Community Health Council

Community Health Council Board Meeting Minutes
Date: Monday, November 9, 2020
Time: 6:00 PM
Location: Zoom

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

Board Members	Title	Y/N
David Aguayo	Treasurer	Y
Fabiola Arreola	Vice Chair	Y
Tamia Deary	Member-at-Large	Y
Iris Hodge	Board Member	N
Kerry Hoeschen	Board Member	Y
Nina McPherson	Board Member	Y
Susana Mendoza	Board Member	Y
Harold Odhiambo	Chair	Y
Pedro Sandoval Prieto	Secretary	Y
Staff/Elected Officials	**Title**	**Y/N**
Hasan Bader	ICS Finance Project Manager	Y
Len Barozzini	Dental Director, Interim	N
Lucia Cabrejos	Spanish Interpreter	Y
Patricia Charles-Heathers	Health Department Director	N
Brieshon D'Agostini	Interim Quality Director	N
Adrienne Daniels	ICS Deputy Director	Y
Amy Henninger	Interim Medical Director	Y
Toni Kempner	Regional Clinic Manager	Y
Michele Koder	Pharmacy and Lab Services Director	Y
Charlene Maxwell	Deputy Nurse Practitioner Director	Y
Linda Niksich	Community Health Council Coordinator	Y
Christine Palermo	Dental Program Manager	N
Debbie Powers	Primary Care Clinical Deputy Director	Y
Jordana Sardo	Administrative Analyst/Scribe	Y
Dawn Shatzel	Primary Care Services Director, Interim	N
Tasha Wheatt-Delancy	ICS Director	Y
Trista Zugel-Bensel	Budget Analyst Senior, DCM	Y

Guests: Aluzzine Konteh; Lauren Yauk; Brandi Valasquez; Darrell Wade

Action Items:

- Provide summary of 1st quarter net collection rates.
- Provide a breakdown by schools next time Student Health Center financials are reviewed.

Decisions:

- Approved October 12, 2020 Meeting Minutes
- Approved Request County HIPAA lawyer provide analysis HIPAA case to IT analysis
- Approved Request Assessment from IT security to Determine if there are other alternatives to CEDARs in order to protect patient level data
- Approved Retain Forensic Financial Auditor to provide health center program revenue analysis
- Approved Cost benefit analysis for hiring an internal financial auditor compared to what it would mean to lose the health center grant and revenue
- Approved Request an internal assessment for incorporating the Board and what are the benefits and constraints
- Approved HRS.04.03 Policy Update
- Ballot Vote Results; Approved Pedro 1-year term extension
- Ballot Vote Results; Approved Fabiola 2nd 3-year term

Reports Received:

- Monthly/1st Quarter Budget Report FY 2021
- Executive Officer Slate of Candidates for 2021 Announced

The meeting was called to order at 6:17pm by Board Chair, Harold Odhiambo.

The Meeting Ground Rules (special considerations for online meetings) were presented by Board Chair, Harold Odhiambo.

Board attendance was taken by roll-call. Noted that quorum was met with 8 members in attendance.

<u>October 12, 2020 Meeting Minutes Approval</u> (VOTE REQUIRED)
(See Document - October 12, 2020 CHC Meeting Minutes)

No questions or comments were raised by CHC members

Motion by Fabiola to approve the October 12, 2020 Meeting Minutes.
Seconded by Tamia
7 aye; 0 nay; 1 abstain

Motion carries

Executive Session 6:30pm - 8:08pm

HC Compliance Update

Presented by Tasha Wheatt-Delancy, ICS Director, and Adrienne Daniels, ICS Deputy Director. Council members move into a private Executive Session for discussion. Executive Sessions are not open to the Public.

Council members emerged from Executive Session to vote on topics discussed in Executive Session **(VOTE REQUIRED)**

Break

Approve all five items that had been discussed in Executive session

Motion by Tamia to approve all five items that had been discussed in Executive session
Seconded by Nina
1 aye; 1 nay; 6 abstain
Motion fails

Request County HIPAA lawyer provide analysis HIPAA case to IT analysis

Motion by Kerry to approve the Request County HIPAA Lawyer provide analysis of HIPAA case in addition to IT analysis
Seconded by Tamia
8 aye; nay; abstain
Motion carries

Request Assessment from IT security to Determine if there are other alternatives to CEDARs in order to protect patient level data

Motion by Kerry to approve the Request Assessment from IT security to determine if there are other alternatives to CEDARs in order to protect patient level data
Seconded by David
8 aye; nay; abstain
Motion carries

Retain Forensic Financial Auditor to provide health center program revenue analysis

Motion by Nina to approve Retain Forensic Financial Auditor to provide health center program revenue analysis
Seconded by Fabiola
7 aye; nay; 1 abstain
Motion carries

Cost benefit analysis for hiring a forensic financial auditor compared to what it would mean to lose the health center grant and revenue

Motion amended to read:
Cost benefit analysis for hiring an internal ~~forensic~~ financial auditor compared to what it would mean to lose the health center grant and revenue

Motion by Nina to approve Cost benefit analysis for hiring an internal ~~forensic~~ financial auditor compared to what it would mean to lose the health center grant and revenue.
Seconded by David
8 aye; nay; abstain
Motion carries

Request an assessment for incorporating the Board and what are the benefits and constraints

Motion amended to read:
Request an internal assessment for incorporating the Board and what are the benefits and constraints

***Motion by David to* Request an internal assessment for incorporating the Board and what are the benefits and constraints.**
Seconded by Tamia
8 aye; nay; abstain
Motion carries

Monthly/1st Quarter Budget Report
(See Documents- Monthly/1st Quarter Budget Report)

Presented by Hasan Bader, ICS Finance Project Manager.

- Quarterly financials for the first quarter which is July through September 2020.
- Reviewed daily billable visits - Student Health Center billable visits were

anticipated to be low due to school closed during summer. It does not reflect a trend for the year or for following months. Dental billable visits are below budget target but climbing. Reminded Council that the budget was crafted in January prior to COVID. Primary Care billable visits/day dipped in March and April and then saw an upward trend. Billable visits are beginning to improve.

- Monthly percentage for uninsured visits for FQHC Centers - Primary Care saw a slight increase in self pay or uninsured percentages than what was budgeted but no one is turned away for inability to pay. Sometimes the percentage is a little higher than projected. Dental saw a spike of uninsured with COVID but has come down since then.
- Payer Mix for ICS Primary Care Health Centers - Main payer source is CareOregon, 67.8%, followed by Medicaid/DMAP and Medicare
- OHP Primary Care Member Assignment - CareOregon member assignment was 42,119 followed by Providence at 44.
- ICS Net Collection Rate by Payer - This shows payment or net collections of the quarter and the year. Explained definitions of net collection rate (payments divided by Payments plu bad debt), avoidable (bad debt) and payments.
- ICS Net Collection Rate by Service Group - Compares July through September 2020 (1st quarter) to January through September 2020 (year to date).
- FQHC Financial Statement - Grant revenue is one month behind. Expenses are made, then bill to get reimbursed. Internal services were a little behind in July and August so more expenses will be reported in coming months.

Question: *Net collection rates are higher in the quarter than YTD, do you have a sense why?*
Answer: *Will check and get a summary to the Council*

Question: *With schools being closed, the Student Health Center YTD looks like it's doing pretty good. Are students accessing the Student Health Centers that much?*
Answer: *The percentage does not reflect volume. Payment that comes in July is payment for services that were provided earlier in the year.*

Comment: *Please provide a breakdown by schools next time Student Health Center financials are reviewed?*

Comment: *We are renegotiating the gross collection, which is different from net. We are not negotiating contracts with CareOregon yet.*

Question: *When you say expenses for July, why are they not included?*
Answer: *For the finance/business services team, July is the first month of fiscal year and they are also trying to close the last fiscal year. Sometimes posting gets off because*

there is still work being done to wrap up the last fiscal year.

HRS.04.03 Credentialing Policy Update (VOTE REQUIRED)
(see document - Licensing, Credentialing and Privileging)

Presented by Adrienne Daniels, ICS Deputy Director.

- Reviewed changes to Licensing, Credentialing and Privileging policy based on feedback from the last HRSA site visit. We used to have more latitude to decide primary source verification but that has been updated with additional roles in order to follow HRSA rules. The policy statement has added those positions highlighted in yellow.

Question: *If we vote on it, when will it be effective?*
Answer: *It is effective when the board approves it.*

Question: *It would be uploaded tomorrow? Is this an expected or unexpected change?*
Answer: *The change itself was unexpected because of how we interpreted HRSA's rules. The change has a minor impact on us to include more staff in credentialing. process*

Motion by Tamia to approve the HRS.04.03 Credentialing Policy
Seconded by David
8 aye; 0 nay; abstain
Motion carries

Council Business Committee Updates

Announcements:
- Online Ballot Vote Results for Pedro 1-year term extension to complete Executive Officer Term as Secretary; Approved
- Online Ballot Vote Results for Fabiola 2nd consecutive 3-year term; Approved
- Executive Officer Slate of Candidates Announced

The Executive Committee met on 26 October, 2020
- Discussed final plan for Saturday's retreat. There will be a morning session and an afternoon session. Linda will send out materials by this week
- Tasha shared a demonstration of diversity dashboard

- Crafted agenda by previewing proposed agenda items

Adjourned 8;58pm

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

Community Health Council
Public Meeting Agenda

Monday, November 9, 2020
6:00 - 8:00 pm
(via teleconference)
Public Access Call: +1-253-215-8782
Meeting ID: 962 1204 3153
Password: 026710

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 -Meetings are open to the public -**Guests are welcome to observe/listen** -Use timekeeper to focus on agenda -Please email questions/comments outside of agenda items and for guest questions to linda.niksich@multco.us
Council Members Dave Aguayo (Treasurer); Fabiola Arreola (Vice-Chair); Tamia Deary(Member-at-Large); Iris Hodge; Kerry Hoeschen; Nina McPherson; Susana Mendoza; Harold Odhiambo (Chair); Pedro Sandoval Prieto (Secretary)

Item	Process/Who	Time	Desired Outcome
Call to Order/Welcome	• Chair, Harold Odhiambo	6:00-6:05 (5 min)	Call to order Review processes
Minutes **VOTE REQUIRED**	• Approval for October Public Meeting Minutes	6:05-6:10 (5 min)	Council votes to approve
HC Compliance Update	• ICS Director, Tasha Wheatt-Delancy • ICS Deputy Director, Adrienne Daniels	6:10-7:10 (60 min) Executive Session	Council members move into private Executive Session for discussion; Executive Sessions are not open to the Public
BREAK	• All	7:10-7:20 (10 min)	

Monthly/1st Quarter Budget Report	• ICS Finance Project Manager, Hasan Bader	7:20-7:35 (15 min)	Council receives report
HRS.04.03 Credentialing Policy Update **VOTE REQUIRED**	• ICS Deputy Director, Adrienne Daniels	7:35-7:50 (15 min)	Council Discussion and vote
Council Business Committee Updates	• Chair, Harold Odhiambo • Online Ballot Vote Results for Fabiola and Pedro • Executive Officer Slate	7:50-8:00 (10 min)	Council receives update from Chair Conducted via SurveyMonkey Executive Officer Candidates are revealed for Dec Election
Adjourn Meeting	• Chair, Harold Odhiambo	8:00	**Goodnight!**

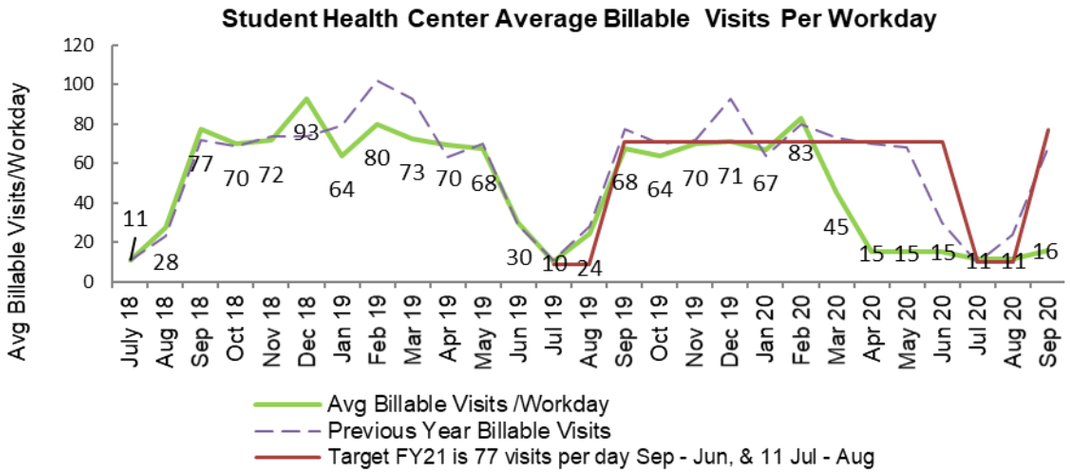
Multnomah County - Federally Qualified Health Center

Monthly Dashboard

September 2020

Prepared by: Larry Mingo

FQHC Weekly Billable Visits Per Department



What this slide shows:

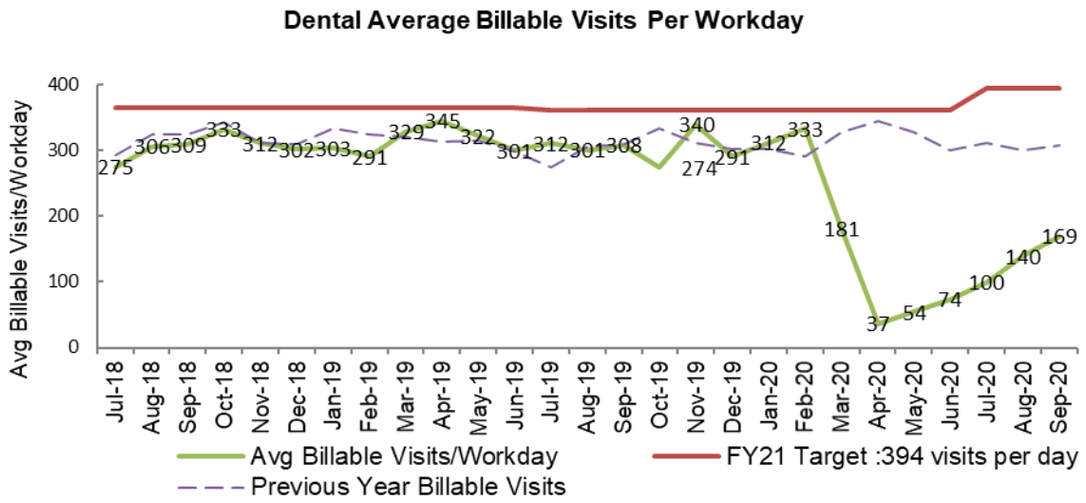
This report takes the total number of billable visits for a month and divides it by total number of work days for an Average Billable Visits per work day, and compares to a Target based on the total # of provider FTE.

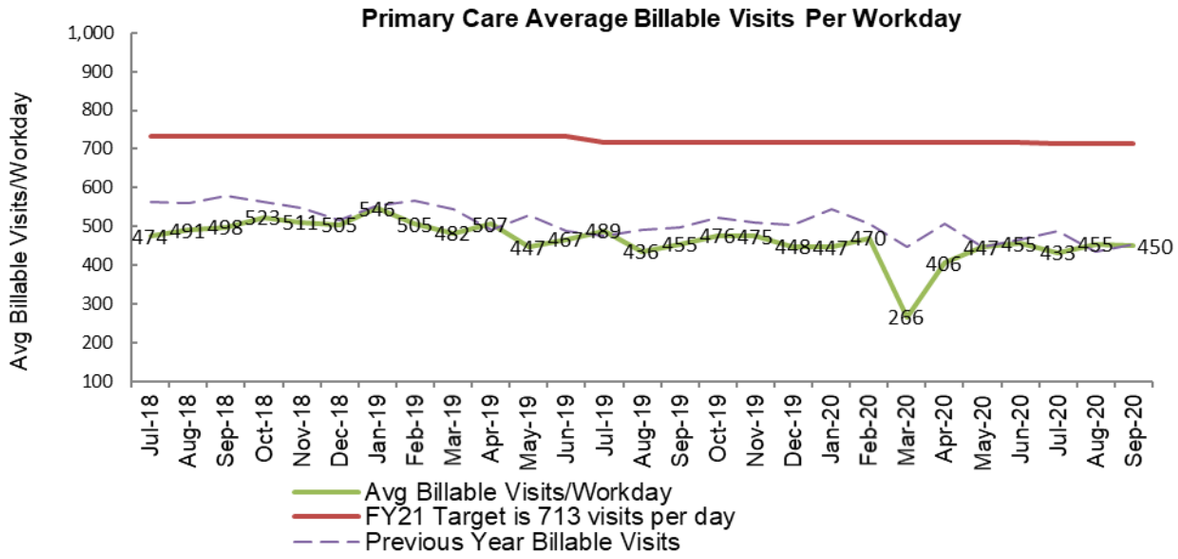
Good performance = the green "actual average" line at or above the red "target" line

Definitions:

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

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





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. Schools closed an additional 7 days in March 2020 due to Covid-19 outbreak

Monthly Percentage of Uninsured Visits for FQHC Centers

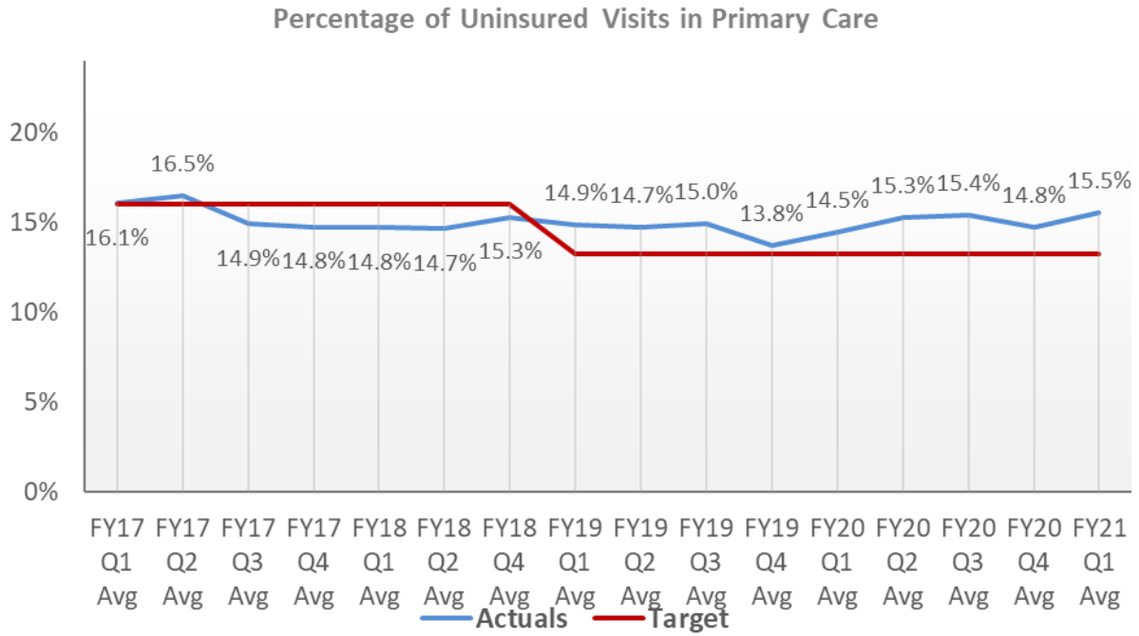
What this slide shows:

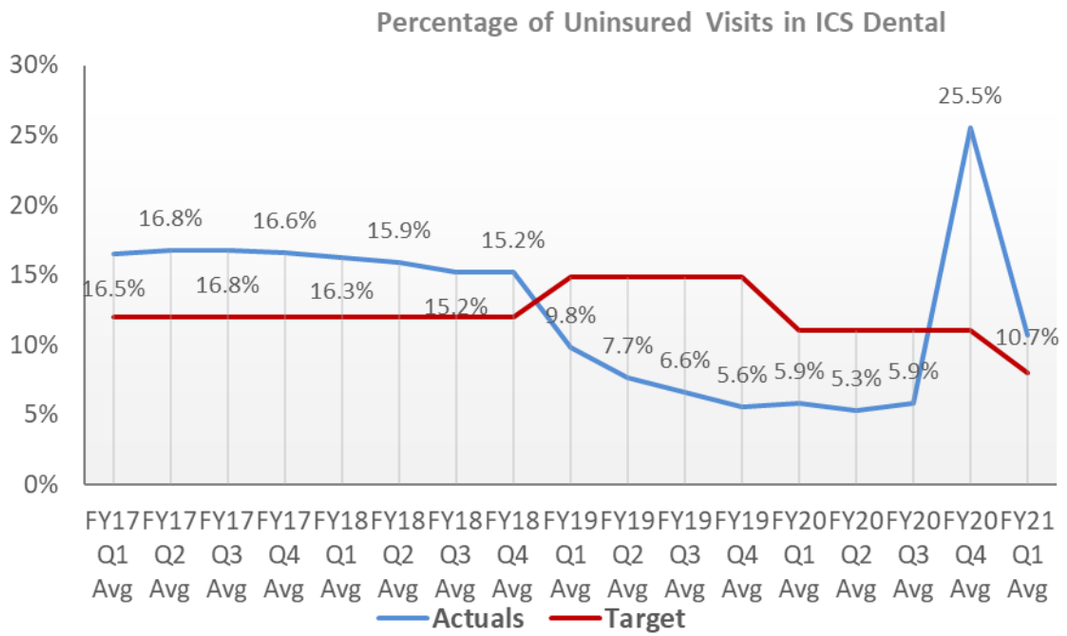
This report shows the average percentage of "self pay" visits per month.

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

Definitions:

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





Comments:
Primary Care target % of Uninsured Visits for FY18: 16%; for FY19: 13.25%; for FY20 13.27%; FY21 13.23%
Dental target % of Uninsured Visits for FY18: 12%; for FY19: 14.85%; for FY20 11.00%; FY21 8%

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

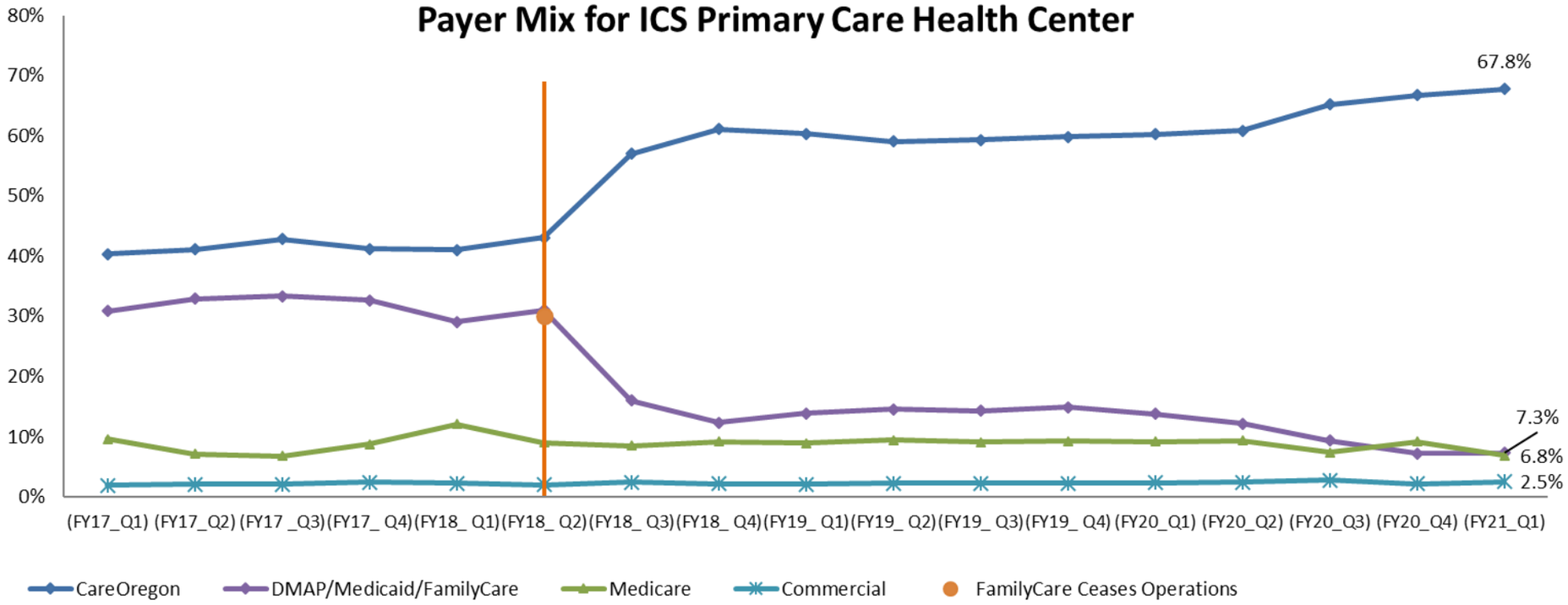
What this slide shows:

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

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

Definitions:

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



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

What this slide shows:

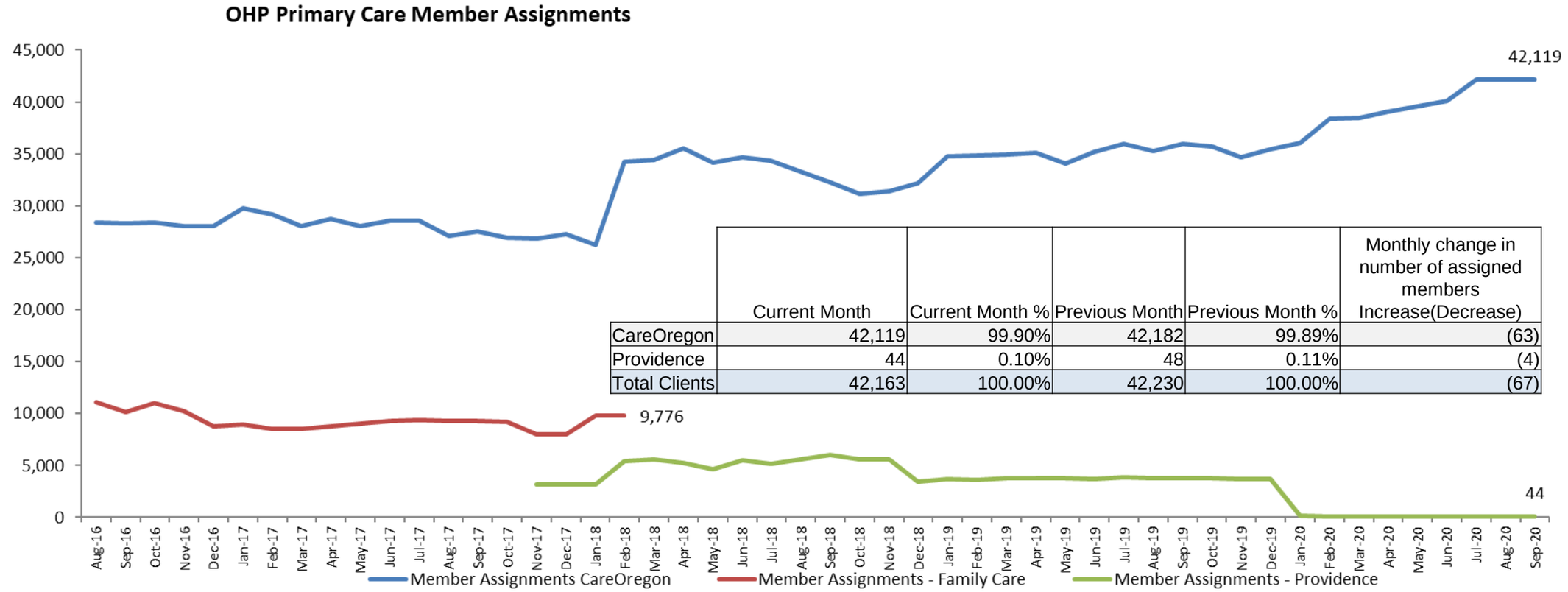
This report shows the total number of patients OHP has assigned to the Multnomah County Health Center Primary Care clinics. *NOTE: Not all of these patients have established care.*

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

Definitions:

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

PMPM: Per-Member-Per-Month. PMPM ranges around $40-60/month, depending on payer. This is only received if the patient is assigned to us by their OHP health plan AND meets criteria for being established and engaged in care (has a qualifying visit or care step)



	Current Month	Current Month %	Previous Month	Previous Month %	Monthly change in number of assigned members Increase(Decrease)
CareOregon	42,119	99.90%	42,182	99.89%	(63)
Providence	44	0.10%	48	0.11%	(4)
Total Clients	42,163	100.00%	42,230	100.00%	(67)

CareOregon FY21 average 42,142 :: Providence FY21 average 47

ICS Net Collection Rate by Payer
Jul'20 – Sep'20 vs Jan'20 – Sep'20 (YTD)

	Jul - Sep Payments	YTD Payments	Jul - Sep Net Collection	YTD Net Collection
CareOregon Medicaid	$2,641,412	$8,228,819	99%	97%
Commercial	$127,689	$728,374	83%	83%
Medicaid	$269,891	$1,129,995	91%	91%
Medicare	$529,897	$1,555,273	98%	95%
Reproductive Health	$35,858	$190,545	98%	99%
Self-Pay	$145,502	$427,675	27%	18%
	$3,750,250	$12,260,682		

What this slide shows:

This report shows the effectiveness in collecting reimbursements by Payer

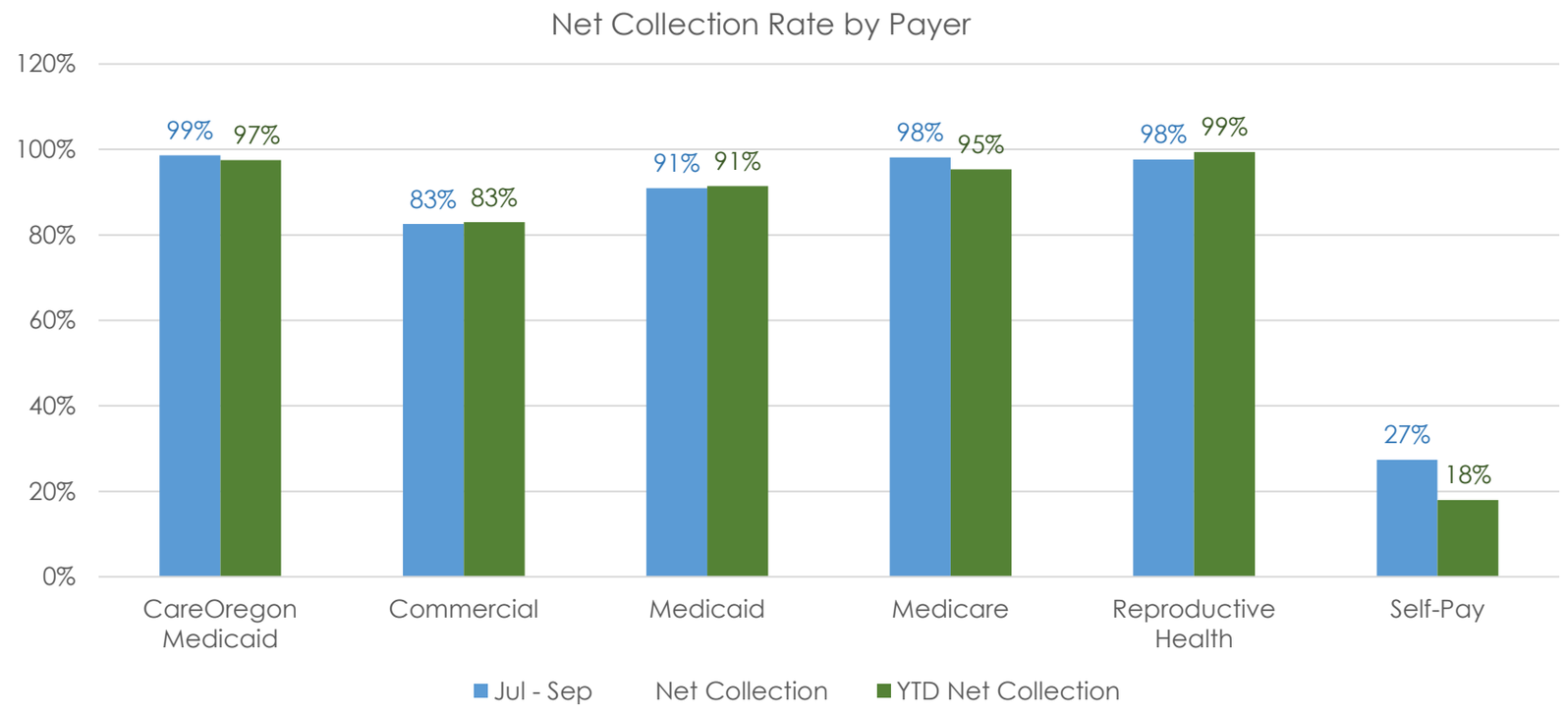
The benchmark for Net Collection Rate is 90% - 100%. Over 95% is ideal per HFMA

Definitions:

Net Collection Rate % = Payments / Payments + Avoidable

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

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



ICS Net Collection Rate by Service Group
Jul'20 – Sep'20 vs Jan'20 – Sep'20 (YTD)

	Jul - Sep Payments	YTD Payments	Jul - Sep Net Collection	YTD Net Collection
MC Dental	$763,931	$3,736,694	92%	91%
MC HSC Health Service Center	$238,705	$919,548	95%	91%
MC Pharmacy - Self Pay Only	$66,994	$181,708	44%	26%
MC Primary Care	$2,600,424	$8,560,293	89%	81%
MC School Based Health Centers	$80,195	$571,185	92%	95%
	$3,750,250	$13,969,428		

What this slide shows:

This report shows the effectiveness in collecting reimbursements by Service Group

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

Definitions:

Net Collection Rate % = Payments / Payments + Avoidable

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

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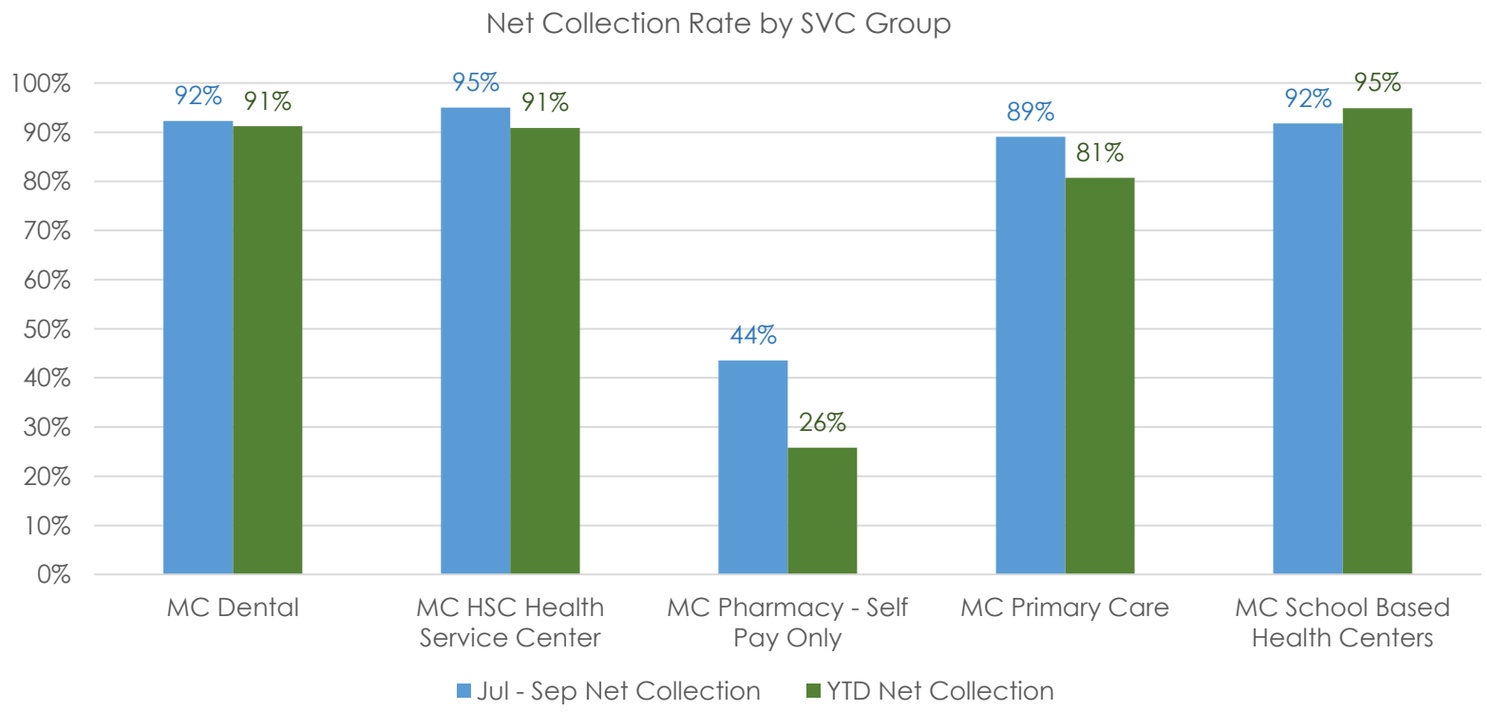

Multnomah County Health Department
Federally Qualified Health Center Financial Statement
For Period Ending September 30, 2020

Community Health Centers - Page 1

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

Behavioral Health: Revenue earned by the Mental Health Division in its capacity as an insurance provider for Medicaid clients (by way of Health Share of Oregon).

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

Medicaid Quality and Incentives (formerly Grants – Incentives): External agreements that are determined by meeting certain metrics.

Grants – All Other: The County receives various Federal and State grants for specific programmatic purposes.

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.

Write-offs: Write-offs occur when the actual amount received for a claim differs from the amount originally recorded at the time of service. Transactions are recorded as revenue, but they can be positive or negative.

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.

Multnomah County Health Department
Federally Qualified Health Center Financial Statement
For Period Ending September 30, 2020

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.

Multnomah County Health Department
Federally Qualified Health Center Financial Statement
For Period Ending September 30, 2020

Community Health Centers - Page 3												September Target:	25%
	Adopted Budget	Revised Budget	Budget Change	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20				
Revenue													
County General Fund Support	$ 10,121,214	$ 10,282,541	$ 161,327	$ 856,878	$ 856,878	$ 856,878	$ -	$ -	$ -	$ 2,570,635	25%		
General Fund Fees and Miscellaneous Revenue	$ -	$ -	$ -	$ 4,818	$ 17,641	$ 7,271	$ -	$ -	$ -				
Grants - PC 330 (BPHC)	$ 9,994,455	$ 9,994,455	$ -	$ -	$ 1,056,312	$ 1,004,805	$ -	$ -	$ -				
Grants - COVID-19	$ -	$ -	$ -			$ 32,174	$ -	$ -	$ -				
Grants - All Other	$ 9,036,672	$ 9,073,908	$ 37,236	$ 698,819	$ 496	$ 933,577	$ -	$ -	$ -				
Medicaid Quality and Incentives	$ 6,722,000	$ 6,722,000	$ -	$ -	$ -	$ 682,500	$ -	$ -	$ -				
Health Center Fees	$ 109,550,304	$ 109,550,304	$ -	$ 779,461	$ 13,191,600	$ 6,340,430	$ -	$ -	$ -				
Self Pay Client Fees	$ 1,214,770	$ 1,214,770	$ -	$ 29,056	$ 57,042	$ 45,990	$ -	$ -	$ -				
Beginning Working Capital	$ 2,515,544	$ 2,515,544	$ -	$ 209,629	$ 209,629	$ 209,629	$ -	$ -	$ -				
Write-offs	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -				
Total	$ 149,154,959	$ 149,353,522	$ 198,563	$ 2,578,661	$ 15,389,598	$ 10,113,253	$ -	$ -	$ -				
Expense													
Personnel	$ 98,585,933	$ 98,751,072	$ 165,139	$ 7,233,842	$ 7,033,847	$ 7,679,089	$ -	$ -	$ -				
Contracts	$ 4,654,127	$ 4,654,127	$ -	$ 90,123	$ 80,949	$ 267,579	$ -	$ -	$ -				
Materials and Services	$ 18,216,003	$ 18,248,980	$ 32,978	$ 1,461,548	$ 1,692,024	$ 1,305,266	$ -	$ -	$ -				
Internal Services	$ 27,437,897	$ 27,438,343	$ 446	$ 1,087,730	$ 2,743,492	$ 1,807,649	$ -	$ -	$ -				
Capital Outlay	$ 261,000	$ 261,000	$ -	$ 8,396	$ -	$ -	$ -	$ -	$ -				
Total	$ 149,154,959	$ 149,353,522	$ 198,563	$ 9,881,639	$ 11,550,311	$ 11,059,583	$ -	$ -	$ -				
Surplus/(Deficit)	$ -	$ -	$ -	$ (7,302,978)	$ 3,839,286	$ (946,331)	$ -	$ -	$ -				

Multnomah County Health Department
Federally Qualified Health Center Financial Statement
For Period Ending September 30, 2020

Community Health Centers - Page 4 — September Target: 25%

	Adopted Budget	Revised Budget	Budget Change	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Year to Date Total	% YTD
Revenue											
County General Fund Support	$ 10,121,214	$ 10,282,541	$ 161,327	$ -	$ -	$ -	$ -	$ -	$ -	$ 2,570,635	25%
General Fund Fees and Miscellaneous Revenue	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 29,730	
Grants - PC 330 (BPHC)	$ 9,994,455	$ 9,994,455	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 2,061,117	21%
Grants - COVID-19	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 32,174	
Grants - All Other	$ 9,036,672	$ 9,073,908	$ 37,236	$ -	$ -	$ -	$ -	$ -	$ -	$ 1,632,891	18%
Medicaid Quality and Incentives	$ 6,722,000	$ 6,722,000	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 682,500	10%
Health Center Fees	$ 109,550,304	$ 109,550,304	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 20,311,491	19%
Self Pay Client Fees	$ 1,214,770	$ 1,214,770	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 132,088	11%
Beginning Working Capital	$ 2,515,544	$ 2,515,544	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 628,886	25%
Write-offs	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
Total	$ 149,154,959	$ 149,353,522	$ 198,563	$ -	$ -	$ -	$ -	$ -	$ -	$ 28,081,510	19%
Expense											
Personnel	$ 98,585,933	$ 98,751,072	$ 165,139	$ -	$ -	$ -	$ -	$ -	$ -	$ 21,946,778	22%
Contracts	$ 4,654,127	$ 4,654,127	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 438,651	9%
Materials and Services	$ 18,216,003	$ 18,248,980	$ 32,978	$ -	$ -	$ -	$ -	$ -	$ -	$ 4,458,838	24%
Internal Services	$ 27,437,897	$ 27,438,343	$ 446	$ -	$ -	$ -	$ -	$ -	$ -	$ 5,638,871	21%
Capital Outlay	$ 261,000	$ 261,000	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 8,396	3%
Total	$ 149,154,959	$ 149,353,522	$ 198,563	$ -	$ -	$ -	$ -	$ -	$ -	$ 32,491,534	22%
Surplus/(Deficit)	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ (4,410,023)	

Notes:
Financial Statement is for Fiscal Year 2021 (July 2020 - June 2021). Columns are blank/zero until the month is closed.

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

> A vacant Senior Finance Manager position was moved from an out-of-scope program in the Financial and Business Management division to an in-scope program in Integrated Clinical Services. General Fund Support and Personnel each increased by $161 thousand.

> $37 thousand Public Health Title V revenue (Grants - All Other) and $37 thousand expenses (Materials & Supplies) were transferred from an out-of-scope Environmental Health program to an in-scope Early Childhood Services program.

> Three positions in ICS were reclassified to better align employees' job titles with their responsibilities. Personnel costs and internal services (indirect expense) increased by $4 thousand, with an offsetting reduction to Materials and Services.

Grants- PC 330 (BPHC): Invoicing of July expenses occurred in period 2 (August). This is a typical timeline.

Grants- All Other: Behavioral Health Grants revenue receipt from July to September received in July. We expect to receive this revenue monthly starting in October.
Programs don't always spend in a uniform manner, sometimes they fluctuate, especially with school based grants, summer is winding down and school doesn't ramp up until September.
Expenses for a period are invoiced in the next period as per the typical timeline.

Internal Services: Due to normal delays associated with the closing of the prior fiscal year, is typical to be behind in posting charges.

Title:	**Licensing, Credentialing and Privileging**		
Policy #:	HRS.04.03		
Section:	Human Resources	Chapter:	Licensing, Credentialing, Scope of Practice
Approval Date:	03/09/2020	Approved by:	Amy Henninger, MD /s/, Medical Director Harold Odhiambo /s/, CHC Chair
Related Procedure(s):	Not Applicable		
Related Standing Order(s):	Not Applicable		
Applies to:	Medical physician, osteopathic physician, nurse practitioner, physician assistant, licensed clinical social worker, certified community health specialist 2, certified community health workers, dentist, dental hygienist, psychologist, psychiatrist, clinical pharmacist, pharmacist, pharmacy technician, acupuncturist, medical laboratory technician, laboratory technologist and other licensed or certified practitioners: LPN, RN, CMA, EFDA .		

PURPOSE

This policy provides the basic guidelines used to ensure that the organization has a process in place by which providers are licensed, credentialed and privileged prior to giving client care.

DEFINITIONS

Term	Definition
Medical provider	Licensed medical practitioner to include medical doctor (MD, DO), physician assistant (PA), nurse practitioner (NP), psychologist, licensed clinical social worker, and pharmacist.
Dental provider Acupuncturist	Dentist (DMD or DDS), dental hygienist Licensed Acupuncturist (LAc)
Nurses	Registered Nurse (RN) Licensed Practical Nurse (LPN)
Clinical Pharmacist	Licensed clinical pharmacist to include pharmacist
CMA	Certified Medical Assistant
EFDA	Expanded Function Dental Assistant

POLICY STATEMENT

It is the policy of Multnomah County Health Department to engage in a process to ensure that all providers employed by the department are fully qualified and competent. This process includes documentation review, identity verification, and consideration of the applicant's credentials by the Oregon Medical Board (OMB), the Oregon State Board of Nursing, Oregon Board of Clinical Social Workers, the Oregon Board of Pharmacy, the Oregon Board of Dentistry, National Center for Competency Testing (NCCT), American Association of Medical Assistants (AAMA), National Health career Association (NHA), American Medical Technologists (AMT), Dental Assistant National Board (DANB), Multnomah County Health Department (MCHD) and the respective credentialing boards and committees used by our practices. The credentialing process applies to all roles listed as required to be enrolled in the National Practitioner Data Base (NPDB) currently including: medical physicians, osteopathic physicians, nurse practitioners, physician assistants, licensed clinical social workers, certified Community Health Specialists 2, certified community Health workers, dentists and dental hygienists, psychologists, psychiatrists, pharmacists, acupuncturists, medical laboratory technicians, pharmacy technicians, pharmacy technologists, LPNs, RNs, CMAs, EFDA's and all contracted and practicing employees in all health centers.

REFERENCES AND STANDARDS

- Joint Commission Standards HR.02.01.03
- HRSA PIN 2001-16, HRSA PIN 2002-22

PROCEDURES AND STANDING ORDERS

A. Delegation of Credentialing

The Multnomah County Board of Commissioners and the Community Health Council share responsibility for ensuring credentialing and privileging of Multnomah County Health Department providers (HRS.04.03). Both Boards agreed to grant the Health Department Director authority for credentialing and privileging, and may designate the Medical and Dental Directors as responsible for credentialing (Board Resolution 04-151). The Medical Director presents a quarterly report on fully credentialed and privileged Licensed Independent Practitioners (LIPs) to the Community Health Council for their review and approval.

The credentialing process can be contracted to a Credentials Verification Organization (CVO) to obtain the primary source verification or assigned to relevant managed care organizations e.g., CareOregon, Family Care, etc.), which are agencies that conduct a review and approval of provider credentials according to their internal policies and procedures.

The medical, dental, pharmacy, lab, operations, human resource director or designee of Multnomah County Health Department, will conduct a review of their respective practitioners' credentials; including other licensed practitioners as applicable and is responsible for final approval of all credentials and privileges, as well as formal appointment.

B. Initial Credentialing and Privileging- Multnomah County Health Department Providers

Applicant must submit to MCHD a completed, signed and dated Oregon Practitioner Credentialing Application or an MCHD employment application along with the following documents:

1. As applicable a copy of a license from the associated licensing entity.
2. A copy of DEA certification or prescriptive privileges, if applicable.
3. A copy of specialty board certificate, if applicable.
4. Peer references and release of information for each.
5. Evidence of any encumbrances to practice.
6. Application for privileges with documentation as needed (see below for details).
7. Curriculum vitae.
8. Valid government issued picture ID.
9. Current CPR Card, if applicable
10. Documentation of immunization and PPD status. In accordance with Multnomah County Executive rule no.270 and Health Department Human Resources retention schedule (DOH 50), immunization and PPD status (medical records) are not stored with employee or credentialing files. These records are maintained by Occupational Health and are available upon request.

C. Initial Credentialing and Privileging- Contracted Providers

Contracted providers are required to be credentialed and privileged by their employer in accordance with local, state and federal laws. OHSU contracted employees are credentialed and privileged. These credentials are available and monitorable on their credentialing website. For all other contracted providers, the contracted employee must be in good standing/credentialed with their employer. Additionally an up to date contract must be on file with the contracted employer to ensure they are in compliance with maintaining staffing and credentialing in accordance with HRSA requirements.

D. Verification of Training and National Practitioner Data Bank Query

1. Licensed Independent Practitioners: The credentialing program specialist or CVO will verify training using primary sources. In cases where a licensing entity completes primary source verification, a current license may be used as verification.
2. Other licensed and certified staff: The credentialing program specialist or human resources will verify and document training with primary or secondary sources. In cases

where a licensing entity completes primary source verification, a current license may be used as verification.

3. All licensed independent practitioners will be enrolled in the National Practitioner Data Bank (NPDB) upon hire. MCHD receives funding from the federal government through the Health Resources and Services Administration (HRSA) as a Federally Qualified Health Center through a Health Center grant. HRSA requires that licensed independent practitioners and other licensed or certified staff are enrolled and queried using NPDB. MCHD is signed up for continuous query. Real time reporting from the NPDB will alert MCHD of any reports made in an enrolled licensed independent practitioner and other licensed or certified staff members files. Reports are downloaded and saved to the employees credentialing file.

E. Fitness for Duty

An additional requirement of HRSA is an attestation to Fitness for Duty. The definition of Fitness for Duty according to HRSA is the "ability to perform the duties of the job in a safe, secure, productive and effective manner." Licensed independent practitioners who are credentialed attest to fitness for duty during the credentialing process. MCHD accepts this self-report as documentation of fitness for duty. All licensed or certified staff who do not undergo provider credentialing will be required to self-report and sign this attestation statement which is then reviewed by MCHD.

F. Competencies

The Multnomah County Health Department uses the following six competencies to evaluate competency:

- **Patient care**- The expectation is for all staff to provide compassionate, appropriate, and effective patient care for the promotion of health, prevention of illness and treatment of disease. This will be evaluated through peer reviews, clinical quality measures, and patient feedback surveys
- **Medical/Clinical Knowledge**- It is the expectation for all staff to: maintain certifications and licenses, attend county training offered during Grand Rounds, obtain CMEs per protocol, and complete Health Stream and other on-line training as assigned. This will be evaluated through tracking course completions in Health Stream, verifying attendance at trainings, and tracking of CMEs
- **Practice-based learning and improvement-** It is the expectation for the primary care teams to Utilize clinical quality metrics to measure for improvement. These metrics will be reviewed frequently by leadership.
- **Interpersonal and Communication Skills-** It is the expectation for all staff to interact with patients and each other in a respectful manner. This will be evaluated through patient satisfaction surveys, complaint cards, and incident reports.

- **Professionalism-**It is the expectation for all staff to demonstrate behaviors that reflect continuous professional development, diversity, and ethics. This will be measured through patient surveys, complaint cards, and attendance to annual diversity training and completion of the annual Code of Ethics review.
- **Systems-based practice-** It is the expectation all staff demonstrate an understanding of the contents and systems in which healthcare is provided. This can be evaluated through attendance to EPIC and Dentrix training, ad-hoc training for new equipment and systems.

G. Verification of License Renewals

All licensed independent practitioners and other licensed or certified practitioners will have proof of current licensure or certification in their credentialing files at all times. Practitioners will be notified of upcoming expirations of licenses. Human Resources, the Credentialing Program Specialist or designee will monitor licenses for renewal to ensure those who have a license will renew their license prior to expiration. Providers and other licensed practitioners whose license or certification has expired will not work until license or certification is renewed according to the requirements of the applicable Oregon and National Boards for the discipline of the practitioner. Tracking reports of upcoming expirations are managed by the credentialing program specialist and submitted to directors and worksite leadership upon request. Renewal of licensure is the responsibility of the employee.

H. Renewal of Credentials

Each provider must renew privileges and credentials at a minimum every two years. Licensure must be renewed as required by licensing entities. Renewal of credentials and privileges are the responsibility of the employee.

I. Denial of Credentials

When an applicant has been informed that credentialing or re-credentialing has been denied, the applicant may appeal the decision. The applicant may request a hearing before a credentialing committee as designated by respective MCHD, ICS medical, dental, pharmacy, behavioral health, and lab directors or the managed care organization's board of directors before the decision is final.

J. Medical Clinical Privileges

Medical clinical privileges are granted to practitioners based on education, clinical training, experience, demonstrated current competence and/or documented results of patient care.

Core Privileges:

Core privileges are the scope of practice as listed within each field of medicine identified in HRS.04.07. Applicants must be graduates of approved training programs and possess an active license in the state of Oregon for their discipline.

Core Privileges do not require additional documentation beyond proof of having current licensure and completion of the appropriate training program and board certification. This documentation is collected during the credentialing process.

Specialty Privileges:

Specialty privileges are granted to perform those procedures that require specific training to perform competently, and are not necessarily within the provider's core training curriculum.

Specialty privileges are granted only with the approval of the medical director or deputy medical director. Granting Specialty Privileges requires primary source verification of appropriate training. Providers must also qualify for Core Privileges.

K. Prenatal Privileging

1. All new providers/graduates who are determined to need to provide prenatal care will be enrolled in the "new" initial training/review process protocol.
2. All experienced providers who are determined to need to provide prenatal care will be enrolled in the "experienced" initial training/review process protocol.
3. All established providers must see on average 20 prenatal patients per year to maintain prenatal care privileges.
4. All below criteria must be supported with program documentation and/or prior practice documentation from medical director or equivalent. Program documentation must be submitted to the credentialing specialist.

	FP-MD	**PA**	**NP**
New provider/new graduate	Completed residency (RRC requirements)	At least 40 hours of clinical experience in prenatal/ postpartum care	At least 40 hours of clinical experience in prenatal/ postpartum care
Experienced provider	Must have cared for on average 20 prenatal patients in the last year	Must have cared for on average 20 prenatal patients in the last	Must have cared for on average 20 prenatal patients in the last

	of their practice	year of their practice	year of their practice

L. Dental Clinical Privileges

Clinical privileges for dentists and dental hygienists will be granted at a minimum every two years as part of the MCHD credentialing and re-credentialing process by the dental director.

Procedures requiring additional permits, such as Nitrous oxide permit, or parenteral sedation by the Oregon Board of Dentistry will be verified as part of the privileging process.

M. Pharmacist Clinical Privileges

Core privileges for the entire scope of practice as defined in HRS.04.07 excluding collaborative drug therapy management are granted upon proof of current licensure in good standing and completion of pertinent training programs during the credentialing process.

Privileging for collaborative drug therapy management is granted after demonstrating competency, sound clinical decision-making, and ability to adhere to protocol via peer-to-peer shadowing, review of medical record documentation, and coaching. Until such privileging is granted, the clinical pharmacist shall pend all medication orders to the primary care provider.

N. Approval and Renewal of Privileges

Medical Providers:

Applications for privileges will be submitted with documentation as needed to the medical director for review and signature. Privileges will be reviewed every two years at the time re-credentialing takes place.

Dental Providers:
Applications for privileges will be submitted with documentation as needed to the dental director for review and signature. Privileges will be reviewed at a minimum every two years at the time re-credentialing takes place.

Clinical Pharmacists:
Applications for privileges will be submitted with documentation as needed to the pharmacy director and medical director for review and signature. Privileges will be reviewed at a minimum every two years at the time re-credentialing takes place.

When there is a request for a change or revision in clinical privileges for a medical or dental provider, a search of the National Provider Data Bank (NPDB) will be performed, evaluated and documented in the subject provider's file.

O. Denial or Revocation of Privileges

The medical or dental director may deny a request for approval or renewal of privileges or may revoke existing privileges. In the event of denial or revocation of privileges, the provider may appeal the denial. A committee will be convened to review the documentation and to hear the appeal. The committee will consist of the following providers:

Medical credentialing and privileging:

- Deputy Medical Director
- A Site Medical Director
- Corrections Health Medical Director or County Health Officer
- School-Based Health Lead

The following will be excluded from the appeals hearing: MCHD medical director and the direct supervisor of the provider.

Dental credentialing and privileging:

- Medical director
- Deputy Dental Director
- Dental providers (3)

The following will be excluded from the appeals hearing: Dental director.

The provider making the appeal must submit the request for an appeal in writing, within 30 days of the notification of denial. Letter will be addressed to the MCHD medical/dental director. This director, or designee, will schedule the hearing and notify participants.

The committee will review original documentation submitted to the relevant director in the application. The provider may present oral argument at the hearing if he/she wishes to do so. The committee will discuss (in the absence of the provider) the documentation provided, oral argument, and make a decision regarding the appeal. The provider will be informed by letter of the final privileging decision.

RELATED DOCUMENTS

Name
Attachment A – Provider Scope of Practice HRS.04.07
Attachment B – Board Resolution 04-151

POLICY REVIEW INFORMATION

Point of Contact:	Amy Henninger, MD - Medical Director
Supersedes:	325(3)