98% of the Service Area total population lacks health insurance.

BPR Environment section

Major community, state, and/or regional changes that have directly impacted:

- Major health care providers
  - No major changes - 2 new LGBTQ+ clinics in the CCHC
  - New Behavioral Health Community Health Center
- Key community partnerships and collaborations
  - Redesigned partnership with St. Francis Dining Hall
  - Partnering with Reynolds to open a SHC in Fall
- Insurance coverage, including Medicaid, Medicare, and the Children's Health Insurance Program
  - No major changes - Health Share continues to assign fewer patients
  - Looking forward, 2 CCOs approved

Most significant causes of morbidity & mortality

Health Behaviors

- Binge drinking
- Current cigarette smoking
- Adults not receiving dental visits
- Fruit/vegetable consumption
- Physical activity
- Adults not receiving flu shots
- Older adults not receiving pneumonia vaccine
- Not having a usual source of health care
- Can't afford to see doctor

Morbidity

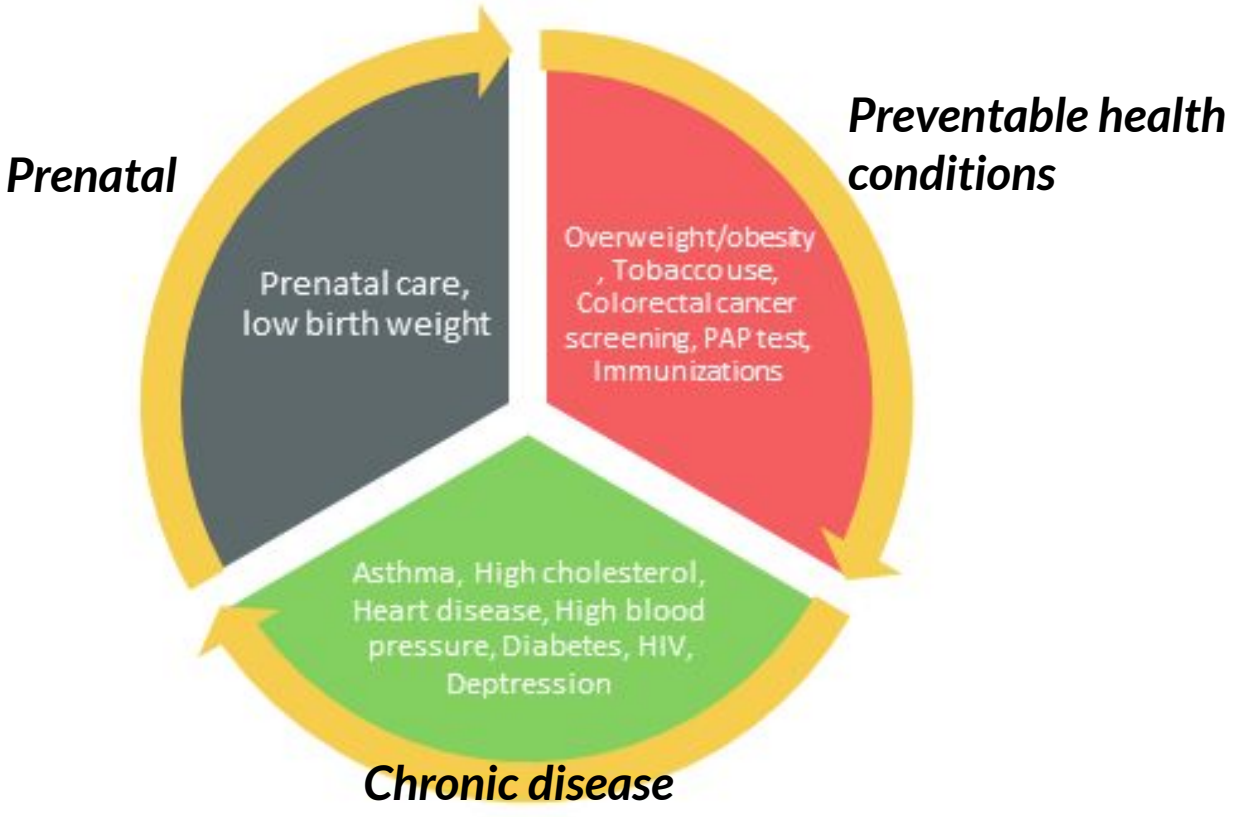
- Cancers--breast, lung, ovarian
- Chlamydia
- Chronic hepatitis C
- Depression in adults
- Gonorrhea
- High blood pressure
- High cholesterol
- Obesity/overweight

Mortality

- Alcohol-induced
- Alzheimer's disease
- Cancers--breast, colorectal, lung
- Chronic lower respiratory disease*
- Diabetes
- Drug-induced
- Heart disease
- Non-transport accidents
- Suicide

Health Disparities

Populations of color and people living on low incomes experience poorer outcomes across Health Center Program clinical performance measures.



Population Experiencing Homelessness

Demographics

- Native Americans, Blacks/African Americans, and Pacific Islanders are disproportionately represented
- The most commonly reported geographic areas to sleep are SE Portland (22%) and Downtown/Old Town/Pearl (21%)
- 22% increase in unsheltered individuals

Healthcare Needs

- 72% have at least one disabling condition (61% in 2017)
- 39% experience mental illness
- 37% experience substance use disorder
- 2.2% are HIV-positive
- 25% have a chronic health condition
- 27% have a physical disability

Organizational Capacity

Major changes since last budget period

- Staffing, including key vacancies
  - Recruitment for pharmacy director and dental director - Summer & Fall 2019
- Board membership
  - 2 members transitioned from CHC; 4 joined - overall increase from 9 to 11
  - Consumer representation up from 55% to 64%
- Operations
  - Removed two SHCs from scope
  - Changed scope of St. Francis Dining Hall
  - Changed HHSC, pharmacy, and HCP admin moved locations
- Systems, including financial, clinical, and/or practice management
  - Epic upgrade in May 2019; Upgrades every 3 months beginning August 2019
  - Workday and MMP implementation
  - Wisdom in October 2019
- Financial status, including most current audit findings
  - No weaknesses or deficiencies

Telehealth

How you use telehealth to

- Communicating with patients/providers/staff and clinical consultations
  - Telehealth appointments on daily basis
  - Telehelath carts at 2 Student Health Centers for behavioral health
  - MyChart
  - Case conference through OHSU Project ECHO
  - Rubicon MD (e-consults)
- Send and receive health care information from mobile devices to remotely monitor patients
  - MyChart
- Provide virtual health care services
  - Telehealth primary care appointments
  - Patients just need phone/internet access
  - Exploring automating through MyChart and video visits

Patient Capacity

Total Unduplicated Patients

2016 Pt #	2017 Pt #	2018 Pt #	% Change 2016-2018 Trend	% Change 2017-2018 Trend	% Progress toward Goal	Projected # of Pts
70,529	66,327	63,726	-9.3%	-3.92%	86.92%	73,318

The number of UDS medical patients increased significantly in 2014, with the ACA, but has been on a slow downward trend since then due to several factors:

- Patients receiving more non-countable visits (care steps)
- Fewer patients assigned by CCO in recent years
- Removed School-Community Oral Health from scope (2,500 patients)
- Workforce capacity (clinical vacancies)
- Hesitancy to access care due to fear of retribution from government entity

Total People Experiencing Homelessness Patients

2016 Pt #	2017 Pt #	2018 Pt #	% Change 2016-2018 Trend	% Change 2017-2018 Trend	% Progress toward Goal	Projected # of Pts
2,670	3,144	2,096	-21.5%	-33.33%	70.10%	2,090

- “Living with others” option was misleading, creating overcount of unstably housed patients
- As of 2018, form now reads, “Living with others temporarily”

Supplemental Awards

Update on FY 17 AIMS

- Hired a Behavioral Health & Addictions Integration Specialist (1.0 FTE). Position was temporarily vacant in 2019 but is not filled.
- Patient education groups on mental health & substance use resources--100 unduplicated patients at 8 health center sites.
- Strengthened referral linkages to community-based providers; trained 52 PCPs on the service array; ongoing outreach and relationship-building with community-based providers.
- Partnered with Northwest ATTC to implement Motivational Interviewing training with 267 staff from all sites and role groups, completing over 1,300 training hours.
- Standardized workflow for referrals; options appraisal for improved storage of 42 CFR part 2 SUD treatment records; improved naloxone training and increased naloxone prescriptions (more than double)

One-Time Funding

Updates on FY 17 Quality Improvement Assistance

QI work:

- Patient satisfaction surveys; planning for electronic comment kiosks pilot at Rockwood
- Joint Commission compliance; TJC Site Audit
- Emergency Preparedness planning; active shooter training
- Workflow training, newsletters for clinical quality metrics
- Tracking instrument sterilization
- Representation on CCO quality improvement committee

Data analysis/reporting:

- Patient satisfaction surveys
- PAC performance
- CQM performance monitoring
- APCM and DTP State metrics reporting

Updates on FY 18 Quality Improvement Assistance

- Money not spent due to carryover funds from FY17.
- HRSA approved the carryover request, which will be used this year to support work on patient satisfaction, risk analysis, and better data capture.

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:	Program / Service Area: Health Center Program		
Presenters: Vanetta Abdellatif			
This funding will support:	**X** Current Operations	□ Expanded services or capacity	□ New services
Project Title and Brief Description: ● HRSA Health Center Program FY20 Budget Period Renewal ● Non-competing continuation application for the HRSA Bureau of Primary Care Health Center Program grant that funds Multnomah County's Community Health Centers and Healthcare for the Homeless programs. The CHC approved the competitive application (referred to as the			

Service Area Competition/SAC) in 2018 for a three year project period (1/1/2019-12/31/2021). This non-competing continuation will initiate year 2 of the project period (1/1/2020-12/31/2020).

- The Multnomah County Health Department (MCHD) has been receiving this funding since 1980. Funds are used to operate MCHD's seven Community Health Centers, eight student health centers, six dental clinics, seven pharmacies, and HIV Health Services Center.
- Funds associated with this non-competing continuation application are for continuation of existing services.

What need is this addressing?

- MCHD's Community Health Centers provide comprehensive primary care, dental, and behavioral health services for 39% of Multnomah County's population that lives on incomes below 200% of the Federal Poverty Level (about 276,000 people).
- 9% of Multnomah County's population is uninsured, and around 4,200 people experience homelessness.

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

- Under this funding, MCHD's target is to serve 69,953 patients annually by December, 31 2020.
- There are also clinical and financial performance measures MCHD is expected to meet.
- Grant funds support salaries for Health Center Program staff including: Administrative Analysts, Administrative Specialists, Business Process Consultants, Clerical Unit Coordinators, Clinical Services Specialists, Community Health Nurses, Community Health Specialists, Data Analysts, Dental Assistants, Dental Hygienists, Eligibility Specialists, Finance Specialists, Finance Technicians, Laboratory Technicians, Licensed Practical Nurses, Medical Assistants, Nurse Practitioners, Nurse Practitioner Manager, Nursing Supervisors, Office Assistants, Operations Supervisors, Physicians, Physician Assistants, Program Coordinators, Program Specialists, Program Technicians, and Project Managers.

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

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

Presentation Summary

Briefly describe the outcome of a "YES" vote by the Council *(be sure to also note any financial outcomes)* A "yes" vote means MCHD will submit the required non-competing continuation application in order to receive the second year of Health Center Program funding associated with the competitive application submitted last year. This funding will continue operation of current sites and 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 means MCHD will not submit the required application, meaning MCHD does not meet the requirements to receive the second year of funding associated with the competitive application submitted and awarded last year.
Related Change in Scopes Requests: *(only applicable in cases in which project will represent a change in the scope of health center services, sites, hours or target population)*

Proposed Budget (when applicable)

Project Name, Start Date through End Date

Multnomah County Health Department

	Budgeted Amount	**Comments** (Note any supplemental or matching funds)	**Total Budget**
A. Personnel, Salaries and Fringe			
Position Title			
Position Description			
Position Title			
Position Description			
Total Salaries, Wages and Fringe			
B. Supplies			
Description of supplies			
Total Supplies			
C. Contract Costs			
Contract description			
Total Contractual			
D. Other Costs			

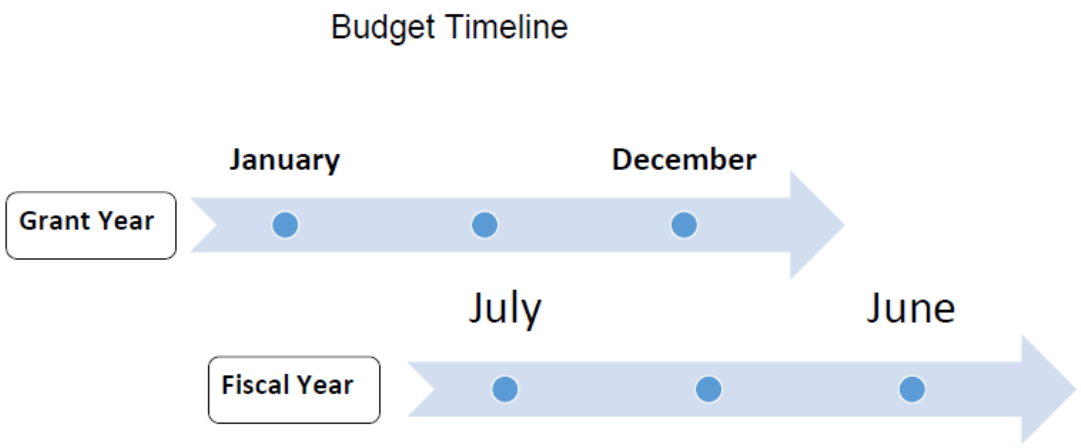
Presentation Summary

Description of training and other costs			
Total Other			
Total Direct Costs (A+B+C+D)			
Indirect Costs			
The FY 2018 Multnomah County Cost Allocation Plan has set the Health Department's indirect rate at 12.16% of Personnel Expenses (Salary and Fringe Benefits). The rate includes 2.69% for Central Services and 9.47% for Departmental. The Cost Allocation Plan is federally-approved.			
Total Indirect Costs (12.16% of A)			
Total Project Costs (Direct + Indirect)			

	Revenue	**Comments** (Note any special conditions)	**Total Revenue**
E. Direct Care Services and Visits			
Medicare			
Description of service, # of visits			
Medicaid			
Description of service, # of visits			

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

BUDGET NARRATIVE AND JUSTIFICATION
Section I: General Information
January 1, 2020 – December 31, 2020



BUDGET NARRATIVE AND JUSTIFICATION
Section I: General Information
January 1, 2020 – December 31, 2020

A. INTRODUCTION

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

All presentations share the grant January 1, 2020 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

The following budget presentation represent the second grant year (2020). Subsequent grant year, year three, is not expected to have substantive or material budget changes.

B. SOURCE OF BUDGETARY INFORMATION

Multnomah County operates on a July 1 - June 30 fiscal year. The County adopted its FY 2019/2020 operating budget. This operating budget includes appropriations and corresponding revenue estimates for the entire scope of the project. The budget presentation is based on this operating budget. The operating budget covers the first six months of the grant application period. 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 first year.

C. COST ALLOCATION

The source document for cost allocation is the recently adopted 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 combined indirect rate includes Central Services cost allocation plan that identifies and distributes the cost of services provided by central County support organizations (e.g. Budget Office, County Auditor), and the Health Department Administration cost allocation 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 indirect rate. Internal 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. A complete copy of the County 2019-2020 Indirect Cost Allocation Plan is available upon request.

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.

The FY 2019/2020 adopted budget included a pay increase of 4.0% for all employees for Cost of Living Adjustment (COLA).

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 41.32% of the base pay. This includes PERS retirement (26.4%), PERS Bond (6.5%), FICA (7.65%), and Tri-Met transit tax (0.77%). PERS retirement for employees hired after August ‘03 is (20.23%) with a total expense of 35.15% 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 $16,946 for full-time employees (0.8 – 1.0 FTE). For Local 88 union three-quarter time employees, it is $12,710 and $9,673 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 type of coverage and family size.

For employees contributing to these programs, the average budgeted cost of benefits as a percentage of payroll dollars for FY 2019-2020 is 40.4%**.** For FY 2018-19 the average was 40.0%.

Multnomah County Health Department has 679 full-time staff, 44 part-time staff (0.50 – 0.79 fte except for Local 88 Union), 29 half-time staff, and 45 three-quarter-time staff (0.75 – 0.79 fte local 88 Union).

F. PROJECT REVENUES

Schedule of State, Local, and Other Funding

1- Other Federal Grants (Income Analysis – Form 3)	**3,715,352**
Other Federal Ryan White I	1,293,679
Other Federal Healthy Start	892,500
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 Supplemental QI Funding	141,000
Other Federal Maternal Infant Early Childhood Home Visit	25,000
2- State (Income Analysis – Form 3)	**5,379,330**
State MH Grant	2,733,346
State Student Health Centers	766,648
State FFS Insurance Rcpts	659,431
State OR Department of Education- Youth Development Division	423,966
State Oregon Youth Authority	207,442
State Oregon Health Authority Ryan White	115,006
State Child & Adolescent	100,000
State OHA HIV Care Assitance	98,601
State Babies First	88,802
State Family Planning	87,588
State Refugee Screening	85,000
State Vocational Rehab - Early Assessment & Support Alliance	13,500
3- Local Government (Income Analysis – Form 3)	**421,339**
School-Based MH Expanion - PPS SUN Comm	177,010
Portland Public Schoold - Head Start	146,829

School-Based MH Expanion - Centennial	75,000
School-Based MH Expanion - Parkrose	22,500
4- Private Grants (Income Analysis – Form 3)	**580,478**
Gilead FOCUS - HIV	293,010
CareOregon PC-Dental Coordination	142,070
Local UW AIDS Educ Training Center	81,400
Pharmacy ADAP/CARE Assist	50,875
OHSU HIV Counseling - Russell St.	13,123
5- Other Medicaid/Medicare (Income Analysis – Form 3)	**38,918,711**
Other Medicare Pharmacy FFS	13,777,709
Other Medicaid Pharmacy FFS - CareOregon	10,658,460
Other Medicaid Quality & Incentive Pay - CareOregon	8,179,053
Other Child Mental Health Srvices	5,480,760
Other Medicaid Pharmacy FFS	593,439
Other Patient Fees Pharmacy	229,290
6- Applicant - CGF (Income Analysis - Form 3)	**12,098,050**

County General Fund (Applicant Funding)

The Portland metropolitan economy continues to grow, but the rate has started slowing relative to the post- Great Recession expansion. As of February 2019, the 3.9% unemployment rate in Multnomah County remains at a historically low level, but is higher than last year. At the state level, Oregon's unemployment rate of 4.4% in February was higher than the national rate of 3.8%.

Locally, the residential real estate market slowed considerably, matching activity across large, Western cities. As measured by the S&P Case- Shiller Home Price Index for the Portland metropolitan area, home prices increased by 3.9% during 2018. Similarly, multi-family housing rents have declined slightly after years of increases.

Property taxes are the single largest discretionary source of revenue in the General Fund, accounting for 59% of ongoing revenues. General Fund growth, therefore, is particularly sensitive to taxable value growth and compression. The FY 2020 budget assumes the following rates of growth (as measured from the FY 2019 Adopted budget) for each revenue source:

- Property Tax – An increase of 2.8%
- Business Income Tax – An increase of 13.6%
- Motor Vehicle Rental Tax – An increase of 2.0%
- Recording Fees/CAFFA Grant – A decrease of 8.7%
- US Marshal jail bed rental – An increase of 20.0%

In FY 2020, the Business Income Tax (BIT) is forecasted to make up 18% of County General Fund revenues. FY 2019 was the 10th year of the current BIT expansion. In the May 2019 forecast update, BIT revenues were increased in all years of the forecast due to a structural change resulting from the Federal Tax Reform. The current forecast includes a slight decline in BIT revenues in FY 2020 and FY 2021 based on the mature stage of the economic cycle, declining development activity, and one-time-only payment received in FY 2018 and FY 2019.

The US Marshal jail bed rental increase is driven by a higher number of beds used (93 per day rather than 85) and a higher rate of $140 per bed, per day.

As measured from the FY 2019 Adopted budget, ongoing General Fund resources for FY 2020 are projected to increase by nearly 4.5%. However, as measured from currently forecasted FY 2019 revenues, General Fund resources will increase by a more modest 1.4%

Total direct resources, or "revenues," for FY 2020 are $1.64 billion vs. $1.70 billion in FY 2019 (excluding service reimbursements and cash transfers between funds). Intergovernmental revenues are the County's single largest revenue category at $536.8 million or 33.0%. This reflects a $55.6 million or 3.3% decrease from FY 2019.

Taxes constitute the next largest revenue source at 30.1% and include property tax, business income tax, motor vehicle rental tax, transient lodging tax, and county gas tax. For FY 2020, tax collections are anticipated to increase 3.5% from $478.9 million in FY 2019 to $495.7 million.

Beginning working capital (BWC) is the County's third largest resource for FY 2020, at $386.8 million or 23.5%. In dollar terms, BWC decreased from $401.0 million in FY 2019 to $386.8 million in FY 2020.

The County's General Fund expenditures are forecast to grow at roughly 3.6% to 4.5% annually through FY 2024, 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 $1.82 billion in FY 2020 vs. $1.88 billion in FY 2019.

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 Munltnomah County Health Department.

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 2019, the number of Care Oregon clients assigned to Multnomah County averaged 33,491 clients per month. The number of Providence clients assigned to the Health Department averaged 4,547 clients per month.

BUDGET NARRATIVE AND JUSTIFICATION
Section I: General Information
January 1, 2020 – December 31, 2020

Attachments:

1. Combined 424 Summary (Budget Information)
2. Budget Justification and Program Budget Details
3. Combined Income Analysis
4. Staffing List for 330 Primary Care Grant
5. Grant Request Summary

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	$ 130,961,933	$ 138,467,417
2. HCH	93.224	$ -	$ -	$ 2,136,710	$ 6,640,595	$ 8,777,305
TOTALS				$ 9,642,194	$ 137,602,528	$ 147,244,722

SECTION B - BUDGET CATEGORIES

6. Object Class Categories	Federal	Non-Federal	Total
a. Personnel	$ 5,091,569	$ 51,271,709	$ 56,363,278
b. Fringe Benefits	$ 3,421,877	$ 34,706,243	$ 38,128,120
c. Travel	$ -	$ 146,674	$ 146,674
d. Equipment	$ -	$ 609,000	$ 609,000
e. Supplies	$ -	$ 15,697,677	$ 15,697,677
f. Contractual	$ 142,040	$ 5,088,973	$ 5,231,013
g. Construction	$ -	$ -	$ -
h. Other	$ -	$ 20,978,664	$ 20,978,664
i. Total Direct Charges *(sum of 6a - 6h)*	$ 8,655,486	$ 128,498,940	$ 137,154,426
j. Indirect Charges	$ 986,708	$ 9,103,588	$ 10,090,296
k. TOTALS *(sum of 6i and 6j)*	$ 9,642,194	$ 137,602,528	$ 147,244,722

SECTION C - NON-FEDERAL RESOURCES

Grant Program Function or Activity	Applicant	State	Local	Other	Program Income	Total
CHC 93.224	$ 9,770,812	$ 5,379,330	$ 421,339	$ 41,913,805	$ 73,476,647	$ 130,961,933
HCH 93.224	$ 2,327,238	$ -	$ -	$ 1,300,736	$ 3,012,620	$ 6,640,595
TOTAL	12,098,050	5,379,330	421,339	$ 43,214,541	$ 76,489,267	$ 137,602,528

SECTION D - FORECASTED CASH NEEDS (Optional)

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

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

(a) Grant Program	FUTURE FUNDING PERIODS (Years) First	Second	Third	Fourth
CHC 93.224	$ 7,505,484	$7,505,484	N/A	N/A
HCH 93.224	$ 2,136,710	$2,136,710	N/A	N/A
			N/A	N/A
			N/A	N/A
TOTAL	$ 9,642,194	$9,642,194	N/A	N/A

SECTION F - OTHER BUDGET INFORMATION

Direct Charges:	See narrative
Indirect Charges	See narrative
Remarks	

BUDGET NARRATIVE AND JUSTIFICATION
Section II: Program Budget Details
January 1, 2020 – December 31, 2020

		Federal Request	Non-Federal Resources	Total Budget
A.	**PERSONNEL**	**5,091,569**	**51,271,709**	**56,363,278**
	Salaries (Combined Personnel By Pos.)			
B.	**FRINGE BENEFITS**	**3,421,877**	**34,706,243**	**38,128,120**
	Salary related expenses: FICA (7.65%), Retirement PERS (26.4%), PERS Bond (6.5%), and Transit tax (0.77%) for a total of 41.32% of pay. Retirement for employees hired after August 03 is (20.23%) with a total espense of 35.15% of pay.	1,901,637	19,779,868	**21,681,505**
	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 $16,946 per full-time employee. For Local 88 three-quarter time employees, it is $12,710. For half-time employees, the rate is $9,673 per employee.	1,520,240	14,926,375	**16,446,615**
C.	**TRAVEL & TRAINING**	**-**	**146,674**	**146,674**
D.	**EQUIPMENT**		**609,000**	**609,000**
	Pharmacy/Lab Equipment	-	609,000	**609,000**
			-	**-**
E.	**SUPPLIES**	**-**	**15,697,677**	**15,697,677**
	Pharmaceuticals	-	12,817,907	**12,817,907**
	Medical & Dental Supplies	-	1,927,592	**1,927,592**
	Office Supplies	-	952,178	**952,178**
F.	**CONTRACTUAL**	**142,040**	**5,088,973**	**5,231,013**
	Patient Care			

Primary Care Contracts				
Lab & X-Ray Svcs: Contracted lab services with EPIC Imaging, Quest Diagnostics, OR Health Divisiton, Blood Lead Testin Svcs, OHSU Radiology Svcs.		-	701,285	**701,285**
MH Family Partners and Peer Support Svcs: NAMI		-	362,668	**362,668**
MH Consultation for Children: Morrison Center		-	207,682	**207,682**
MH Consultation for Children: NAMI		-	169,460	**169,460**
MH Crisis Stabilization: Catholic Community Services		-	161,984	**161,984**
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 Training and implementation		-	120,000	**120,000**
OHSU Nurse Practioner Contract		-	97,000	**97,000**
OHSU contract for OBGYN Services		-	81,000	**81,000**
MH Case Management - Family Support: NAMI		-	78,797	**78,797**
In-service and Consultation: Honorarium for provider speakers and workshop facilitation		-	67,583	**67,583**
After Hours RN medical advice - Phone Advice		-	62,000	**62,000**
Behavioral Health and Psychiatric consultation to juveniles involved in the juvenile justice treatment programs		-	60,500	**60,500**
School-Based Svcs contract from State to OHSU		-	56,000	**56,000**
Pharmacy Professional Staffing		-	52,200	**52,200**
MH Consumer Leadership: Latino Network		-	50,000	**50,000**
MH A&D Outpatient Services: NAMI		-	50,000	**50,000**
Data Development and Integration Projects		-	32,000	**32,000**
Psychiatrric Svcs for Youth and Young Adults: Cascadia		-	13,500	**13,500**
Lab Waste Disposal		-	10,440	**10,440**
Shredding Svcs: AccuShred Confidential Shredding		-	6,000	**6,000**

Dental Contracts				
Lab & X-Ray Svcs: 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**
Repair and Calibration: CHR contract for Equipment tracking and repair		-	39,371	**39,371**
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**
Courier Services		-	5,482	**5,482**
Field Services				
Babies First: Targeted Case Management		-	821,157	**821,157**
Community Groups support		-	100,000	**100,000**
Nurse Family Partnership Support: staff training through Nurse Family Support program		-	78,642	**78,642**
MH Services For Immigrant and Refugee families		-	69,000	**69,000**
MH Services and Consulting for HBI Clients		-	57,000	**57,000**
MH and Trauma Consultation		-	27,600	**27,600**
Client Incentives and Support		-	4,000	**4,000**
Non-Patient Care				
Interpretation: the Department 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		-	87,000	**87,000**
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**
Courier Svcs		-	17,229	**17,229**
Transportation - Clients		-	10,720	**10,720**
G. CONSTRUCTION		**-**	**-**	**-**
H. OTHER		**-**	**20,978,664**	**20,978,664**
ANCILLARY SERVICES				

	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		-	10,002,130	**10,002,130**
	Building Occupancy: Routine building costs, including space, utilities, maintenance, lease payments, and debt service		-	5,310,098	**5,310,098**
	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		-	2,021,288	**2,021,288**
	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		-	441,549	**441,549**
	Dues & Subscriptions: Membership to reagional and national organizations and access to professional websites. This includes NACHC, Northwest Reagional 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		-	98,971	**98,971**
	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		-	21,085	**21,085**
I.	**TOTAL DIRECT CHARGES**		**8,655,486**	**128,498,940**	**137,154,426**
J.	**INDIRECT CHARGES**		**986,708**	**9,103,588**	**10,090,296**
K.	**TOTAL COSTS**		**9,642,194**	**137,602,528**	**147,244,722**
	LESS				
	PROGRAM INCOME		**-**	**76,489,267**	**76,489,267**
	LOCAL GRANT SUPPORT		**-**	**6,381,147**	**6,381,147**
	FEDERAL FUNDS REQUESTED		**9,642,194**	**-**	**9,642,194**
	OTHER FEDERAL FUNDING		**-**	**3,715,352**	**3,715,352**
	OTHER - PHARMACY FEES / PCPCH		**-**	**38,918,711**	**38,918,711**
	GENERAL FUND MATCH (Applicant)		**-**	**12,098,050**	**12,098,050**
	RESIDUAL		**-**	**-**	**-**

OMB No.: 0915-0285. Expiration Date: 9/30/2016

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	51,758	225,666	313.09	70,653,768	65,736,668
2	Medicare	5,292	23,071	151.44	3,493,872	2,815,823
3	Other Public	-	-		-	-
4	Private	2,943	12,361	125.06	1,545,867	1,045,145
5	Self Pay	9,661	41,641	19.11	795,760	799,145
6	Total (lines 1-5)	69,654	302,739	N/A	76,489,267	70,396,781
Part 2: Other Income - Other Federal, State, Local and Other Income						
7	Other Federal				3,715,352	4,459,751
8	State Government				5,379,330	5,742,862
9	Local Government				421,339	411,792
10	Private Grants/Contracts				580,478	444,992
11	Contributions				-	-
12	Other - Pharmacy Fees / PCPCH				38,918,712	37,574,424
13	Applicant (County General Fund)				12,098,050	11,982,315
14	Total Other (lines 7-13)				61,113,261	60,616,136
Total Non-Federal (Non-section 330) Income (Program Income Plus Other)						
15	Total Non-Federal (lines 6 + 14)				137,602,528	131,012,917
Comments/Explanatory Notes (if applicable)						

Public Burden Statement: An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid OMB control number. The OMB control number for this project is 0915-0285. Public reporting burden for this collection of information is estimated to average 1 hour per response, including the time for reviewing instructions, searching existing data sources, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to HRSA Reports Clearance Officer, 5600 Fishers Lane, Room 10-33, Rockville, Maryland, 20857.

Federally-Supported Personnel Justification Table

Note: The award funds may not be used to pay the salary of an individual at a rate in excess of Federal Executive Level II or $192,300 . Provide all base salaries at the full amount even if they exceed the salary limit

POSITION TITLE	FTE APPLIED TO FEDERAL GRANT FUNDS	TOTAL FEDERAL SUPPORT REQUESTED
Business Process Consultant	1.00	$ 84,575
Clerical Unit Coordinator	0.70	$ 42,930
Clinical Services Specialist	0.80	$ 63,903
Community Health Nurse	10.90	$ 987,988
Community Health Specialist 2	1.40	$ 75,445
Dental Assistant (EFDA)	2.00	$ 98,841
Dental Hygienist	1.00	$ 87,298
Eligibility Specialist	2.65	$ 149,136
Executive Specialist	1.00	$ 56,009
Finance Specialist 1	1.00	$ 56,547
Finance Technician	0.45	$ 21,083
Licensed Community Practical Nurse	4.25	$ 276,140
Medical Assistant	12.65	$ 609,464
Nurse Practitioner	3.20	$ 418,222
Nurse Practitioner Manager	0.60	$ 88,114
Office Assistant 2	10.78	$ 488,705
Office Assistant Senior	0.67	$ 31,088
Operations Process Specialist	1.00	$ 70,761
Operations Supervisor	1.00	$ 69,727
Physician	3.30	$ 634,590
Physician Assistant	0.80	$ 96,439
Program Communications Specialist	0.50	$ 36,575
Program Coordinator	1.00	$ 66,787
Program Specialist	2.00	$ 119,649
Program Specialist Senior	2.00	$ 169,987
Program Technician	0.85	$ 43,156
Project Manager (NR)	1.00	$ 100,716
Project Manager Represented	0.50	$ 47,694
Totals	**69.00**	**$ 5,091,569**

HRSA GRANT BUDGET
Grant # H80CS00149
Grant Year 19

PERSONNEL	**$ 5,091,569**
Salaries for health center staff including: 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	**$ 3,421,877**
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 access and remain in Primary Care, access drug therapies and includes supportive counseling.	
TOTAL DIRECT CHARGES	**$ 8,655,486**
"Direct" charges are costs connected to specific services or products	
INDIRECT CHARGES	**$ 986,708**
The FY 2020 Multnomah County Cost Allocation Plan has set the Health Department's indirect rate at 11.59% of Personnel Expenses (Salary and Fringe Benefits). Indirec charges are costs to maintain the health center's day-to-day operations but that are not connected to specific services or products.	
TOTAL COSTS (Direct and Indirect Charges)	**$ 9,642,194**

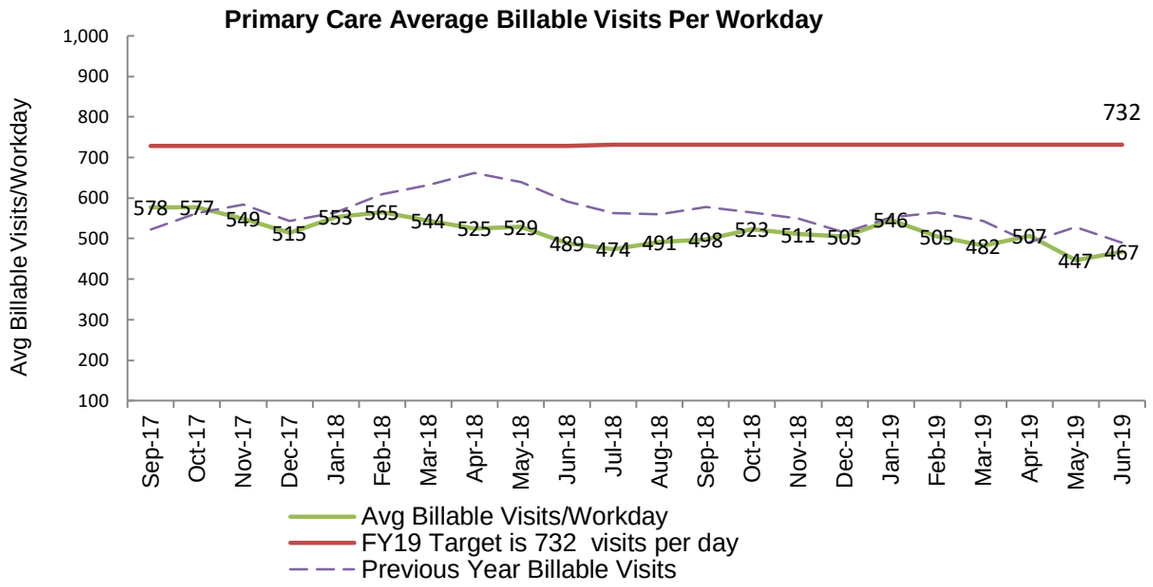
Multnomah County - Federally Qualified Health Center

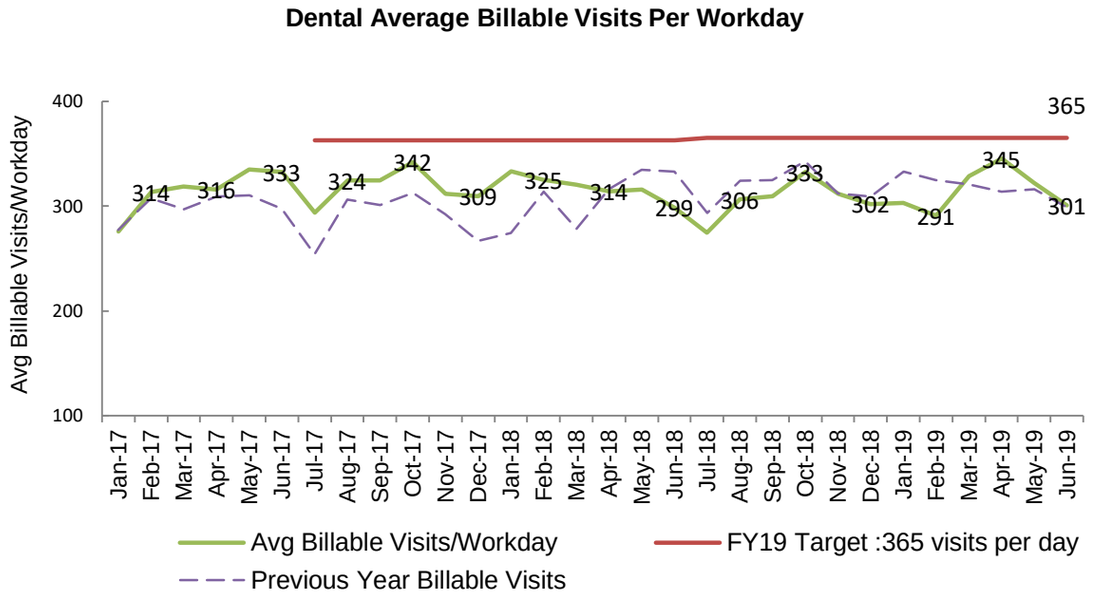
Monthly Dashboard

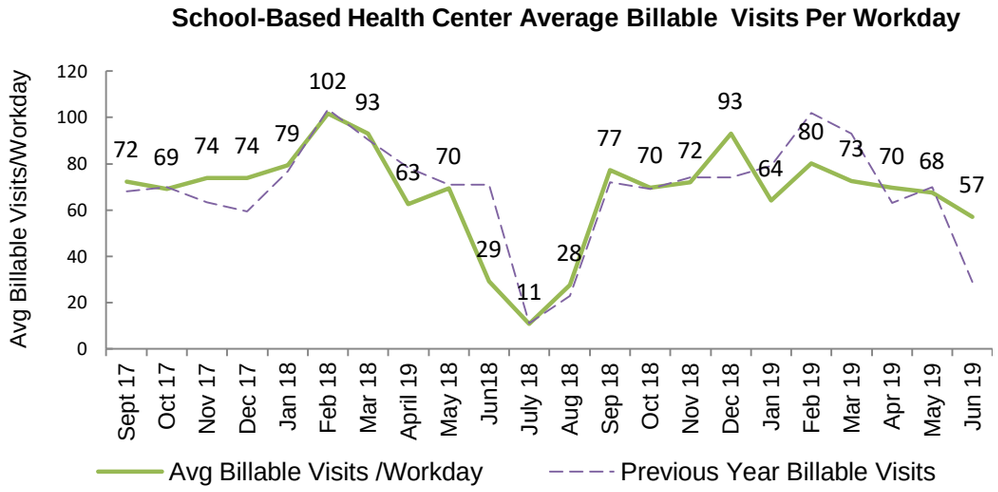
Jun 2019

Prepared by: Larry Mingo

FQHC Weekly Billable Visits Per Department



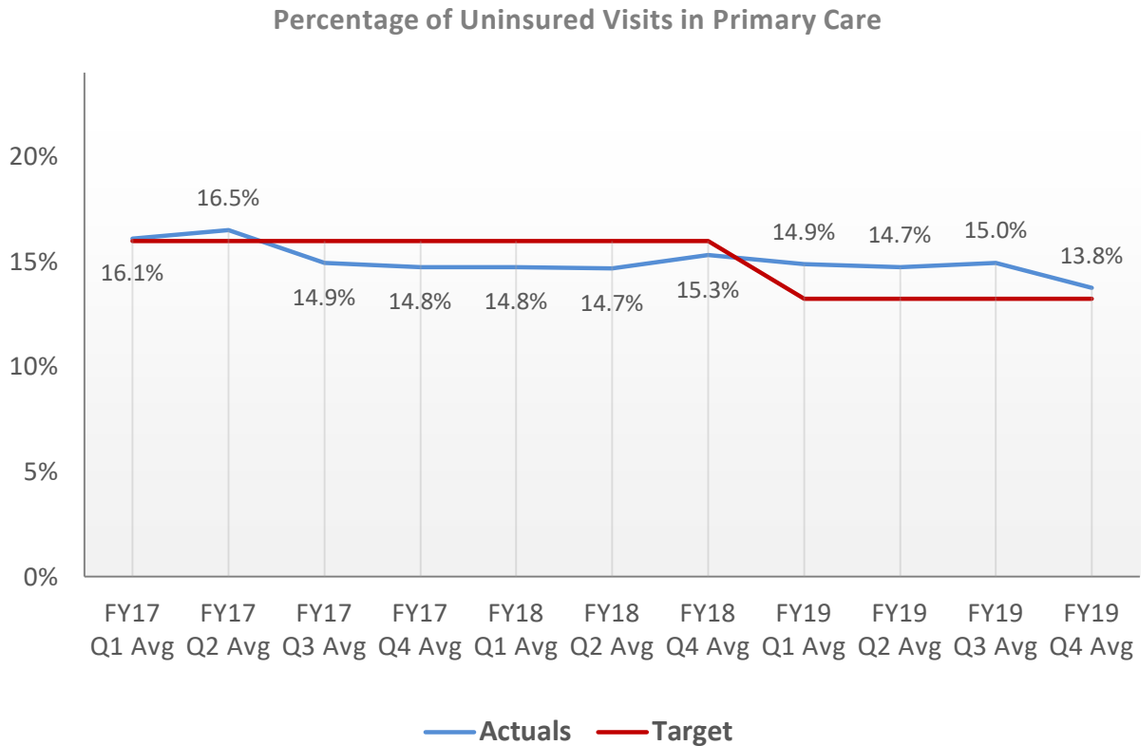


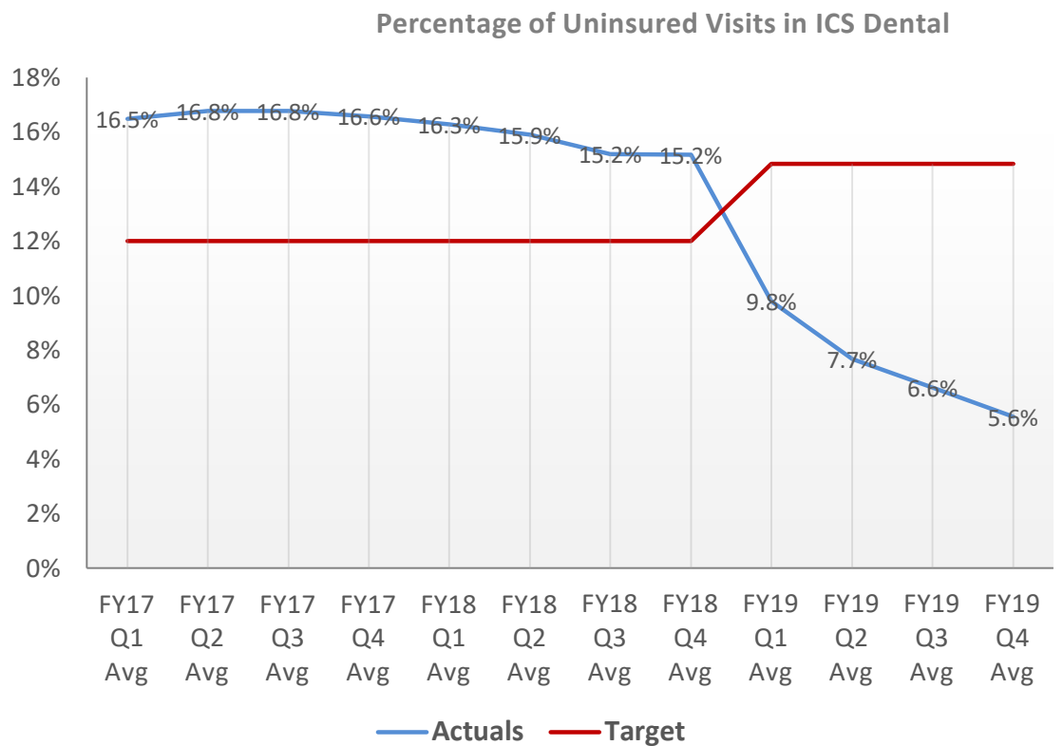


* SBHC clinics are closed during the month July except Parkrose SBHC

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.

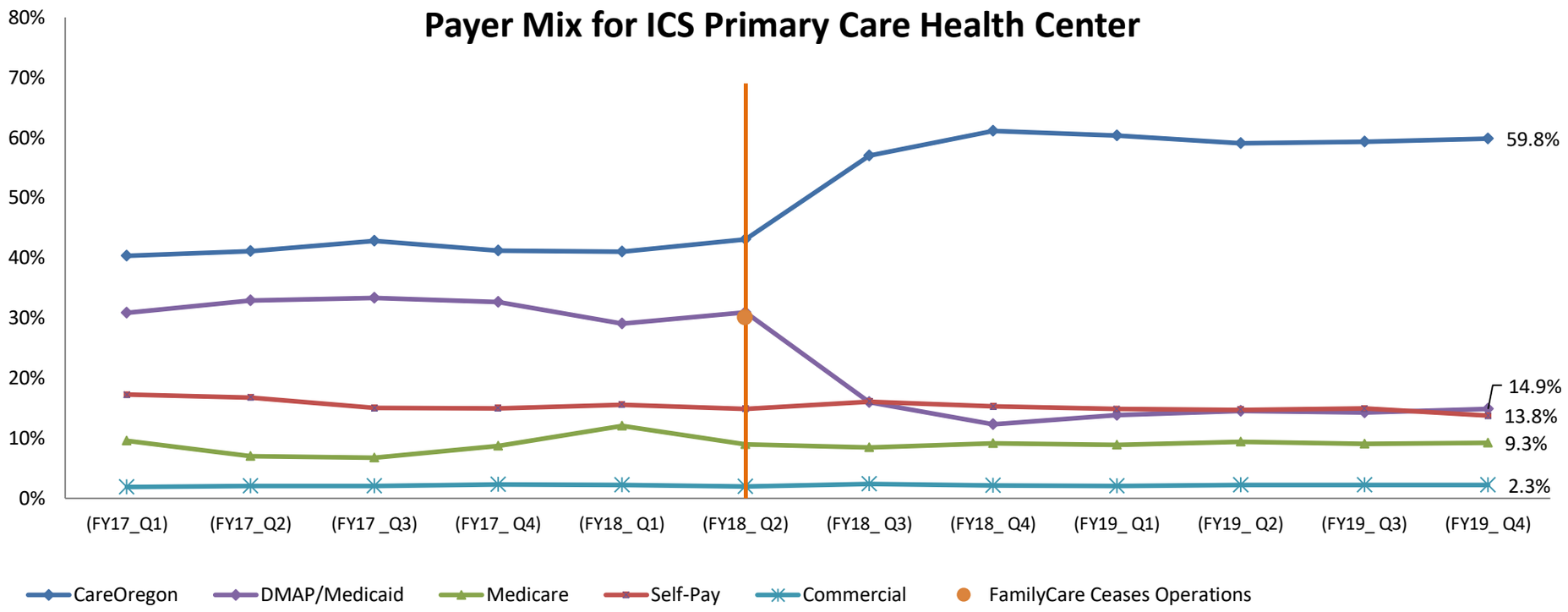
Monthly Percentage of Uninsured Visits for FQHC Centers





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%

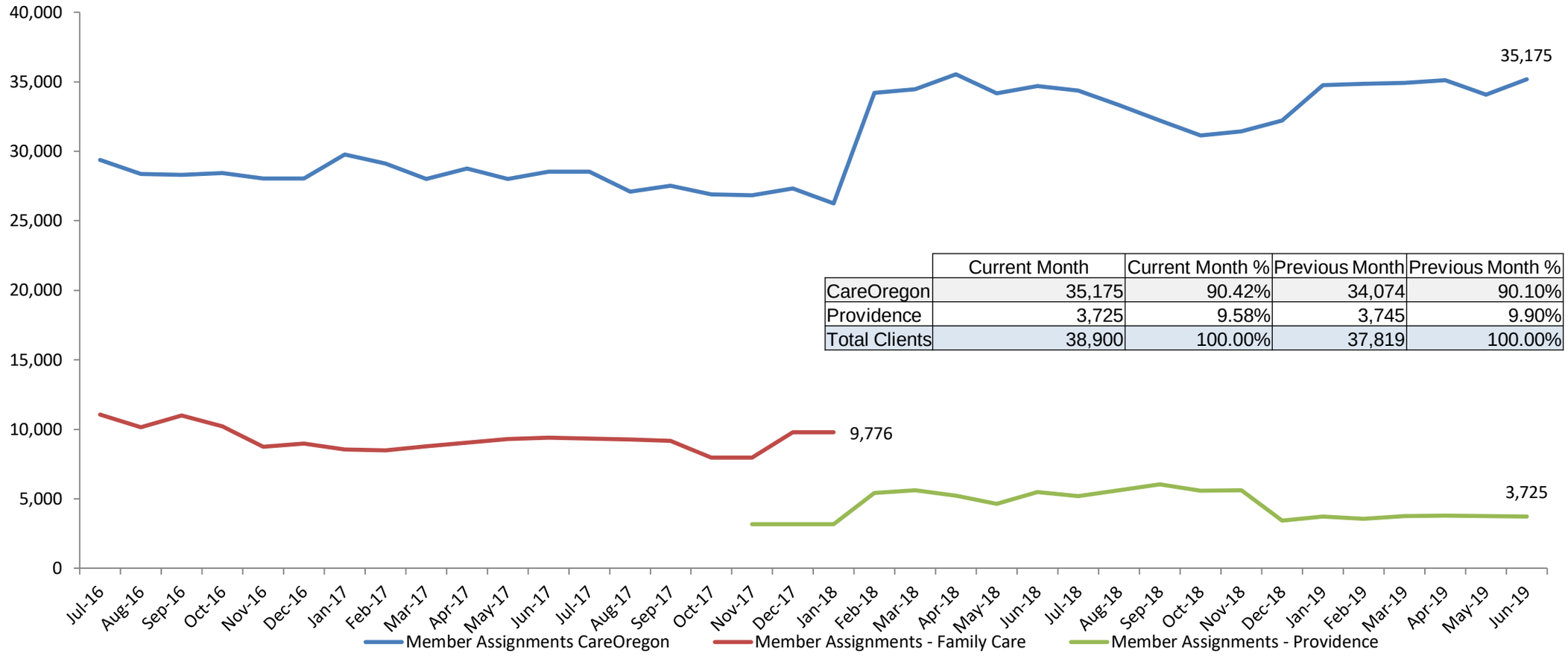
FQHC Monthly Percentage of Visits by Payer for ICS Primary Care Health Centers



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

OHP Primary Care Member Assignments



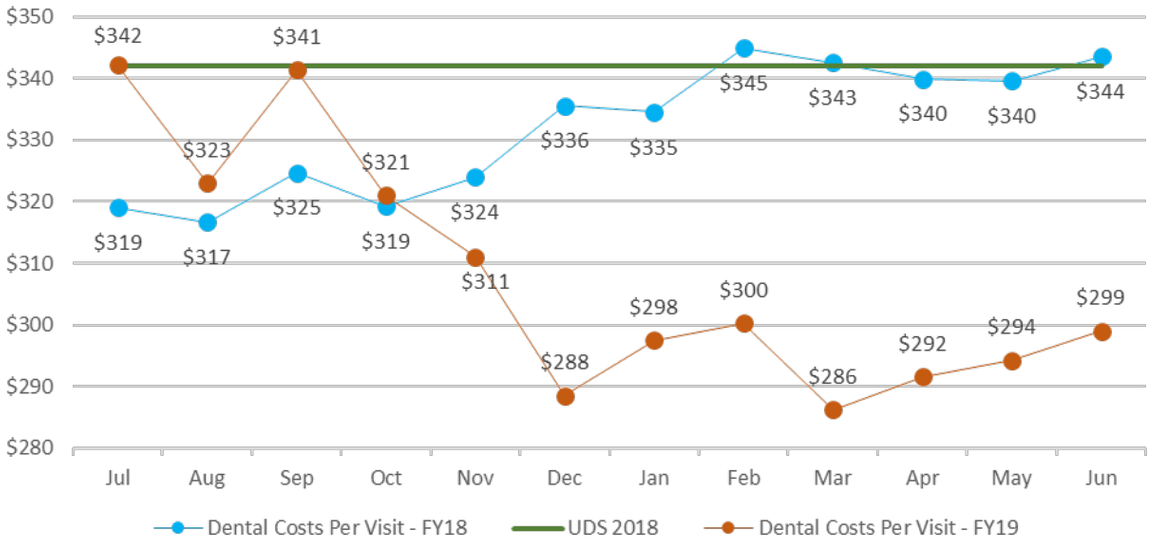
	Current Month	Current Month %	Previous Month	Previous Month %
CareOregon	35,175	90.42%	34,074	90.10%
Providence	3,725	9.58%	3,745	9.90%
Total Clients	38,900	100.00%	37,819	100.00%

CareOregon FY19 average: 33,631

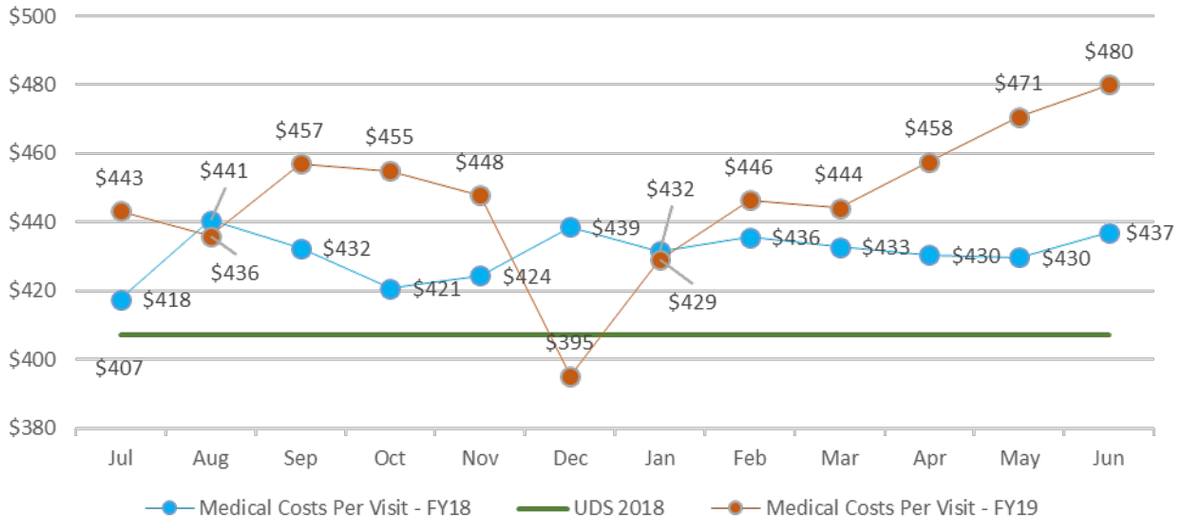
Providence FY19 average: 4,479

Key UDS Indicators
Jul 2017 – Jun 2019

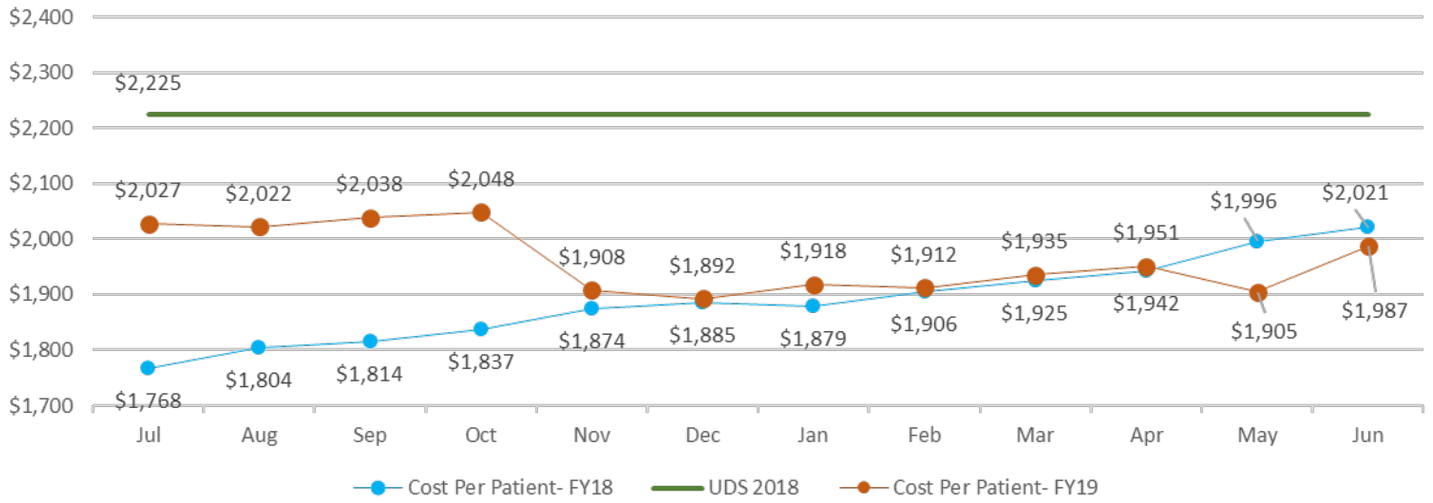
Dental Cost Per Dental Visit



Med Cost per Med Visit

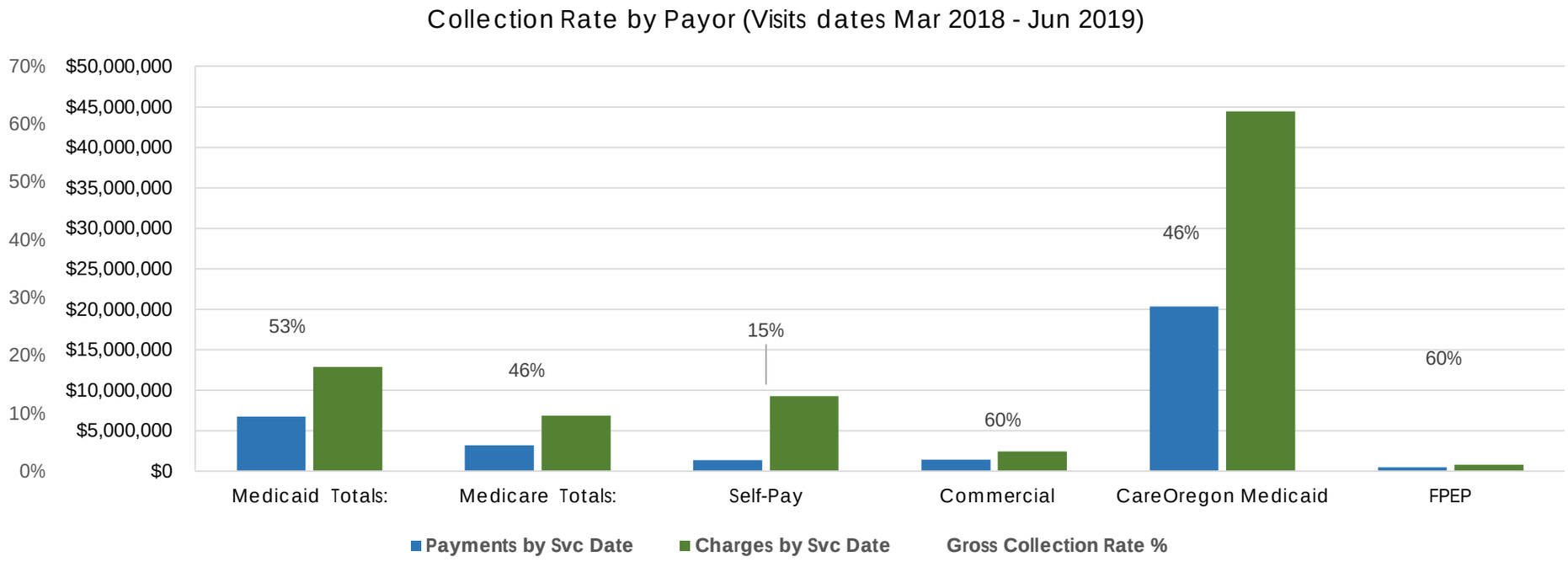


Cost Per Patient: Rolling 12 Months



FQHC Gross Collection Rate by Payer
March 2018 – Jun 2019

	Medicaid Totals:	Medicare Totals:	Self-Pay	Commercial	CareOregon Medicaid	FPEP
Payments by Svc Date	$6,785,909	$3,188,661	$1,389,985	$1,470,403	$20,377,096	$475,269
Charges by Svc Date	$12,890,541	$6,914,490	$9,294,904	$2,449,442	$44,452,046	$787,851
Gross Collection Rate %	53%	46%	15%	60%	46%	60%



Community Health Council

Changes in Scope for Student Health Centers: Increasing Access

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

Date of Presentation: 8/12/2019	Program / Area: Student Health Centers School and Community Oral Health
Presenters: Alexandra Lowell & Courtney Kappes	

Project Title and Brief Description:

Student Health Centers (SHC): Increasing Access:

1. Switching days of access to nurse practitioner (NP) and registered nurse (CHN)
2. Increasing access to behavioral health services, and
3. Moving the dental hygiene services from Centennial SHC to the new SHC at Reynolds slated to open winter 2020.

Describe the current situation:

.

Site	Prior State	Change
Centennial	Non-NP day Monday (CHN covers) Oral Hygiene chair 1 day/wk	Non-NP day Tuesday (CHN covers) Oral Hygiene chair moves to Reynolds when open
Cleveland	No changes	
David Douglas	NP coverage 5 days/week	Adding 2nd NP every Thursday
Franklin	No changes	
Jefferson	Non-NP day Thursday (CHN covers) Closed Tuesday	Non-NP day Wednesday (CHN covers) Closed Friday

Madison	Non-NP day Wednesday (CHN covers)	Non-NP day Thursday (CHN covers) Moving to Marshall Campus for 2 years due to school remodel
Parkrose	No Behavioral Health provider (BHP)	Adding 2 days BHP time
Reynolds		Opening tentatively January 2020 Open Monday/Wednesday/Friday NP 3 days BHP 2 days Oral Hygiene chair moves from Centennial
Roosevelt	Non-NP day Friday (CHN covers) No BHP	Non-NP day Thursday (CHN covers) Behavioral Health intern 2 days/week

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

· As a measure to address the County budget deficit, SHC eliminated a vacant Community Health Nurse (CHN) position. This decision resulted in the need to shift the day of the week the non-NP day falls to ensure the three existing CHNs could cover all 8 sites (Reynolds not slated to have non-NP day).

· SHC has sought ways to increase access to behavioral health at our sites. SHC hired one BHP at .8 FTE and secured one Portland State University masters of social work intern at .4 FTE.

· SHC has one dental hygiene chair at Centennial SHC since May 2014 that has been consistently underutilized. Reynolds School District included dental services in their scope of services and would like MCHD to provide the services.

Briefly describe the history of the project so far *(be sure to note any actions taken to address diverse client needs and cultures; to ensure fair representation in review and planning)*

There are several compelling reasons to move the dental hygiene services from Centennial to Reynolds SHC.

- Reynolds has a higher concentration of our Medicaid target audience than Centennial

Community Health Council

- Reynolds school enrollment is nearly double that of Centennial (high school: 2,700 students vs. 1,700 students, district: 11,276 vs. 6,215)
- Despite our greatest efforts with outreach, we have not seen the demand for services grow at Centennial and feel the resources will be better utilized at Reynolds. FY16: 137 vs FY19: 139
- Space: a space is included in the health center design layout and will not have a negative impact on our medical exam rooms.
- Cost: it will cost $1500 to move the equipment for Centennial HS to Reynolds HS. All other costs associated with the build out of this room will be covered by Reynolds in the capital construction budget.

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

· N/A

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

· Non-NP days (CHN only days) are determined, schedule is finalized and communicated to SHC team.

· Behavioral health days are determined, schedule is finalized and communicated to SHC team, and 920 BH visits to be provided in FY20.

· Dental hygiene services are moved from Centennial to Reynolds SHC in Dec 2019.

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

· We won't have the ideal staffing schedule of a CHN always available during non-NP days.

· The dental hygiene chair will remain at Centennial. Reynolds School District will find another dental sponsor to provide the dental hygiene services.

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

· SHC management team, affected NPs, CHNs, and BHPs

· Len Barozzini, Christine Palermo, Vanetta Abdellatif, Tasha Wheatt-Delancy

Who are the area or subject matter experts for this project? *(& brief description of qualifications)*

· SHC management team, School and Community Oral Health team

· Vanetta Abdellatif, Tasha Wheatt-Delancy, Len Barozzini, Christine Palermo

Community Health Council

What have been the recommendations so far? · All support the proposed changes.
How was this material, project, process, or system selected from all the possible options?

Council Notes:

Title:	**Patient Rights and Responsibilities**		
Policy #:	ICS.04.18		
Section:	Agency Wide Clinical	Chapter:	**General**
Approval Date:	08/12/2019	Approved by:	Vanetta Abdellatif, MPH Integrated Clinical Services Director Tara Marshall Chair, Community Health Council
Related Procedure(s):	Not Applicable		
Related Standing Order(s):	Not Applicable		
Applies to:	All Dental, Lab, Pharmacy, and Primary Care Staff		

PURPOSE

This policy ensures that the health center respects patient rights, providing an important aspect of care that has been shown to encourage patients to become more informed and involved in their care. These empowered patients ask questions and develop better relationships with their caregivers. This acknowledgement of patient rights also helps patients feel supported by the health center and those people directly involved in their care, treatment, and services. The health center defines these responsibilities and then relays them to the patient. When patients understand and accept their responsibilities, the concept of the patient as a partner in care becomes a dynamic component of the patient's episode of care.

DEFINITIONS

Term	Definition
N/A	

POLICY STATEMENT

All patients served within ICS Health Centers shall be informed of their rights and responsibilities.

Rights and Responsibilities statements shall be prominently posted throughout patient areas, in English and other major languages served by the health center. Copies of Rights and Responsibilities statements shall also be available in health center reception areas, and upon request from any health center employee. Health Center management staff shall be responsible

for answering questions or addressing concerns of patients related to their rights and responsibilities.

REFERENCES AND STANDARDS

Joint Commission Requirements regarding the Rights and Responsibilities of the Individual

- Standard RI.01.01.01: The organization respects patient rights.
- Standard RI.01.01.03: The organization respects the patient's right to receive information in a manner he or she understands.
- Standard RI.01.02.01: The organization respects the patient's right to participate in decisions about his or her own care, treatment, and services.
- Standard RI.01.03.01: The organization honors the patient's right to give or withhold informed consent.
- Standard RI.01.05.01: The organization addresses patient decisions about care, treatment, and services received at the end of life.
- Standard RI.02.01.01: The organization informs the patient about his or her responsibilities related to his or her care, treatment, and services.

PROCEDURES AND STANDING ORDERS

Not applicable

RELATED DOCUMENTS

Name
Attachment A - Patient Rights and Responsibilities statement - PC-120 (available in Spanish, Russian and Vietnamese)

POLICY REVIEW INFORMATION

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

Multnomah County
Health Department

Your Rights and Responsibilities

Welcome to the Multnomah County Health Department's Health Care Clinics. We have a full range of health care professionals to address your health care needs and work with you to maintain good health. We keep your information private and your visit is always confidential.

As a patient at a Multnomah County Health Department clinic, you have **rights** regarding your health care.

You have the right . . .

- To receive dignified and high-quality treatment regardless of your race, color, national origin, disability, religion, age, sexual orientation, gender identity and expression, marital status, immigration status, veteran status, source of income, ability to pay, and family status.
- To receive appropriate assessment and treatment for your health care problems.
- To be assured of confidentiality, privacy, and security.
- To be free from mental, physical, sexual and verbal abuse, neglect, and exploitation.
- To be informed of matters concerning your health care.
- To have your pain addressed and treated effectively.
- To understand your condition and participate in your treatment.
- To end your exam at any time without losing your health care services.
- To refuse treatment if you so choose.
- To choose providers, services and consultations from those available in our clinics.
- To submit a complaint if you have problems with our services.
- To seek telephone medical advice when your clinic is closed.
- To receive interpreter services if you are a non-English speaking client.
- To receive services which meet Americans with Disabilities Act (ADA) requirements (including hearing or speech disabilities).
- To receive information about formulating an advance directive for end of life decisions, by speaking with your primary care provider.

You also have **responsibilities** related to your health care.

You have the responsibility . . .

- To show proof that you are eligible for services.
- To call for appointments and arrive on time.
- To cancel appointments you are unable to keep as far in advance as possible.
- To report changes of address and financial status.
- To be sure you understand and follow instructions about your treatment and medicines.
- To ask questions about anything you do not understand.
- To pay all of your share of your charges on a sliding scale according to your income.
- To provide current insurance information so we may bill all or part of your charges to your insurance company.
- To follow the policies of the Multnomah County Health Department.
- To be respectful of other patients, staff, and property in a manner that is dignified and courteous.
- To provide accurate and complete information about your health.
- To accept the consequences of not following treatment

Multnomah County
Health Department

Sus Derechos y Responsabilidades

Bienvenidos a las clínicas de atención médica del Departamento de Salud del Condado de Multnomah. Contamos con un amplio rango de profesionales de la salud para abordar sus necesidades de atención médica y trabajar con usted para mantener una buena salud. Mantenemos su información privada y su visita siempre es confidencial.

Como paciente en la clínica del Departamento de Salud del Condado de Multnomah, usted tiene **derechos** con respecto a la atención médica.

También tiene **responsabilidades** relacionadas con su atención médica.

Usted tiene derecho a: . .

- Recibir tratamiento digno y de alta calidad sin importar su raza, color, origen nacional, discapacidad, religión, edad, orientación sexual, identidad y expresión de género, estado civil, estado de inmigración, estado de veterano, fuente de ingresos, capacidad de pago y estado familiar.
- Recibir la evaluación y el tratamiento adecuado para sus problemas de salud.
- Que se le garantice la confidencialidad, privacidad y seguridad.
- Estar libre de abuso mental, físico, sexual y verbal, negligencia y explotación.
- Ser informado sobre asuntos relacionados con su atención médica.
- Que su dolor sea tratado y tratado con eficacia.
- Entender su condición y participar en su tratamiento.
- Terminar su examen en cualquier momento sin perder sus servicios de atención médica.
- Rechazar el tratamiento si así lo desea.
- Elegir proveedores, servicios y consultas disponibles en nuestras clínicas.
- Presentar una queja si tiene problemas con nuestros servicios.
- Buscar consejo médico por teléfono cuando su clínica esté cerrada.
- Recibir servicios de interpretación si usted es un cliente que no habla inglés.
- Recibir servicios que cumplan con los requisitos de la Ley de Americanos con Discapacidades (ADA) (incluyendo discapacidades auditivas o del habla).
- Recibir información sobre cómo formular una voluntad anticipada para las decisiones de fin de vida, hablando con su proveedor de atención primaria.

Usted tiene la responsabilidad de: . .

- Demostrar que es elegible para los servicios.
- Llamar para programar citas y llegar a tiempo.
- Cancelar las citas a las que no podrá asistir con la mayor antelación posible.
- Reportar cambios de domicilio y estado financiero.
- Asegurarse de entender y seguir las instrucciones sobre su tratamiento y medicamentos.
- Hacer preguntas sobre todo lo que no entienda.
- Pagar la parte de sus cargos en una escala progresiva de acuerdo a sus ingresos.
- Proporcionar información actual de seguro para que podamos facturar todos o parte de sus cargos a su compañía de seguros.
- Seguir las políticas del Departamento de Salud del Condado de Multnomah.
- Ser respetuoso con otros pacientes, personal y propiedad de manera digna y cortés.
- Proporcionar información precisa y completa sobre su salud.
- Aceptar las consecuencias de no seguir el tratamiento.

Title:	**Policy Approval by the Co-Applicant Board**		
Policy #:	ICS.01.41		
Section:	Integrated Clinical Services	Chapter:	**General**
Approval Date:	08/12/2019	Approved by:	Vanetta Abdellatif, MPH Director, Integrated Clinical Services Tara Marshall Chair, Community Health Council
Related Procedure(s):	Link to the procedural document(s) for this policy. Write "See section below" if included in this policy document or "Attached" if the procedure document is an attachment or write "Not Applicable.".		
Related Standing Order(s):	Not Applicable		
Applies to:	ICS Director, Primary Care Services Director, ICS Quality Director, Dental Director, Medical Director, Deputy Medical Director, Pharmacy and Lab Services Director, Lab Manager, CSI Manager, Health Center Operations Supervisors, Dental Operations Manager, and any other staff who develop health center policies		

PURPOSE

To describe a process for developing, reviewing, and approving clinical and administrative guidelines that require Co-Applicant Board approval to ensure compliance with the Health Resources Services Administration (HRSA) regulations and Joint Commission Standards.

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	Definded by the Health Center Program's authorizing statute as a health center funded through a section of 330 grant to a public agency.
Co-Applicant Agreement	The Co-Applicant Agreement delegates the required authorities and and functions of the Co-Applicant Board (the Multnomah County Community Health Council) and delineates the roles and responsibilities of the public agency and the co-applicant in carrying out the health center project.

POLICY STATEMENT

The following policies must be reviewed and approved by the CHC to meet HRSA program requirements:

Policy Title and #	**Policy Description**
ADM.01.04 ICS Vision, Mission, and Values	Describes the vision, mission, and values for ICS.
ICS.01.45 Health Center Service Area Criteria	Describes the service area where the Community Health Centers operate and provide care to patients.
ICS.01.44 ICS Quality Improvement Policy	Describes the quality improvement and assurance policy for Integrated Clinical Services and related health center programs.
ICS.01.19 Primary Care Provider Assignment and Selection	Describes the process used to link each ICS primary care client with a Primary Care Provider (PCP).
ICS.01.29 Patient Discharge from Clinical Services	Describes the reasons that can result in the discharge of an existing patient from clinical services. Describes the methods used to protect that patient's rights and needs.
ICS.01.41 Policy approval by the Co-applicant board	Describes the process for approving guidelines with the Co-Applicant Board.

~~ICS.01.42 Multnomah County Public Center Governance Staff Guidelines Community Health Council Board & Board of County Comissioners Co-Applicant Relationship~~	~~Describes the unique and shared governance responsibilities between the Community Health Council and the Board of County Comissioners.~~
ICS.04.08 Patient No show policy	Describes how clinics will address and respond to clients who do not attend or cancel scheduled appointments.
ICS.04.16 ICS Health Centers - Feedback and Complaint Policy	Describes how the Health Centers will receive, process, and address patient compliants.
ICS.04.18 Patient Rights and Responsilbilities	Describes how patients' rights and responsibilities are communicated to patients and employees.
ICS.05.03 Client Eligibility Criteria – School-Based Health Centers	Describes patient eligibility for receiving services at a School-Based Health Clinic (Student Health Center).
AGN.10.03 Integrated Clinical Services Fee Policy	Describes the payment model for services that balances the client's need for services, advocacy for the underserved, and fiscal sustainability.
FIS.01.06 Write Offs for Uncollectable Patient Accounts	Describes the specific circumstances when the health center will waive uncollected fees or payments due to any patient's inability to pay.
HRS.04.03 Licensing, Credentialing, and Privileging	Describes the process and activities performed to review, assess, and verify the credentials for providers working in Multnomah County.
HRS.04.07 Provider Scope of Practice	Describes the approved procedures and scope of practice by provider field of medicine.
ICS.01.47 HRSA Consolidated Appropriations Act and Legislative Mandate Review	Describes the Health Center's requirements and obligations to follow the HRSA Consolidated Appropriations Act(s) and related laws.

REFERENCES AND STANDARDS

Joint Commission Standard, LD.01.03.01 EP-6: Governance works with other leaders to annually evaluate the organization's performance in relation to its mission, vision, and goals.

~~HRSA PIN 2014-01: Health Center Program Governance~~

HRSA Health Center Program Requirements

HRSA Health Center Program Compliance Manual

Authorizing Legislation:

Section 330 of the Public Health Service Act (42 U.S.C. 254b)

Program Regulations: 42 CFR Part 51c and 42 CFR Parts 56.201-56.604

Grant Regulations: 45 CFR Part 74

PROCEDURES AND STANDING ORDERS

1. The policies requiring Co-Applicant Board approval will be presented to the CHC when modified and at least every three years.
2. The CHC will discuss the details of the policies and ICS Community Health Center administration will be available to answer questions.
3. If the CHC cannot approve the policy as submitted, the CHC will make recommendations for the revisions. Input and feedback from the co-applicant board will be collected and incorporated into a revised policy.
4. A majority vote of the CHC present is required for approval. A quorum of CHC members must be present.
5. If approved, the policy will be published by ICS Community Health Center administration. The CHC's approval will be documented in the minutes.
6. If not approved, the CHC's reasons for rejection will be documented. Policies that have not been approved by the CHC will be revised and brought back to the CHC for reconsideration.

Policies described above will not be implemented until CHC approval has been obtained.

RELATED DOCUMENTS

Name
Attachment A – Co-Applicant Board Agreement
Attachment B – Community Health Council Bylaws, 2017-19

POLICY REVIEW INFORMATION

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