HRSA Project Director / Medical Director Report to CAB
March 18, 2022

1. **Strategic Plan**
   (a) Space
      i. SCHC leadership submitted required information for the grant scope adjustment, is working on clarifying if we need a force account labor letter, and will submit the pre-approval for pre-award costs once the invoice is received from the Department of General Services
      ii. DHA now pushed to May, with hopes of Primary Health staff moving in during June.

   (b) Staffing
      i. We have found providers to work in Refugee Clinic. Drs. Nazeela Awan and Dr. Farah Shaheen will split time between Refugee Clinic and the Internal Medicine/Adult clinic. Family Nurse Practitioner (FNP) Amber Ramage will work in Refugee and help complete General Assistance evaluations.
      ii. Drs. Nazeela and Asad Awan will be joining the Internal Medicine team.
      iii. Division Manager- Currently in recruitment and interview phase
      iv. Progress on hiring Senior Office Assistants- we will be interviewing three candidates on 3/18
      v. Clerical Supervisor- Awaiting final information from HR whether we can fill this position
      vi. Temporary RNs for COVID vaccination- Two RNs recruited to help permanent RN staff focus on other duties

   (c) Focus on serving homeless individuals
      i. Growth request placed to add Homeless Lead (UCD Internist Dr. John Landefeld) to the County- UCD contract
      ii. SCHC is also talking with Loaves and Fishes management about safety issues.
      iii. The mobile van was approved as a new site by HRSA.
      iv. The team is still working on the scope of services, service locations, and staffing of the van.

2. **Grants**
   (a) HRSA ARPA
   (b) HRSA APR Capital
   (c) Anthem-Diabetic
   (d) HRSA 330e/h (main grant)
   (e) Refugee
   (f) HIV

3. **Compliance Issues**
   (a) Audits- Uniform Data System (UDS) reporting 'audit' completed and responses regarding fiscal, operations and clinical performance accepted. This is an annual audit required by health centers with a 330 designation.
   (b) 340B Program- allows entities serving the MediCal population to purchase drugs from manufacturers at a significantly reduced price. We may be audited any time in the next year so we need to really assess and eliminate areas of noncompliance. Since this will be our first 340b audit, we are looking into hiring audit consultants to help us prep

4. **Operations**
   (a) Complex Care Coordination (CCC) team services have shown a 50-60% reduction in ER/hospitalization by enrolled patients. The findings have been submitted as an abstract to Society of General Internal Medicine and accepted for presentation.
   (b) Comprehensive Perinatal Services Program (CPSP)
   (c) Neurodevelopmental Disability Assessments for children- Starting discussion with clinicians from the MIND institute.
   (d) Referrals- due to grant funding to an e-consult company (ConferMed), electronic consults to specialty services will be free to SCHC regardless of managed care plan/IPA. This may include Healthy Partners patients as well.
   (e) Healthy Partners patients 50+ will be sent a notification by DHCS regarding eligibility for full scope MediCal as of May 2022.

5. **Executive Team Leadership and Organization Development**
   (a) I am working on a potentially year-long training for the manager/supervisor on conversational intelligence, trust building and team work skills, and leadership qualities. Goal will be for us to develop tools to maximize team performance, and successful goal setting for individuals, teams and the health center.

County of Sacramento Department of Health Services Division of Primary Care Sacramento County Health Center Policy and Procedure	Policy Issuer (Unit/Program)	Clinic Services
	Policy Number	08-08
	Effective Date	08-26-2013
	Revision Date	3-8-2022
Title: Advanced Health Directive	Functional Area: Health Information Management	
Approved By: Susmita Mishra, MD, Medical Director		

I. POLICY

Sacramento County Health Center's (SCHC) policy is to empower patients to exercise the right to make decisions about their treatment. This policy is based on the law that establishes advance directives in California, the Health Care Decisions Act, which is based on the Uniform Law Commission's Uniform Health Care Decisions Act. This is a part of the California Probate Code, Sections 4670 through 4806 (see

California Probate Code.

Click the "Division 4.7. Health Care Decisions" link for the Health Care Decisions Act.).

SCHC will not condition the provision of care, or otherwise discriminate against patients, based on whether they have executed advance directives and/or made complaints regarding the care they have received.

II. PROCEDURE

A. Definitions

1. Advanced Health Care Directive (AHD): The AHD describes an individual's health care wishes, in the event the individual becomes seriously ill due to a general medical illness and are unable to speak for themselves. An individual may appoint another person (agent) who will have legal authority (Power of Attorney) to make decisions about the medical care if the individual becomes unable to make the decisions. The directive does not pertain to lack of capacity due to a severe mental illness.

   Types of Advance Directives

   - Living Will/Living Trust
   - Durable power of attorney for health care/Medical power of attorney.
   - POLST (Physician Orders for Life-Sustaining Treatment)-The POLST form is a portable medical order for specific medical treatments the patient would want (based on his/her diagnosis, prognosis and goals of care). POLST forms are appropriate for individuals with a serious illness or frailty near the end-of-life.
   - Do not resuscitate (DNR) and Do not Intubate (DNI) orders.
   - Organ and tissue donation.

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2. Power of Attorney (POA)- Any adult relative or any person trusted by a beneficiary who is willing to communicate the beneficiary's physical healthcare wishes if the beneficiary is unable to do so. The law prohibits a beneficiary from appointing his or her doctor, a person who works in the health facility in which s/he is being treated, or any person in the community care or residential care facility in which s/he receives care, unless that person is related by blood, marriage, or adoption, or is a co-worker.

   The person who is assigned POA may not be physically present at the time of signing.

   An attorney is not needed to assist patients in completing a directive. The only exception applies to individuals who are under conservatorship. The beneficiary must be represented by legal counsel and satisfy the requirements in California Probate Code 4659.

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B. General Information

1. Patients have a right to formulate advance directives. They are not required to have an AHD to receive treatment at the SCHC.

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2. All AHD forms should be signed by 2 witnesses

3. If a patient presents in an incapacitated state and is unable to receive information or articulate whether or not s/he has an executed advance directive, the information will be given to the patient's Power of Attorney

4. In the event of an emergency, SCHC will initiate treatment if unknown DNR or DNI status and will transfer patient to an acute care facility.if needed.

5. The copy of AHD will be sent to acute care facility, if available.

C. Patient Information

1. Registration staff will give patients a copy of the Health Care Directive brochure, the , and the Acknowledgment of Receipt as part of their clinic materials packet. They will be asked to read the brochure and sign the acknowledgment electronically in the EHR

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2. Witnesses will also sign electronically

3. Patients will be provided the paper copy of the Health Care Directive forms upon request.

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5. If patient declines to sign, the registration staff will enter declination in the EHR. “AHD offered, patient declined to complete” in the AHD document.

D. Documentation

1. Registration staff will provide members with the Advance Health Care Directive Brochure and obtain an electronic signature

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References
California Probate Code 4659

Attachments
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Acknowledgement of Receipt of Advance Health Care Directive Information
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Contact Information:
Sandra Johnson, Senior Health Program Coordinator

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		Policy Number	08-08
		Effective Date	08-26-2013
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Title: Advanced Health Directive		Functional Area: Health Information Management	
Approved By: Susmita Mishra, MD, Medical Director			

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County of Sacramento **Department of Health Services** **Division of Primary Health Services** **Policy and Procedure**	Policy Issuer (Unit/Program)	**Clinic Services**
	Policy Number	**04-22**
	Effective Date	**2-8-2022**
	Revision Date	
Title: **Patient Discharge from Care**	Functional Area: **Clinical Services**	
Approved By: Dr. Susmita Mishra, Medical Director		

Purpose:
To identify reasons as to why and how a patient would be dismissed from the services offered at the Sacramento County Health Center (SCHC).

Policy:

It is the policy of the Sacramento County Health Center (SCHC) to maintain a cooperative and trusting provider-patient relationship with their patients. When such a relationship is no longer proceeding in a mutually productive manner, it is the policy of the SCHC to terminate the provider-patient relationship within the bounds of applicable State and Federal laws, rules and regulations. This policy will establish guidelines for dismissing patients from care or refusing care from the services offered.

Procedure:

There are situations and circumstances that arise when it may be appropriate to dismiss patients from care or refuse patients care from the services offered at the SCHC.

The most common dismissal reasons include, but are not limited to:

A. Aggressive and threatening behavior towards staff;
   This reason is used whenever a patient exhibits behavior, either verbally and/or physically, in which an employee perceives the situation to be hostile and/or dangerous.
B. Conflict of interest;
   This reason is used whenever a patient, typically an employee or former employee, is aware of internal processes and tries to game the system in her/his favor at the expense of the organization.
C. Doctor shopping;
   This reason is used whenever a patient sees multiple providers, either during a single illness episode or to procure prescription medications illicitly, or to procure medical treatment/services that are not approved by a provider.
D. Drug seeking behavior;
   This reason is used whenever a patient exhibits behavior that is perceived as a mechanism for obtaining additional medications, from 1 or more providers and/or 1 or more pharmacies.
E. Excessive no-shows;
   This reason is used whenever a patient has three or more no-shows in a 6- month period.

F. Failure to maintain acceptable behavior;
   This reason is used whenever a patient is acting in an inappropriate manner towards either staff, providers or other patients. This can include public intoxication with disruptive behavior that is not conducive to appropriate care.

G. Lewd and inappropriate behavior towards staff;
   This reason is used whenever a patient exhibits behavior in which an employee perceives the situation to be harassing and/or sexual in nature.

H. Manipulation of health records and/or documents;
   This reason is used whenever a patient is found to have altered or manipulated her/his health records or documents, e.g., modifying optometry-related records to appear blind in an effort to qualify for disability.

I. Misrepresentation;
   This reason is used whenever a patient is found to have intentionally provided inaccurate information about her/himself or has claimed to be an entirely different patient altogether, e.g. using the insurance of another patient to avoid having to pay for services.

J. Multiple failed drug screenings;
   This reason is used when a patient fails multiple drug screens and a provider requests s/he be dismissed.

K. Non-compliance with medical advice to include but not limited to: Behavioral Health and Dental Advice
   This reason is used whenever a Medical provider feels that a patient does not agree with the medical advice or care plan that is recommended
   and believes there is nothing further s/he, as the provider, can do for the patient.

L. Property damage/vandalism;
   This reason is used whenever a patient intentionally causes property damage and/or vandalism to SCHC assets/property.

M. Self-requested dismissal; and
   This reason is used whenever a patient states that s/he no longer wants to be seen at SCHC

N. Theft
   This reason is used whenever a patient steals any item of value from SCHC.

Warning to Terminate Patient:

1. When the provider or other staff person identifies a patient with whom the provider-patient or SCHC relationship has been negatively affected, after having a significant event or more than one negative occurrence, the patient will be served with a warning notice, which may include a warning to terminate letter, if inappropriate behavior persists.
2. Providers and/or staff will ensure concise and appropriate documentation to support the warning of the dismissal of patient in EMR
3. Documentation regarding the warning (EMR or letter) will outline the concerns in a clear, concise, and respectful manner in regards to the inappropriate/hostile behavior, and that such behavior will result in possible termination as a patient of SCHC.
4. The type of circumstances that can result in a warning to a patient include, but are not limited to the following:
    a. Persistent noncompliance with treatment plan recommended by the health center, physician or other health care provider
    b. Failure to keep appointments (e.g., no shows at least 3 times in a row or excessive no shows within 6 months).
    c. Exemplifying rude, disruptive or unreasonable demanding behavior toward staff.
    d. Threatening or verbally abusive behavior directed at staff, physicians, or other health care providers or patients.
    e. Sexual harassment toward staff or other patients.
    f. Refusal to apply for financial relief if bill payment is onerous or to pay a bill for services within 30 days of service if financial relief was not warranted.

Intent to Terminate Patient:

1. The type of circumstances that can result in immediate termination include, but are not limited to, the following:
    a. Persistent noncompliance with medical advice and/or treatment recommended by the health center, physician or other health care
    b. The patient fails to keep appointments (e.g. no shows three times in a row, or greater than three missed appointments in a six-month period
    c. The patient exhibits persistent threatening or verbally abusive behavior (including sexual, racial or ethnic harassment) directed at office staff, physicians, other health care providers or patients, even after the issue has been brought to the patient's attention.
    d. The patient abuses medication or is a drug-seeker.
    e. The patient decides to leave the practice.
    f. The patient falsifies or providing misleading medical history.
    g. The patient refuses to pay bills or to apply for financial assistance to pay for services rendered.

Warning/Termination Follow-up Process:

1. An incident report is created by the provider and/or staff to report the circumstance.
2. The provider and/or staff notifies the Supervisor, Health Program Manager for Operations, and/ or Medical Director of a concern.
3. The manager will review the case at the Health and Safety Committee meeting or request an ad hoc meeting depending on the urgency of the dismissal where a course of action will be decided.
4. SCHC will seek advice from County legal counsel if necessary.
5. In severe cases, termination might be indicated immediately.
6. The Medical Director or provider or his/her designee will utilize the Standard Warning or Termination template to complete the letter (see Attachments A & B for Warning and Termination Letters).Termination letter template will:
    a. Inform the patient of the discharge from the health center and sent letter to IPA notifying of the dismissal.
    b. Include reasons for the termination.
    c. Attach valid medical records release form.
    d. Explain to the patient that SCHC values a mutually cooperative, trusting provider-patient relationship which clearly does not exist.
    e. Explain to the patient that during initial registration with the clinic, the patient signed the “Patients’ Rights and Responsibilities” acknowledging that inappropriate behavior will not be tolerated by the Health Center. If necessary, provide a copy of the “Patients’ Rights and Responsibilities” brochure.
    f. Identify any medical conditions that require immediate or continued care.
7. Notify the patient that care will continue for 30 days from the date the termination letter was sent. Patient will be responsible to contact his/hers Health Plan for reassignment of new medical home.
8. Patient Dismissal reports are routed to the Quality Improvement & Compliance Manager and the Medical Director
9. The Medical Director or assigned staff must entered an alert in the patient’s chart to notify staff with the following alert phrase: “Patient has been sent a termination notice as of “enter the date the letter was sent.” Staff will enter the 30 day timeframe that starts from the date the letter was sent. During the 30 days timeframe, the patient can be seen for transition of care”. Designation of PCP will be updated to “None”
10. Two copies of the termination letter will be mailed to the patient, one sent certified mail, one regular mail by clinic support staff
11. Support staff will place a copy of the letter directly into the patient’s medical record, under the “Confidential Admin Use” folder.
12. A copy of the letter will be uploaded in the Variance folder

References:

Attachments:

Contact:
Susmita Mishra, MD, Medical Director

Attachment A

Patient Warning Letter

Date:
Patient Name:
Patient Address:
Patient City, State, Zip:
Patient Account Number:
Patient Date of Birth:

Dear (Patient),

Although we are concerned about your health, this letter is a written warning to notify you that you are in violation of the center's Patient Rights and Responsibilities, and that if inappropriate behavior such as abuse, harassment, or violence of any kind continues to exist, this will result in your immediate termination as a patient of SCHC. The primary difficulty has been one or more of the following…

____Inappropriate verbal/physical abusive behavior directed at Provider and/or office staff
____Noncompliance with treatment recommended by Provider/health center
____Failure to keep appointments
____Patient abuse of medication
____Falsifying or providing misleading medical history
____Sexual harassment toward staff or other patients
____Other:

Our center has a zero-tolerance policy on for any behavior that violates the SCHC code of conduct such as: abuse, harassment, or violence of any kind to name some examples. On **(date) and (date)** our staff witnessed this inappropriate behavior(s). Your violation to the SCHC code jeopardizes the trust between the patient and the SCHC, which is the cornerstone of a good patient-provider relationship.

Sincerely,

Provider Signature
Provider Name
SC Health Center

Attachment B

Patient Dismissal/Termination Letter

Date:
Patient Name:
Patient Address:
Patient City, State, Zip:
Patient Account Number:
Patient Date of Birth:

Dear Patient's name,

Although we are concerned about your health, this letter is written to notify you that your status as a patient of SC Health Center will be terminated. The reason(s) for the termination include:

____Repeated inappropriate verbal/physical abusive behavior directed at Provider and/or office staff
____Noncompliance with treatment recommended by Provider/health center
____Consistent failure to keep appointments
____Patient abuse of medication
____Falsifying or providing misleading medical history
____Sexual harassment toward staff or other patients
____Other:

After consideration, we have determined that you should seek medical care with another medical home (clinic) We find it necessary to inform you that we will no longer be able to serve as your medical home as of 30 days from the date of this letter. I/ PCP will remain available to provide medical services to you on an emergency basis. You may want to contact your health plan to obtain names of other physicians who are accepting new patients as soon as you can. Any delay could jeopardize your health, so I urge you to act promptly. SCHC staff can review with you any medical conditions that require immediate attention.

A medical record release authorization form is enclosed for your convenience. Upon receipt of your signed authorization, a copy will be forwarded of your medical record. If requested, the SCHC staff will discuss your case with the physician who assumes your care. Should you have any questions concerning the contents of this letter, contact this health center as soon as possible.

Please find enclosed the phone number for your health plan Member Services.

Sincerely,

Provider Signature
Provider Name
SC Health Center

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To identify reasons as to why and how a patient would be dismissed from the services offered at the Sacramento County Health Center (SCHC).

Policy:

It is the policy of the Sacramento County Health Center (SCHC) to maintain a cooperative and trusting provider-patient relationship with their patients. When such a relationship is no longer proceeding in a mutually productive manner, it is the policy of the SCHC to terminate the provider-patient relationship within the bounds of applicable State and Federal laws, rules and regulations. This policy will establish guidelines for dismissing patients from care or refusing care from the services offered.

Procedure:

There are situations and circumstances that arise when it may be appropriate to dismiss patients from care or refuse patients care from the services offered at the SCHC.

The most common dismissal reasons include, but are not limited to:

A. Aggressive and threatening behavior towards staff;
   This reason is used whenever a patient exhibits behavior, either verbally and/or physically, in which an employee perceives the situation to be hostile and/or dangerous.
B. Conflict of interest;
   This reason is used whenever a patient, typically an employee or former employee, is aware of internal processes and tries to game the system in her/his favor at the expense of the organization.
C. Doctor shopping;
   This reason is used whenever a patient sees multiple providers, either during a single illness episode or to procure prescription medications illicitly, or to procure medical treatment/services that are not approved by a provider.
D. Drug seeking behavior;
   This reason is used whenever a patient exhibits behavior that is perceived as a mechanism for obtaining additional medications, from 1 or more providers and/or 1 or more pharmacies.
E. Excessive no-shows;
   This reason is used whenever a patient has three or more no-shows in a 6- month period.

F. Failure to maintain acceptable behavior;
   This reason is used whenever a patient is acting in an inappropriate manner towards either staff, providers or other patients. This can include public intoxication with disruptive behavior that is not conducive to appropriate care.

G. Lewd and inappropriate behavior towards staff;
   This reason is used whenever a patient exhibits behavior in which an employee perceives the situation to be harassing and/or sexual in nature.

H. Manipulation of health records and/or documents;
   This reason is used whenever a patient is found to have altered or manipulated her/his health records or documents, e.g., modifying optometry-related records to appear blind in an effort to qualify for disability.

I. Misrepresentation;
   This reason is used whenever a patient is found to have intentionally provided inaccurate information about her/himself or has claimed to be an entirely different patient altogether, e.g. using the insurance of another patient to avoid having to pay for services.

J. Multiple failed drug screenings;
   This reason is used when a patient fails multiple drug screens and a provider requests s/he be dismissed.

K. Non-compliance with medical advice to include but not limited to: Behavioral Health and Dental Advice
   This reason is used whenever a Medical provider feels that a patient does not agree with the medical advice or care plan that is recommended
   and believes there is nothing further s/he, as the provider, can do for the patient.

L. Property damage/vandalism;
   This reason is used whenever a patient intentionally causes property damage and/or vandalism to SCHC assets/property.

M. Self-requested dismissal; and
   This reason is used whenever a patient states that s/he no longer wants to be seen at SCHC

N. Theft
   This reason is used whenever a patient steals any item of value from SCHC.

Warning to Terminate Patient:

1. When the provider or other staff person identifies a patient with whom the provider-patient or SCHC relationship has been negatively affected, after having a significant event or more than one negative occurrence, the patient will be served with a warning notice, which may include a warning to terminate letter, if inappropriate behavior persists.
2. Providers and/or staff will ensure concise and appropriate documentation to support the warning of the dismissal of patient in EMR
3. Documentation regarding the warning (EMR or letter) will outline the concerns in a clear, concise, and respectful manner in regards to the inappropriate/hostile behavior, and that such behavior will result in possible termination as a patient of SCHC.
4. The type of circumstances that can result in a warning to a patient include, but are not limited to the following:
    a. Persistent noncompliance with treatment plan recommended by the health center, physician or other health care provider
    b. Failure to keep appointments (e.g., no shows at least 3 times in a row or excessive no shows within 6 months).
    c. Exemplifying rude, disruptive or unreasonable demanding behavior toward staff.
    d. Threatening or verbally abusive behavior directed at staff, physicians, or other health care providers or patients.
    e. Sexual harassment toward staff or other patients.
    f. Refusal to apply for financial relief if bill payment is onerous or to pay a bill for services within 30 days of service if financial relief was not warranted.

Patient Response / Appeal

Need to discuss formal process – how to appeal; process to do so

The warning letter needs to include this as well.

Commented [BD1]: CAB asks that this gap be addressed and asks the Operations Team to work on it and return it.

Intent to Terminate Patient:

1. The type of circumstances that can result in immediate termination include, but are not limited to, the following:
    a. Persistent noncompliance with medical advice and/or treatment recommended by the health center, physician or other health care
    b. The patient fails to keep appointments (e.g. no shows three times in a row, or greater than three missed appointments in a six-month period
    c. The patient exhibits persistent threatening or verbally abusive behavior (including sexual, racial or ethnic harassment) directed at office staff, physicians, other health care providers or patients, even after the issue has been brought to the patient's attention.
    d. The patient abuses medication or is a drug-seeker.
    e. The patient decides to leave the practice.

f. The patient falsifies or providing misleading medical history.

g. The patient refuses to pay bills or to apply for financial assistance to pay for services rendered.

Warning/Termination Follow-up Process:

1. An incident report is created by the provider and/or staff to report the circumstance.
2. The provider and/or staff notifies the Supervisor, Health Program Manager for Operations, and/ or Medical Director of a concern.
3. The manager will review the case at the Health and Safety Committee meeting or request an ad hoc meeting depending on the urgency of the dismissal where a course of action will be decided.
4. SCHC will seek advice from County legal counsel if necessary.
5. In severe cases, termination might be indicated immediately.
6. The Medical Director or provider or his/her designee will utilize the Standard Warning or Termination template to complete the letter (see Attachments A & B for Warning and Termination Letters).Termination letter template will:
   a. Inform the patient of the discharge from the health center and sent letter to IPA notifying of the dismissal.
   b. Include reasons for the termination.
   c. Attach valid medical records release form.
   d. Explain to the patient that SCHC values a mutually cooperative, trusting provider-patient relationship which clearly does not exist.
   e. Explain to the patient that during initial registration with the clinic, the patient signed the “Patients’ Rights and Responsibilities” acknowledging that inappropriate behavior will not be tolerated by the Health Center. If necessary, provide a copy of the “Patients’ Rights and Responsibilities” brochure.
   f. Identify any medical conditions that require immediate or continued care.
7. Notify the patient that care will continue for 30 days from the date the termination letter was sent. Patient will be responsible to contact his/hers Health Plan for reassignment of new medical home.
8. Patient Dismissal reports are routed to the Quality Improvement & Compliance Manager and the Medical Director
9. The Medical Director or assigned staff must entered an alert in the patient’s chart to notify staff with the following alert phrase: “Patient has been sent a termination notice as of “enter the date the letter was sent.” Staff will enter the 30 day timeframe that starts from the date the letter was sent. During the 30 days timeframe, the patient can be seen for transition of care”. Designation of PCP will be updated to “None”
10. Two copies of the termination letter will be mailed to the patient, one sent certified mail, one regular mail by clinic support staff
11. Support staff will place a copy of the letter directly into the patient’s medical record, under the “Confidential Admin Use” folder.
12. A copy of the letter will be uploaded in the Variance folder

References:

Attachments:

Contact:
Susmita Mishra, MD, Medical Director

Commented [HS2]: These should be filled in.

Attachment A

Patient Warning Letter

Date:
Patient Name:
Patient Address:
Patient City, State, Zip:
Patient Account Number:
Patient Date of Birth:

Dear (Patient),

Although we are concerned about your health, this letter is a written warning to notify you that you are in violation of the center's Patient Rights and Responsibilities, and that if inappropriate behavior such as abuse, harassment, or violence of any kind continues to exist, this will result in your immediate termination as a patient of SCHC. The primary difficulty has been one or more of the following…

____Inappropriate verbal/physical abusive behavior directed at Provider and/or office staff
____Noncompliance with treatment recommended by Provider/health center
____Failure to keep appointments
____Patient abuse of medication
____Falsifying or providing misleading medical history
____Sexual harassment toward staff or other patients
____Other:

Our center has a zero-tolerance policy on for any behavior that violates the SCHC code of conduct such as: abuse, harassment, or violence of any kind to name some examples. On **(date) and (date)** our staff witnessed this inappropriate behavior(s). Your violation to the SCHC code jeopardizes the trust between the patient and the SCHC, which is the cornerstone of a good patient-provider relationship.

Sincerely,

Provider Signature
Provider Name
SC Health Center

Attachment B

Patient Dismissal/Termination Letter

Date:
Patient Name:
Patient Address:
Patient City, State, Zip:
Patient Account Number:
Patient Date of Birth:

Dear Patient's name,

Although we are concerned about your health, this letter is written to notify you that your status as a patient of SC Health Center will be terminated. The reason(s) for the termination include:
____Repeated inappropriate verbal/physical abusive behavior directed at Provider and/or office staff
____Noncompliance with treatment recommended by Provider/health center
____Consistent failure to keep appointments
____Patient abuse of medication
____Falsifying or providing misleading medical history
____Sexual harassment toward staff or other patients
____Other:

After consideration, we have determined that you should seek medical care with another medical home (clinic) We find it necessary to inform you that we will no longer be able to serve as your medical home as of 30 days from the date of this letter. I/ PCP will remain available to provide medical services to you on an emergency basis. You may want to contact your health plan to obtain names of other physicians who are accepting new patients as soon as you can. Any delay could jeopardize your health, so I urge you to act promptly. SCHC staff can review with you any medical conditions that require immediate attention.

A medical record release authorization form is enclosed for your convenience. Upon receipt of your signed authorization, a copy will be forwarded of your medical record. If requested, the SCHC staff will discuss your case with the physician who assumes your care. Should you have any questions concerning the contents of this letter, contact this health center as soon as possible.

Please find enclosed the phone number for your health plan Member Services.

Sincerely,

Provider Signature
Provider Name
SC Health Center

Period	**7**
Current Month	**January**
Percentage of Year	**58%**

CAB Financial Report

Line Item	Budget	Current Month	Year to date	*Encumbrance*	*Total* (YTD+Encumbrance)	YTD Percentage (Total/Budget)	Notes
Revenue							
Inter/Intrafund Reimbursements	$9,525,910	807,247	2,962,945	*$0*	*$2,962,945*	31%	
Intergovernmental Revenue	$10,828,547	1,049,690	6,174,773	*$0*	*$6,174,773*	57%	Medi-Cal Revenue
Charges for Services	$52,000	6,540	44,502	*$0*	*$44,502*	86%	CMISP old pre-2014 service charges
Miscellaneous Revenue	$17,368		16,268	*$0*	*$16,268*	94%	
Total Revenue	**$20,423,825**	**$1,863,476**	**$9,198,487**	**$0**	***$9,198,487***	**45%**	
Expenses							
Personnel	$11,351,014	825,653	5,653,853	*$0*	*$5,653,853*	50%	Permanent vacancies in recruitment
Services & Supplies	$10,314,243	546,726	4,577,063	3,404,113	*$7,981,176*	44%	SCOE contract slow to invoice
Other Charges	$449,477	36,771	240,804	228,028	*$468,833*	54%	
Equipment	$247,077		141,765	105,311	*$247,076*	57%	Encumbrance is for radiology upgrades
Intrafund Charges (Allocation costs)	$2,211,906	198,865	949,094	*$0*	*$949,094*	43%	
Total Expenses	**$24,573,717**	**$1,608,015**	**$11,562,580**	**$3,737,452**	***$15,300,032***	**47%**	

GRAND TOTAL				
(Net County Cost)	**-$4,149,892**	**$255,461**	**-$2,364,092**	

HRSA Grants	Start	End	Total Grant	FY 21/22	FY 21/22 YTD Actual	Notes
HRSA (HCH)	3/1/2021	2/28/2022	$ 1,386,602	$ 924,401	$ 775,298	Spending on-track
HRSA (HCH)	3/1/2022	2/28/2023	$ 1,386,602	$ 462,201	$ -	Grant period has not begun
HRSA ECT H8E*	5/1/2021	4/30/2022	$ 261,424	$ 164,015	$ 143,801	Grant will be fully expended after PPE purchase
HRSA H8F ARPA**	4/1/2021	3/31/2022	$ 1,279,248	$ 1,145,043	$ 339,638	Jul-Dec claims low due to slow hiring, can carryover funds to next FY
HRSA H8F ARPA*	4/1/2022	6/30/2023	$ 1,254,627	$ 469,880	$ -	Grant period has not begun
HRSA C8E ARP CIP*	9/15/2021	9/14/2022	$ 619,603	TBD	$ -	Contruction timeline and costs not yet determined

*Not in FY21/22 budget

**$524,244 in FY21/22 budget

2021 SCHC Quality Improvement Plan
Racial and Ethnic Disparities Analysis

Introduction: QI Plan Goal and Objective

The Co-Applicant Board and the Quality Improvement Committee of the Sacramento County Health Center (SCHC) are committed to improving and reaching equity in health access and outcomes. This commitment was reflected in the SCHC 2021 Quality Improvement Plan, as shown in the Clinical Performance Measures section below.

Clinical Performance Measures

- Goal 1: Improve performance on select UDS and HEDIS quality measures (focused on those that signal a healthy start in life and those focused on secondary prevention of health issues prevalent among SCHC patients) and tackle racial and ethnic disparities in such measures.
    - Objective 3: Reduce racial and ethnic health disparities in control of diabetes and hypertension in 2021 compared to baseline for 2019.

Hypertension and diabetes were the conditions chosen because they are among the most common suffered by our patients and have a serious effect on length of and quality of life. It is very difficult to detect systematic differences in small groups. For this reason, the most common conditions were chosen to see if disparities could be detected.

Racial and ethnic disparities were selected as the focus both because research has shown many large and important racial and ethnic disparities in access to health services and health outcomes and because SCHC has relatively good data available as to the race and ethnicity of its patients. As a federally qualified health center (FQHC), SCHC must report race and ethnicity information about its patients to its funder, the federal Health Resources and Services Agency (HRSA). In addition. SCHC must use the definitions and categories of race and ethnicity produced by the federal Office of Management and Budget (OMB). OMB defines race as a socially constructed category based primarily on skin color and ethnicity as a socially constructed category based primarily on culture and language. With these definitions, race and ethnicity are separate and independent. In the US, the dominant ethnic categories are Hispanic/LatinX and Non-Hispanic/LatinX. A Hispanic/LatinX person (descended from settlers from the Iberian Peninsula) may be of any race. For example, many Hispanics/LatinX from the Caribbean are African or a member of a Native tribe while Hispanics/LatinX from the Philippines are typically Pacific Islanders. Since these are socially created categories, ideas about them change. The newer concept of "people of color" redefines LatinX individuals as a separate "brown" race. SCHC has many patients who self-report as Hispanic/LatinX and no racial category. However, SCHC is mandated to use the federal categories and ask patients to self-report their racial and ethnic identities using them.

Findings

Hypertension

Ethnic Disparities

As shown in the table below, the percentage of hypertensive patients with uncontrolled blood pressure differed in 2021 by patient ethnicity, with the smallest proportion of Hispanic/LatinX patients being uncontrolled.

Table 1: Ethnic Disparities in Hypertension Control, 2021

Ethnic Group	Patients 18-84 w/ Hypertension	% Uncontrolled[1]
Hispanic/LatinX	1,116	45.6%
Non-Hispanic/LatinX	1,089	52.1%
Unreported/Refused	79	70.0%

From CY 2021 UDS Report for SCHC

[1]Percentage of patients aged 18-84 years with hypertension whose blood pressure was ≥140/90 mmHg at the last reading of the year.

To determine whether the ethnic disparities detected were reflective of long-term trends, data were examined for a three-year period. Table 2 shows the percentage of uncontrolled hypertensive patients by ethnicity between 2019 and 2021. The table shows a large increase in the proportion of hypertensive patients whose blood pressure was not under control between 2019 and 2020 and little change between 2020 and 2021. The most likely explanation is related to the public health pandemic, which increased stress in many people at the same it reduced the likelihood of patients seeking care, particularly in person. The higher likelihood of Non-Hispanic/LatinX hypertensive patients being uncontrolled was seen for all three years. The relative risk for the group whose ethnicity is not known was more variable. This is likely due to the much smaller numbers in this group.

Table 2: Trends in Ethnic Disparities in Hypertension Control

	% Hypertensive Patients Uncontrolled		
Ethnic Group	2019	2020	2021
Hispanic/LatinX	35.3%	48.0%	45.6%
Non-Hispanic/LatinX	37.8%	52.4%	52.1%
Unreported/Refused	36.4%	67.7%	70.0%

To help illustrate the relative proportions of uncontrolled patients, Table 3 shows the rank, with '1' indicating the group with the lowest proportion of uncontrolled patients and '3' the group with the highest proportion. The Non-Hispanic/LatinX group has a higher rank (thus more uncontrolled hypertensives) each year than the Hispanic/LatinX group.

Table 3: Rank by Proportion of Uncontrolled Hypertension

Ethnic Group	Rank *(Lowest proportion uncontrolled = 1)*		
	2019	**2020**	**2021**
Hispanic/LatinX	1	1	1
Non-Hispanic/LatinX	3	2	2
Unreported/Refused	2	3	3

The reasons for this ethnic disparity need to be explored so that strategies for helping Non-Hispanic/LatinX (and other) patients control their diabetes can be identified.

Racial Disparities

The percentage of hypertensive patients with uncontrolled blood pressure differed in 2021 by patient self-reported race. As shown in Table 4, in 2021, Native Hawaiian and Other Pacific Islanders had the smallest proportion of patients being uncontrolled, and patients with unidentified race the largest.

Table 4: Racial Disparities in Hypertension Control, 2021

Race	Patients 18-84 w/ Hypertension	% Uncontrolled[1]
American Indian/Alaska Native	13	*N < 30*
Asian/Asian American	284	45.1%
Black/African American	365	56.7%
Multi-racial	8	*N < 30*
Native Hawaiian or Other Pacific Islander	43	37.2%
White	1,389	47.7%
Unreported/Refused to state	182	58.4%

From CY 2021 UDS Report for SCHC

[1]Percentage of patients 18-84 with hypertension with BP ≥140/90 mmHg at last reading

Note: Percentage is not reported for racial groups with fewer than 30 members with hypertension.

To determine whether the disparities detected were reflective of trends through time, data were examined for a three-year period. Table 5 (on the next page) shows the percentages of uncontrolled hypertensive patients by self-reported race, with the groups with fewer than 30 hypertensive patients removed. The table shows great variability in the percentage of uncontrolled patients per group across the three-year time span.

Table 5: Trends in Racial Disparities in Hypertension Control

Race	Percent of Uncontrolled[1] Patients		
	2019	2020	2021
Asian/Asian American	29.5%	54.3%	45.1%
Black/African American	41.4%	55.7%	56.7%
Native Hawaiian or Other Pacific Islander	45.2%	45.0%	37.2%
White	39.2%	47.1%	47.7%
Unreported/Refused to state	34.0%	55.5%	58.4%

To highlight the relative proportions of uncontrolled patients per group per year, Table 6 below ranks the groups by percentage of uncontrolled hypertensive patients, from '1' (smallest proportion of uncontrolled patients) to '5.' Again, the large variability in relative rank per year is shown. For example, in 2019, the Native Hawaiian or Other Pacific Islander group had the highest percentage of uncontrolled hypertensive patients, but this group had the lowest percentage in 2020 and 2021. However, it is clear that Black/African American patients are more likely to have uncontrolled hypertension than White or Asian/Asian American patients.

Table 6: Rank by Proportion of Uncontrolled Hypertension

Race	Rank *(Lowest proportion uncontrolled = 1)*		
	2019	2020	2021
Asian/Asian American	1	3	2
Black/African American	4	5	4
Native Hawaiian or Other Pacific Islander	5	1	1
White	3	2	3
Unreported/Refused to state	2	4	5

Diabetes

Ethnic Disparities

As shown in Table 7 below, the percentage of diabetic patients with uncontrolled blood sugar differed in 2021 by patient ethnicity, with patients whose race was unreported having the smallest proportion of uncontrolled blood sugar. There was essentially no difference in the percentage of Hispanic/LatinX and Non-Hispanic/LatinX patients with uncontrolled diabetes in 2021.

Table 7: Ethnic Disparities in Diabetes Control, 2021

Ethnic Group	Patients 18-75 w/ Diabetes	% Uncontrolled[1]
Hispanic/LatinX	954	60.9%
Non-Hispanic/LatinX	607	60.8%
Unreported/Refused	34	41.2%

From CY 2021 UDS Report for SCHC

[1]Percentage of patients aged 18-75 years with diabetes whose last HbA1c value was >9%.

To determine whether this ethnic disparity detected in 2021 was reflective of longer-term trends, data were examined for a three-year period. Table 8 shows the percentage of uncontrolled diabetic patients by self-reported race between 2019 and 2021. The table shows a large increase in the proportion of patients with uncontrolled diabetes between 2019 and 2020 for Hispanic/LatinX patients and Non-Hispanic/LatinX patients, and then between 2020 and 2021 for both of these groups. During this period, the proportion of uncontrolled Hispanic/LatinX patients started out higher than that of Non-Hispanic/LatinX patients, but the Non-Hispanic/LatinX group's proportion of uncontrolled diabetes rose more sharply to nearly equal the Hispanic/LatinX group in 2021. No clear trend is seen for the patients with unreported race, which may be due to smaller numbers in this group. As discussed in the *Hypertension* section of the report, the most likely explanation for the increase in uncontrolled diabetes is increased stress with unhealthy coping mechanisms and deferred care during COVID pandemic.

Table 8: Trends in Racial Disparities in Hypertension Control

	% Diabetic Patients Uncontrolled		
Ethnic Group	**2019**	**2020**	**2021**
Hispanic/LatinX	38.0%	43.6%	60.9%
Non-Hispanic/LatinX	34.3%	40.1%	60.8%
Unreported/Refused	34.7%	49.2%	41.2%

To help illustrate the relative proportions of uncontrolled patients, Table 9 shows the rank, with '1' indicating the group with the lowest proportion of uncontrolled patients and '3' the group with the highest proportion. The Non-Hispanic/LatinX group has a higher rank (thus a higher percentage of hypertensive patients with uncontrolled blood pressure) in 2019 and 2020 than the Hispanic/LatinX group, but they are essentially equal in 2021.

Table 9: Rank by Proportion of Uncontrolled Diabetes

Ethnic Group	Rank *(Lowest proportion uncontrolled = 1)*		
	2019	2020	2021
Hispanic/LatinX	3	2	2.5
Non-Hispanic/LatinX	1	1	2.5
Unreported/Refused	2	3	1

While SCHC is committed to improving and reaching health equity, the intention is not for groups with better health outcomes to deteriorate to reduce a disparity. Improvement for all groups is the goal, along with the reduction in disparities.

Racial Disparities

Unsurprisingly, the percentage of diabetic patients with uncontrolled blood sugar differed in 2021 by patient self-reported race. As shown in Table 10, in 2021, Native Hawaiian and Other Pacific Islanders had the smallest proportion of patients being uncontrolled, and patients with unidentified race the largest.

Table 10: Racial Disparities in Hypertension Control, 2021

Race	Patients 18-84 w/ Hypertension	% Uncontrolled[1]
American Indian/Alaska Native	11	*N < 30*
Asian/Asian American	210	65.7%
Black/African American	167	59.3%
Multi-racial	6	*N < 30*
Native Hawaiian or Other Pacific Islander	36	58.3%
White	1,047	60.4%
Unreported/Refused to state	118	53.4%

From CY 2021 UDS Report for SCHC

[1]Percentage of patients aged 18-75 years with diabetes whose last HbA1c value was >9%.

Note: Percentage is not reported for racial groups with fewer than 30 members with diabetes.

To determine whether the disparities detected were reflective of trends through time, data were again examined for a three-year period. Table 11 shows the percentages of uncontrolled diabetic patients by self-reported race, with the groups with fewer than 30 diabetic patients removed. The table shows increases year-over-year in uncontrolled diabetes for each group.

Table 11: Trends in Racial Disparities in Diabetes Control

Race	Percent of Uncontrolled Patients		
	2019	2020	2021
Asian/Asian American	27.8%	33.0%	65.7%
Black/African American	42.0%	43.7%	59.3%
Native Hawaiian or Other Pacific Islander	36.4%	42.9%	58.3%
White	36.3%	43.0%	60.4%
Unreported/Refused to state	37.5%	46.8%	53.4%

Figure 1 below also illustrates the increasing trend in uncontrolled diabetes over time. The figure also shows that African Americans had relatively higher likelihood of uncontrolled diabetes than other groups in 2019. However, this disparity was essentially erased, as all groups' uncontrolled proportion increased in 2020 and 2021.

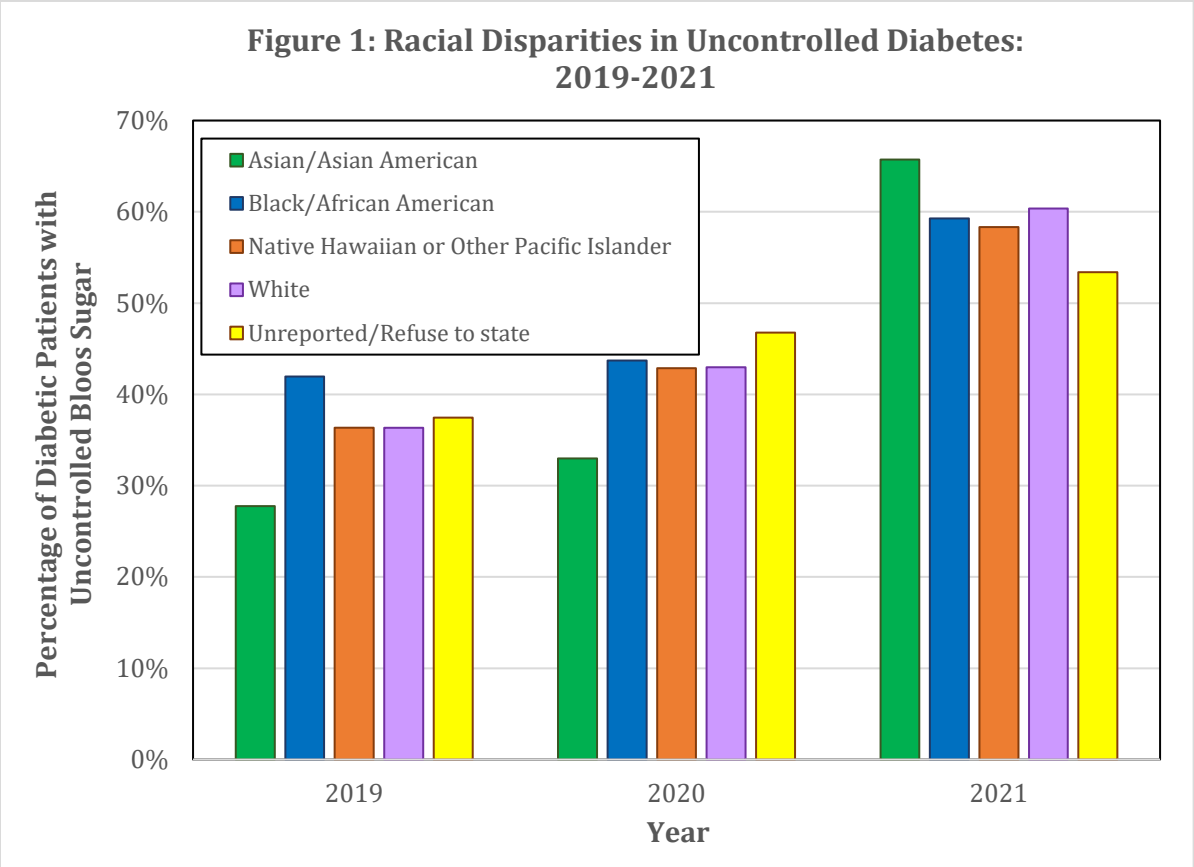

Table 12 ranks the groups by percentage of uncontrolled diabetic patients, from '1' (smallest proportion of uncontrolled patients) to '5.' This table shows a small change in relative rank in proportion of uncontrolled diabetic patients by race from 2019 to 2020, and much larger changes from 2020 to 2021.

Table 12: Rank by Proportion of Diabetic Patients with Uncontrolled Diabetes

Race	Rank *(Lowest proportion uncontrolled = 1)*		
	2019	**2020**	**2021**
Asian/Asian American	1	1	5
Black/African American	5	4	3
Native Hawaiian or Other Pacific Islander	2.5	2.5	2
White	2.5	2.5	4
Unreported/Refused to state	4	5	1

Discussion and Next Steps

The findings presented about racial and ethnic disparities in the two conditions of greatest burden on the SCHC patient population are not easy to interpret or act on. It is important to understand the limitations in the data when thinking about the implications and possible actions.

First, while SCHC has data on self-reported race and ethnicity, not all patients disclose this information. For each analysis, more than 100 patients did not report their race, with a smaller number not reporting their ethnicity. Lack of reporting makes identifying existing disparities more difficult.

Second, it is not clear that everyone is interpreting the categories in the same manner. For example, some new arrivals from Afghanistan report that they are "Asian" (assumedly because Afghanistan is in Asia) while others report that they are "White" (likely based on skin color or tradition). Likewise, an increasing number of Hispanic/LatinX individuals indicate that this is their race and refuse to select a HRSA race category or select "other." SCHC also needs to determine whether staff interpret these categories in the same way, or what type of assistance, if any, they provide to patients with questions about these official categories of race and ethnicity.

Third, the sole ethnic distinction available for HRSA reporting (i.e. Hispanic/LatinX or Non-Hispanic/LatinX) is not relevant to many new arrivals to the US, which make up a substantial minority of SCHC patients. For example, groups such as Hazara, Pashtun,

Uzbek, and Tajik are familiar ethnic categories for individuals from Afghanistan; none are reportable to HRSA, and all these are grouped as "Non-Hispanic/LatinX."

Fourth, direct experience of prejudice is a contributor to poor health. This common finding indicates that other people's perceptions of one's race or ethnicity may be more powerful than one's self-identification in certain ways. SCHC collects only self-reported race and ethnicity.

Fifth, many racial and ethnic disparities are routed in a long history of unequal treatment of racial and ethnic minorities. Institutionalized racism in the US has produced practices such as "red-lining" in which minority groups are confined to less desired places to live, where environmental and other health hazards (including violence) are more common. Factors that negatively affect health (such as minority status, poverty, exposure to health hazards, increased reliance on public transit, and decreased access to financial and education opportunities) tend to geographically cluster. However, not all members of minority groups experience all of these factors.

Sixth, research into ethnic disparities has shown that acculturation (often measured by a proxy variable of time living in the US) is often a confounding factor. This is frequently found for protective factors seen in recent immigrants (e.g. traditional diet) that tend to disappear over generations. SCHC has no way to measure acculturation or time in the US.

Seventh, as briefly mentioned earlier in the report, SCHC patients come from many racial groups, some very small and some much larger. The smaller a group, the harder it is to detect statistical differences. This "small N" problem is why SCHC only looks at very common conditions in these analyses. Only for these conditions are there enough patients from different groups to detect any existing differences. In addition, there may not be sufficient patients in any year's worth of data to actually do so.

These are all reasons, among many others, why disparities in health outcomes and their underlying causes of disparities can be hard to identify and mitigate. However doing so is can help identify that strategies for helping patients control their hypertension and/or diabetes. For example, do Hispanics/LatinX patients experience protective factors that help them control their blood pressure, such as increased social capital, a healthier diet, and/or increased physical activity? Are providers more likely to prescribe medications to this group to control their blood pressure? Are Hispanics/LatinX more likely take to prescribed medications to control blood pressure? Do other groups face particular challenges that place them at higher risk of uncontrolled blood pressure (i.e. risk factors? When protective and risk factors are identified, the next step is to determine whether they can be altered to help patients become healthier.

This report suggests that SCHC leadership can take two sets of actions to further the pursuit of health equity at the Health Center. First, improved data collection and analysis

methods may help identity and clarify existing disparities. SCHC is represented on the UC Davis Health's Workgroup to Reduce Health Inequities, where such data-focused discussions can take place with experts. Second, SCHC can seek input from stakeholders, including members of the Co-Applicant Board, the Quality Improvement Committee, staff and providers, and patients themselves. Such interactions may help identify Health Center practices that (unintentionally) contribute to health disparities as well as factors for which interventions can be identified, including social determinants of health.

The first practical step will be discussion with the Co-Applicant Board on 3/18 and with the Quality Improvement Committee on 3/24.

March 2022: Governance Committee Report to CAB

1.	Strategic Plan Monitoring	Decision
2.	BOS ratification of members	Information
3.	CAB budget for technology and training	Recommendation
4.	Service area competition (SAC) grant process	Information

---

1. Strategic Plan Monitoring

Plan to better serve the homeless based on the needs assessment survey; choose at least one area to focus change efforts.

Priority: *Maintain the historical focus on serving individuals experiencing homelessness* Continue to improve access and continuity of care at 4600 Broadway and Loaves and Fishes **Strategy 1: Conduct a health and related needs assessment of individuals experiencing homelessness.**		
Action Steps	**SMART Objectives**	**Metrics**
1. Use homeless survey results to develop a plan to better serve homeless patients, either directly or through collaboration.	A. By January 30, 2022, SCHC will review the areas of the HC (4600 and Loaves and Fishes) identified in the survey to determine if and what changes can be made to achieve 75% "very good or good" score on following survey elements: • Able to get appointments for check-ups. • Able to make same day appointment when sick or hurt. • Length of time waiting at the clinic. B. By February 15, 2022, the SCHC will choose at least one area on which to focus change efforts and present to the CAB for approval at the March 2022 meeting. C. By March 25, 2022 staff will identify SCHC staff who will contribute to developing a plan for the identified changes. D. By May 15, 2022, a draft plan, including metrics, costs, staffing, partners, etc., will be developed and presented to SHCH leadership for review and approval. E. By June 30, 2022, SCHC will implement the plan and will report to the CAB semiannually on progress beginning December 2022.	A. By the March 2022 **CAB** meeting, CAB will receive, review, discuss and make a decision regarding the proposed focused change(s) to better serve homeless and indigent patients. B. By June 30, 2022, SCHC will begin implementing the plan C. Report to the **CAB Governance Committee** semiannually on progress December 2022 and through December 2023.

The Sacramento County Health Center proposes providing mental health and medication assisted treatment for substance abuse based on the results of the homeless needs assessment survey conducted at Loaves and Fishes.

The Governance committee supports this proposal.

2. **BOS ratification of members**
   On March 22, 2022, the Board of Supervisors will ratify the two existing members whose term has expired and the proposed new members. After ratification, Ms. Miller and Bohamera will be able to vote.

3. **CAB budget for technology and training**
   The Sacramento County Health Center's leadership discussed the idea of developing a budget for CAB. The budget would include items such as member education and training, and technology to help ensure members are able to access CAB documents. The idea will be discussed at the Admin Team meeting on March 17, 2022.

   The Governance committee supports the proposal to establish a budget for CAB and to provide CAB members with a Chromebooks or another device with a hotspot to provide access to CAB and pertinent County documents.

4. **Service area competition (SAC) grant process**
   CAB will be providing guidance on renewal of the Health Centers HRSA grant; the Service Area (SAC) Competition. The application requires a needs assessment. Beginning in May, SAC will be a standing item on the CAB's agenda.

NATIONAL ASSOCIATION OF Community Health Centers®

Board Member Boot Camp:

An Introduction to Health Center Board Roles

February 13, 2022

Agenda

1. Overview of Health Center Board Roles & Legal Duties of Board Members
2. The Fundamentals of Board Financial Oversight
3. Critical Components of Health Center Governance: Quality Oversight & Board Member Advocacy

Virtual Participants

Chat
(use to talk with peers)

Polling/Q&A
(participate in polls, ask questions to faculty)

Key Learning & Action Planning

As you participate in Boot Camp today, consider:

- What key concepts will you take back and use with ***your board***
- What key concepts will make ***you*** a more effective board member

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Overview of Health Center Board Roles & Legal Duties of Board Members

Alecia Cyprian, PhD, CEO, Southeast Community Health Systems
Emily Heard, Director, Health Center Governance, NACHC
Jacqueline C. Leifer, Esq., Senior Partner, Feldesman Tucker Leifer Fidell LLP
Deborah Morrison, Board Chair, Roanoke Chowan Community Health Center
Avni Shridharani, MHS, President, Community Health Strategies LLC

Objectives

- Outline overall health center board roles and responsibilities
- Explore the role of the board compared to the CEO, and discuss components of the board-CEO partnership
- Define the legal duties of individual board members

Poll: What best describes your role?

1. Health Center Board Member
2. Health Center CEO
3. Health Center Staff
4. Primary Care Association (PCA) Staff
5. Other

Live Content Slide

When playing as a slideshow, this slide will display live content

Poll: What best describes your role?

Poll: If you are a health center board member, how long have you served on the board?

1. Less than 1 year
2. 1-3 years
3. 4-6 years
4. 7 years or more

Live Content Slide

When playing as a slideshow, this slide will display live content

Poll: If you are a health center board member, how long have you served on the board?

Poll: Why did you decide to participate?

1. I am a new board member and want to learn about health center board roles
2. I have served on other boards but want to learn about health center board roles
3. I want a “refresher” on board roles
4. I work with our board and want to learn more about health center governance

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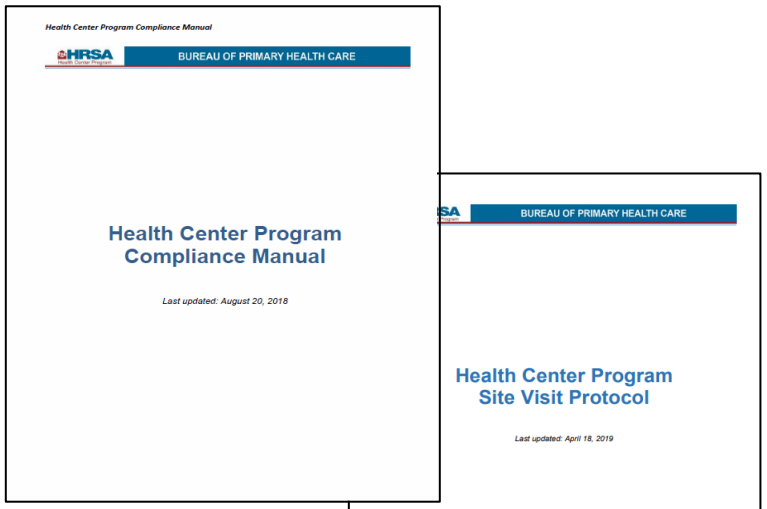
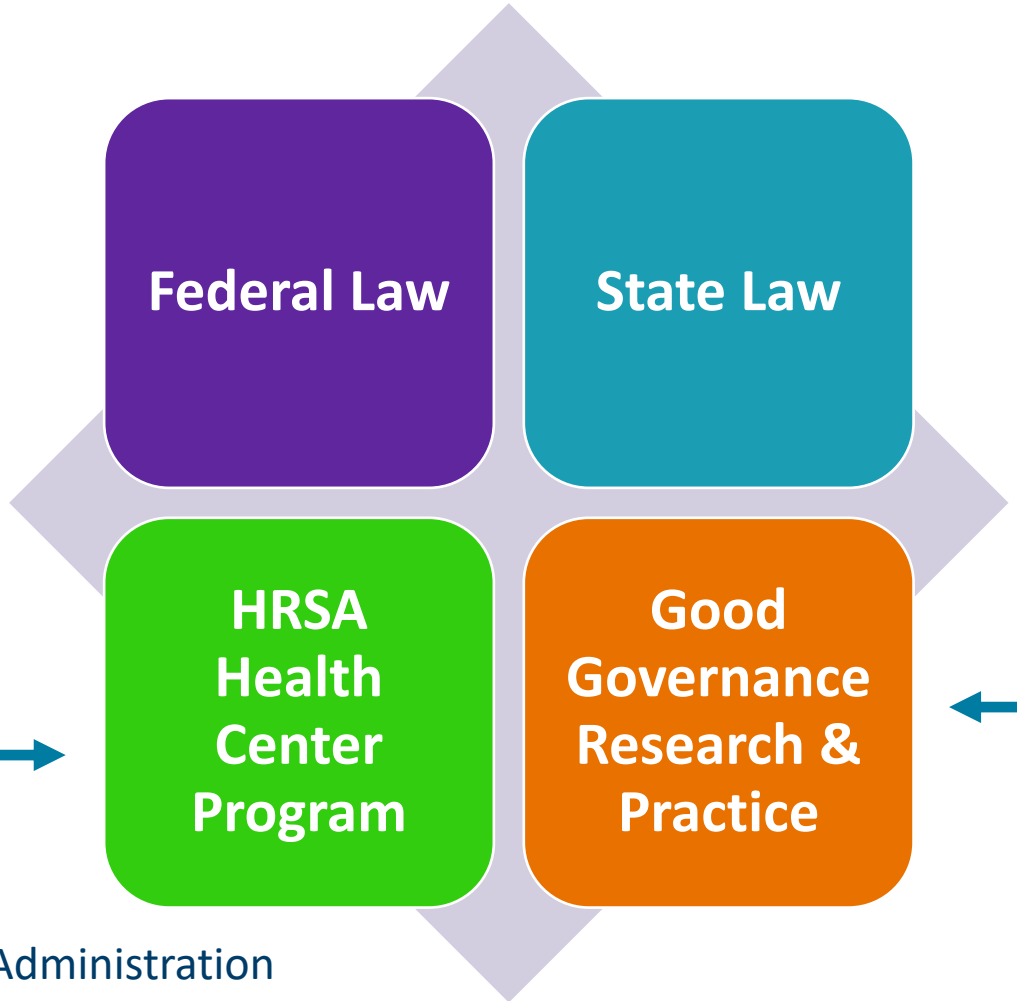
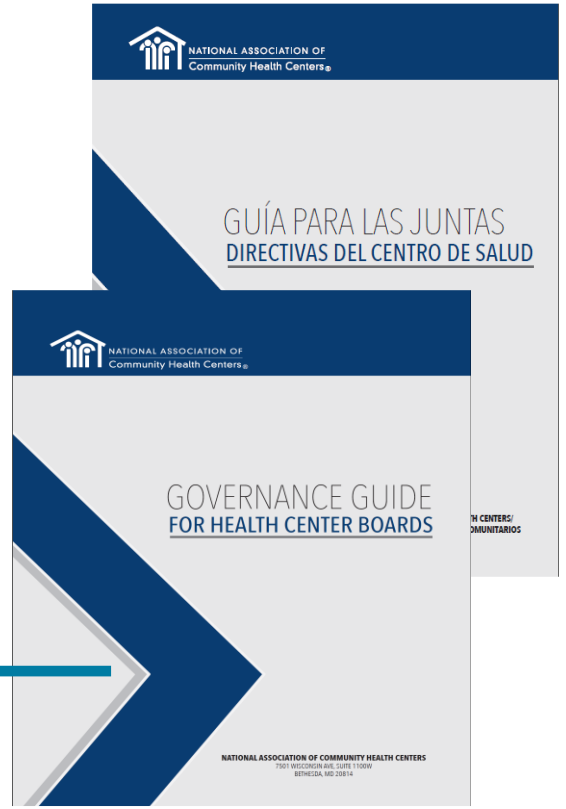
When playing as a slideshow, this slide will display live content

Poll: Why did you decide to participate?

Health Center Governance







HRSA = Health Resources and Services Administration

https://bphc.hrsa.gov/

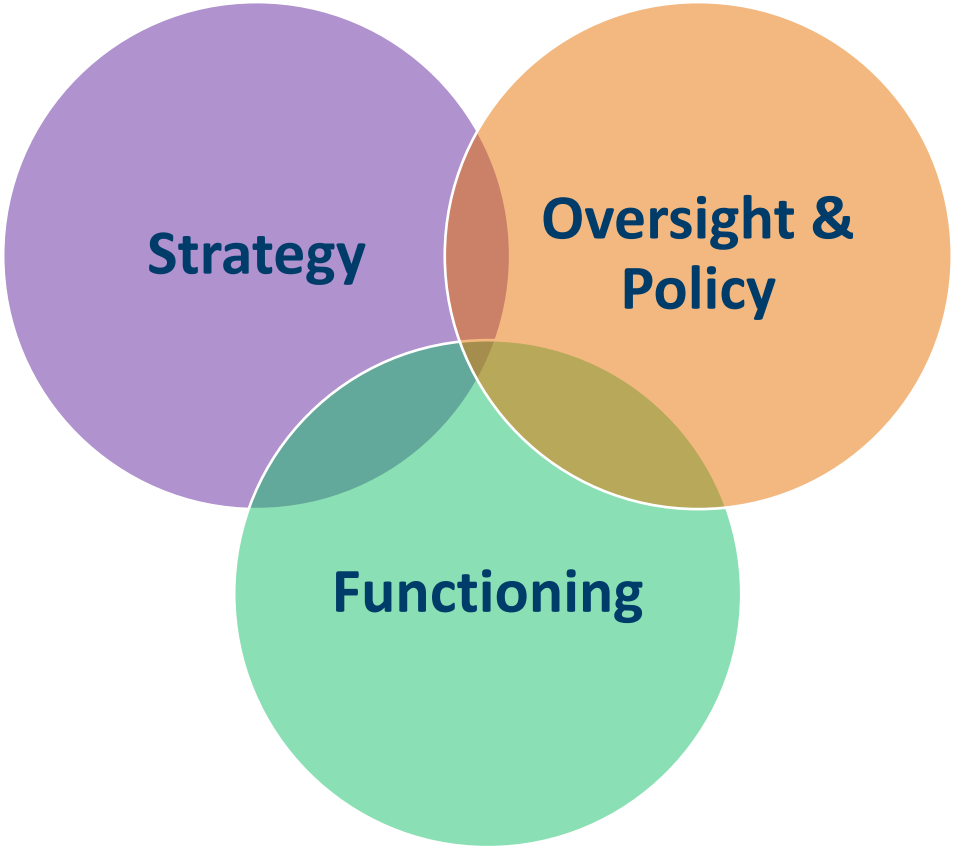
Governance Guide for Health Center Boards

https://www.healthcenterinfo.org/details/?id=2302

Video

Health Center Board Roles

Overall Board Roles



Strategy

- Strategic Board Composition
- Strategic Planning & Thinking

Functioning

- Board Meetings
- Board Committees
- Board Culture

Oversight & Policy

- Provide Oversight
  - CEO Oversight & Partnership
  - Corporate Compliance
  - Health Center Program Compliance
  - Financial
  - Quality
  - Risk Management
- Approve Policy

Governance

Board Decisions

CEO Insight

Partnership

Shared Decisions

Management

Board Insight

CEO Decisions

Tip:

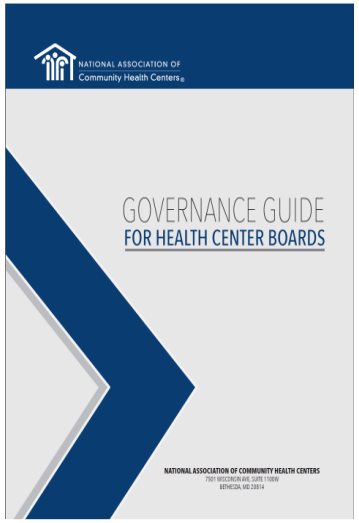
Ensure your board has a system in place to address situations when board member(s) may focus on management!

Tools

Guiding Questions to Maintain Focus on Governance

1. Is it big?
2. Is it about the future?
3. Is it core to the mission?
4. Is it a critical board oversight function?
5. Is a high-level policy decision needed to resolve a situation?
6. Is a red flag flying?
7. Is a "watchdog" watching?
8. Does the CEO want & need the board's support?

Source: Adapted from Barry Bader, "Distinguishing Governance and Management," (Great Boards)
http://trustees.aha.org/boardculture/archive/Great-Boards-fall-2008-reprint-distinguishing-governance-and-management.pdf



Sample Matrix – Chapter 1 of the Governance Guide

	Board /Governance	CEO/Management
Policy	• Approves certain policies	• Makes recommendations to board • Implements policies
CEO & Staff	• Hires, provides oversight of CEO • Establishes CEO compensation • Approves certain personnel policies	• Hires, manages rest of staff • Coaches staff

Poll

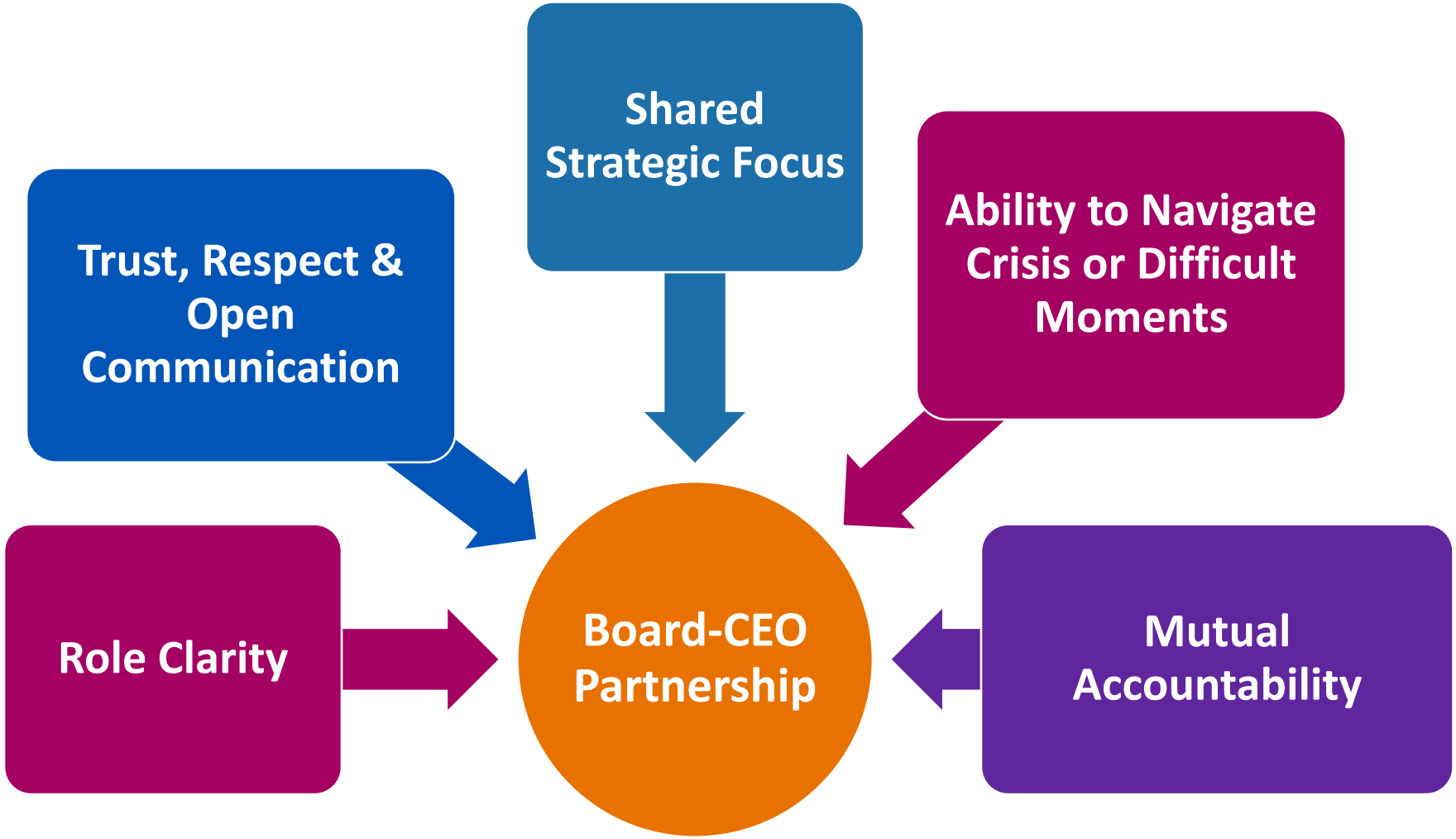
What do you think the board and CEO should expect from one another?

Live Content Slide

When playing as a slideshow, this slide will display live content

Poll: What do you think the board and CEO should expect from one another?

Board-CEO Partnership



Adapted from "Top 10 Principles and Practices of Great Boards," Great Boards and BoardSource, The Source; and "Let's Work Together" – The Sweet Sounds of a Board-CEO Partnership," by Melanie Lockwood Herman and Erin Gloeckner.

CEO Oversight

CEO Goals

CEO Evaluation

CEO Compensation

CEO Contract

Emergency Succession Plan and Succession Policy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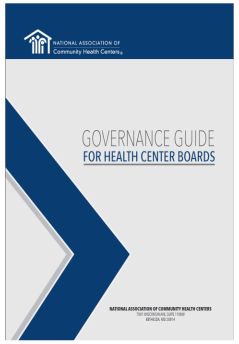
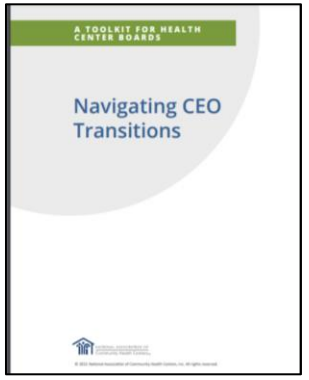
Tools



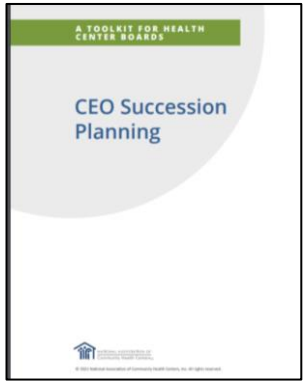
Governance Guide for Health Center Boards

- Chapter 1 addresses Board vs CEO Roles
- Chapter 7: CEO Oversight and Partnership
- Appendix 12: Sample CEO Evaluation

CEO and Senior Executive Compensation – Legal Considerations for Health Centers (Governance Legal Brief 3)

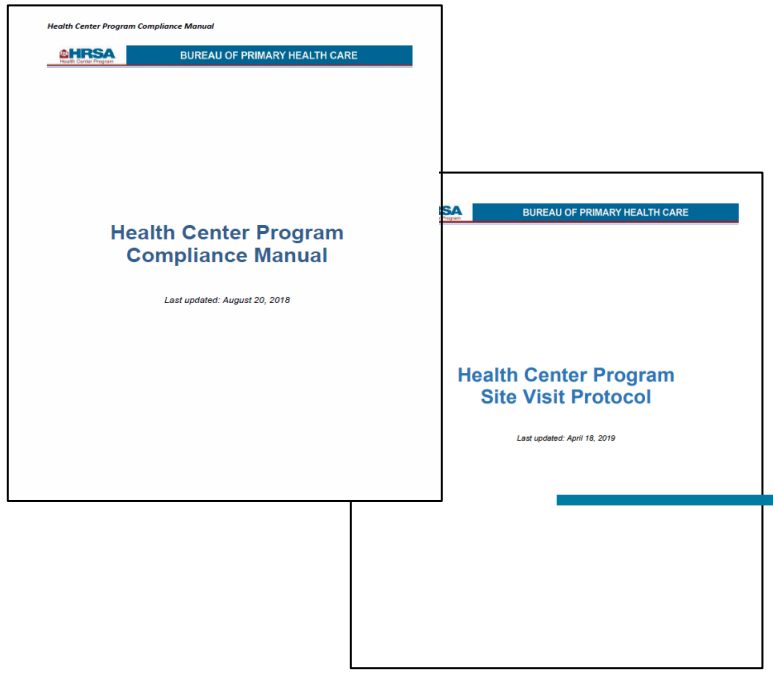


Navigating CEO Transitions: A Toolkit for Health Center Boards

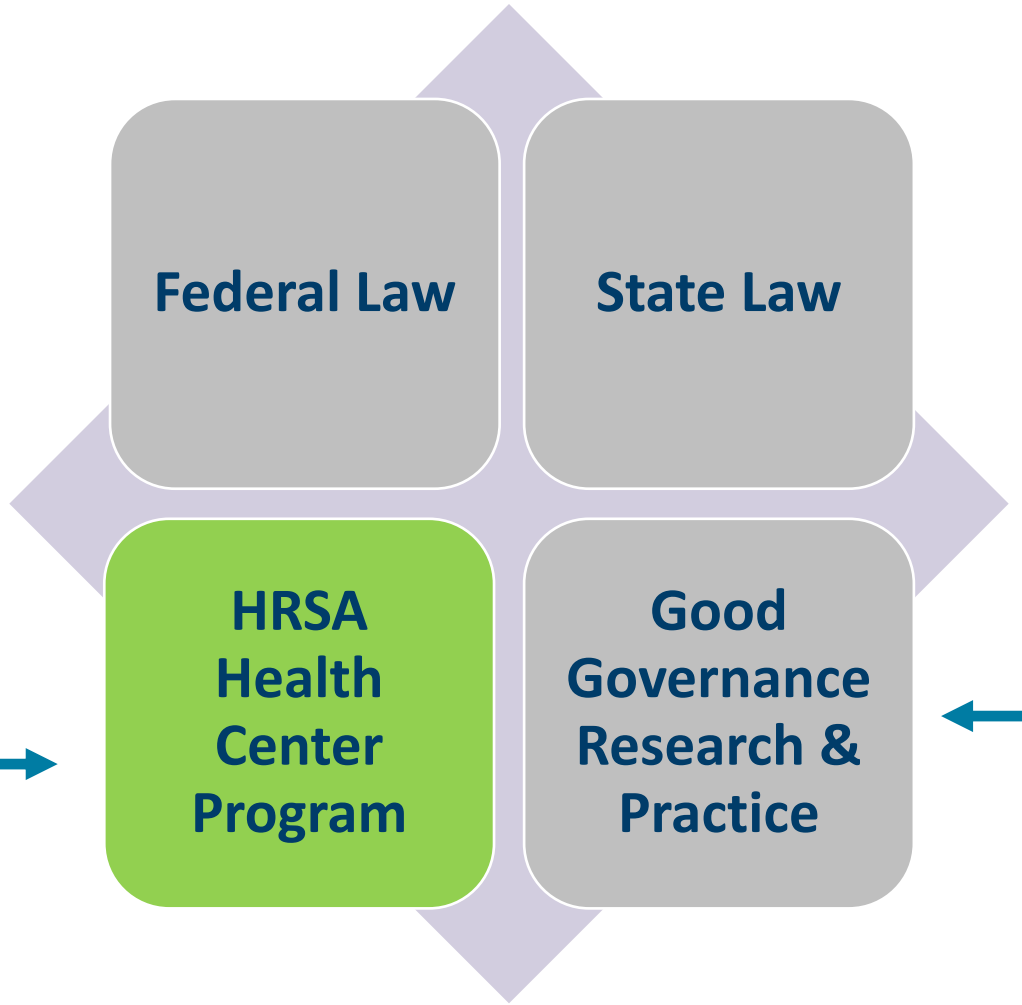


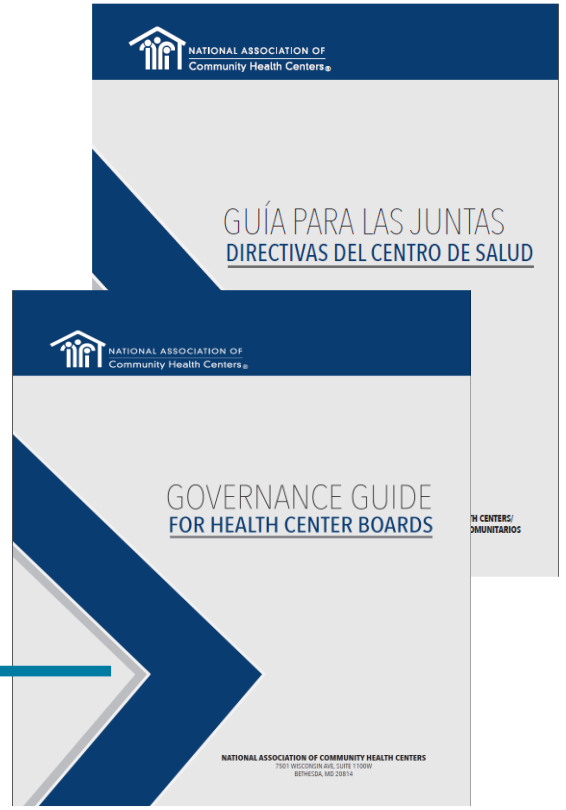
CEO Succession Planning: A Toolkit for Health Center Boards

Health Center Governance



https://bphc.hrsa.gov/





https://www.healthcenterinfo.org/details/?id=2302

Poll: What is your level of familiarity with the board requirements of HRSA Health Center Compliance Program?

1. Our board discusses them during board member orientation
2. Our board discusses them routinely
3. Our board has recently been through an Operational Site Visit (OSV)
4. I'm just starting to learn about this topic

Live Content Slide

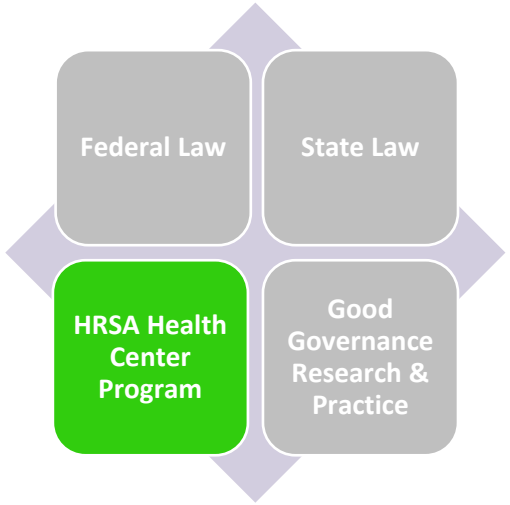
When playing as a slideshow, this slide will display live content

Poll: What is your level of familiarity with the board requirements of HRSA Health Center Compliance Program?

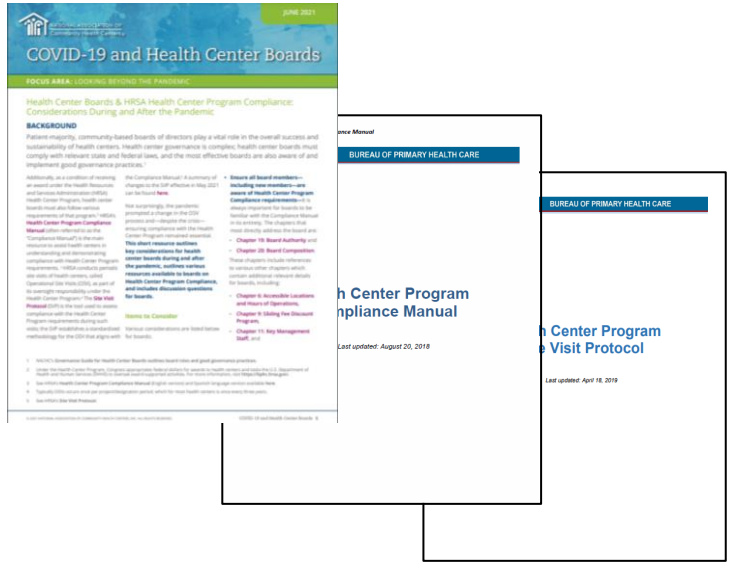
Health Center Program Compliance Risks

- Monthly meetings – no exceptions
- Authorities
  - Approving key policies and updating them periodically
  - Oversight of quality
  - Maintaining autonomy in context of collaboration arrangements with third parties
- Board Composition

Tools



- **Health Center Boards & HRSA Health Center Program Compliance: Considerations During and After the Pandemic**
- Summary in **Appendix** of this Slide Deck
- **On-demand Health Center Board Series Focused on Health Center Program Compliance and Related Good Practices** by the Health Center Association Nebraska https://www.healthcenterinfo.org/details/?id=2912
- **Governance Guide for Health Center Boards** (contains excerpts and maps them to overall board roles)
- **New Board Member Orientation Templates**



https://bphc.hrsa.gov/

Board Member Legal Duties

Duty of **Care**

The level of care that an ordinary prudent person would exercise in a like position under like circumstances

Duty of **Loyalty**

Undivided allegiance to the organization when making decisions affecting the organization

Duty of **Obedience**

Observance of, and faithfulness to, the organizational mission

Board Member Legal Duties

Duty of **Care**

The level of care that an ordinary prudent person would exercise in a like position under like circumstances

Examples:

- Attend and participate in board meetings
- Be informed
- Raise your hand -- ask questions or for more training/information!
- No rubberstamping

Board Member Legal Duties

Duty of **Loyalty**

Undivided allegiance to the organization when making decisions affecting the organization

Examples:

- Navigate conflicts of interest -- decisions in no way influenced by outside factors
- Maintain confidentiality

Board Member Legal Duties

Duty of **Obedience**

Observance of, and faithfulness to, the organizational mission

Examples:

- Make decisions based on the mission

Conflicts of Interest

Safeguarding the Duty of Loyalty

Bylaws or other written board-approved policy	• Prohibit *actual conflicts of interest or the appearance of* conflicts of interest by board members, employees, consultants and those who furnish goods or services to the health center
"Standards of Conduct"	• Define "conflict of interest" and requirements for disclosure and recusal of conflicts of interest • Note: Federal procurement rules provide specific standards when Federal funds support purchase or lease of goods and services • Address confidentiality, nepotism, gifts, gratuities • Specify consequences of violations

Poll: Scenario

A health center was considering asking for a subsidy from a local hospital to help expand certain programming. The governing board was having discussion about the subsidy when one board member, "Joe," became agitated and left the room. It turns out "Joe" was the CFO of the hospital that the health center had planned to ask for the grant. What should Joe have done before the board started its discussions?

A. He should have disclosed the conflict
B. He should have disclosed the conflict, and not participated in deliberation or any voting
C. Nothing – how he handled the situation was "ok"

Live Content Slide

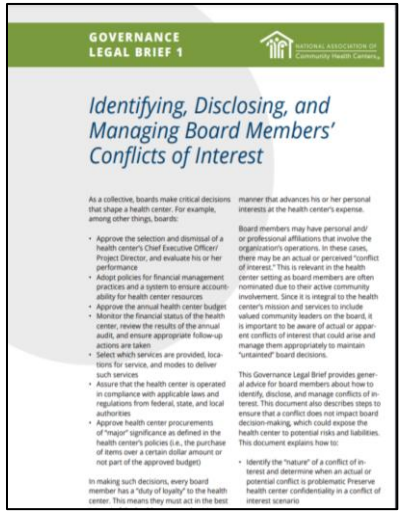
When playing as a slideshow, this slide will display live content

Poll: A health center was considering asking for a subsidy from a local hospital to help expand certain programming. The governing board was having discussion about the subsidy when one board member, “Joe,” became agitated and left the room. It turns out “

Poll: Scenario

In the scenario just described, clearly "Joe" had a conflict of interest. What if the proposed agreement under consideration was with another hospital in the community? What should Joe do?

A. He can participate in the deliberation but should not participate in voting
B. He should recuse himself
C. He can participate in discussions and voting


GOVERNANCE
LEGAL BRIEF 1

Identifying, Disclosing, and Managing Board Members' Conflicts of Interest

Identifying, Disclosing, and Managing Board Members' Conflicts of Interest (Governance Legal Brief 1)
https://www.healthcenterinfo.org/details/?id=2866

Live Content Slide

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Poll: In the scenario just described, clearly “Joe” had a conflict of interest. What if the proposed agreement under consideration was with another hospital in the community? What should Joe do?

Risk Areas

- **Avoid (and address) “rogue” conduct – Board members should not**
  - Individually speak for or act in an official capacity on behalf of the health center unless specifically authorized to do so
  - Publicly disagree with decisions made or actions taken by the full Board and/or management
  - Usurp the CEO’s authority or intervene in day-to-day administration of center
  - Communicate with center staff directly except as authorized
- **Avoid “preferential” treatment**
  - Scheduling patient appointments
  - Contracting with health center to provide goods/services
  - Other

Addressing Risks Through the Health Center's Corporate Compliance Program

7 Elements of Effective Compliance Programs (per federal guidelines)

1. Designate a compliance officer/contact
2. Conduct internal monitoring and audits
3. Develop written standards and policies to implement the Compliance Program and govern health center operations
4. Conduct culturally and linguistically competent training and education programs
5. Develop effective, clear, open lines of communication between compliance and health center personnel - open door policy and policy prohibiting retaliation
6. Investigate detected problems and develop corrective action
7. Publicize and enforce disciplinary standards


Q
&
A

Key Learning & Action Planning

As you participate in Boot Camp today, consider:

- What key concepts will you take back and use with ***your board***
- What key concepts will make ***you*** a more effective board member

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Poll:

- Please consider sharing one key concept that you will take away from this segment

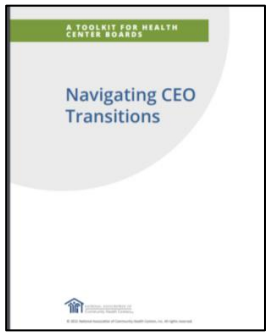
Live Content Slide

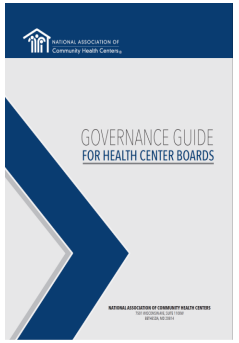
When playing as a slideshow, this slide will display live content

Poll: Please consider sharing one key concept that you will take away from this segment

Governance Resources

- **Governance Guide for Health Center Boards (English/Spanish)**
  - Chapter 1: The Role of the Board (includes Governance vs Management Matrix)
  - Chapter 7: CEO Oversight and Partnership
  - Appendix 12: Sample CEO Evaluation
- **Governance During COVID-19**
  - The Board and CEO Partnership During the Current Public Health Emergency (English/Spanish)
- **CEO and Senior Executive Compensation – Legal Considerations for Health Centers (Governance Legal Brief 3)**





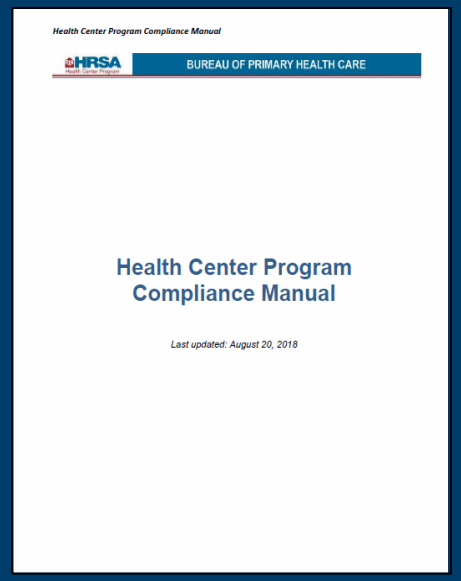
ARE YOU LOOKING FOR RESOURCES?

Please visit our website
www.healthcenterinfo.org

HEALTH CENTER RESOURCE CLEARINGHOUSE

Appendix

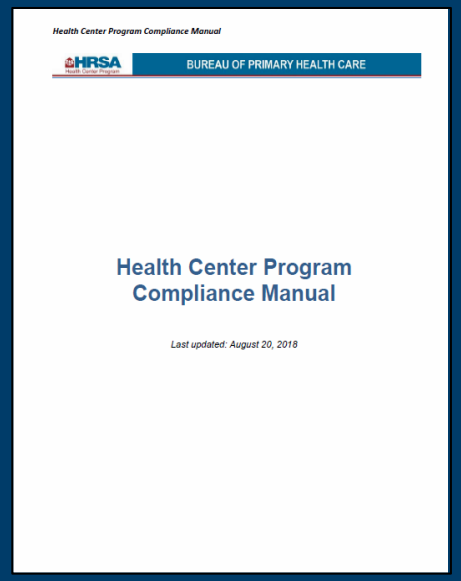
Section 330 Statutory & Regulatory Requirements Regarding Governance



See Chapter 20of the Health Center Program Compliance Manual
https://bphc.hrsa.gov/programrequirements/compliancemanual/introduction.html

- Absent a waiver for certain special population grantees, the health center's Board must comply with board size and composition requirements
  - Between 9 – 25 members
  - Consumer members – At a minimum, 51% must be individuals served by the health center, who, as a whole, reasonably represent the patients served in terms of demographic factors such as race, ethnicity, gender, age, and socioeconomic status
  - Non-consumer members must represent the community served and be selected for expertise in various areas
  - No more than ½ of non-consumer members can derive more than 10 percent of their income from the health care industry
  - No Board member can be an employee or an immediate family member (spouse, child, parent, sibling, by blood, marriage, adoption) of an employee

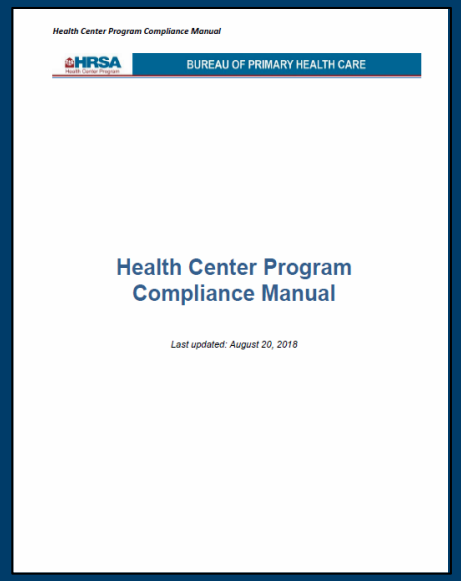
Section 330 Statutory & Regulatory Requirements Regarding Governance



See Chapter 19 of the Health Center Program Compliance Manual
https://bphc.hrsa.gov/programrequirements/compliancemanual/introduction.html

- Board must autonomously exercise certain authorities:
  - Holds monthly meetings and maintain minutes
  - Approves health center application and HRSA requests regarding scope of project
  - Approves annual budget and applications for the health center project
  - Employs, evaluates and, if necessary, dismisses the Project Director/CEO
  - Approves scope of services, as well as hours and locations of services

Section 330 Statutory & Regulatory Requirements Regarding Governance



See Chapter 19 of the Health Center Program Compliance Manual
https://bphc.hrsa.gov/programrequirements/compliancemanual/introduction.html

- Board authorities cont'd:
  - Establishes, reviews and as necessary, revises general operating policies at least once every three years
  - Measures and evaluates progress in meeting annual and long-term programmatic and financial goals (at least once every three years), including, but not limited to: long-term strategic and capital planning; ongoing review of mission and bylaws; monitoring organizational assets and performance
  - Evaluate health center activities, including service utilization patterns, productivity, patient satisfaction, achievement of project objectives
  - Review the results of the annual audit to ensure appropriate follow-up actions are taken

Board's Role in Corporate Compliance

Board Responsibilities	**Establish, provide oversight, and periodically evaluate the corporate compliance program**
Board Tasks	• Pass a resolution reflecting the Board's ongoing commitment to ensuring the health center operates in a legally compliant and ethical manner; approve the key policies that define the compliance program's framework; update annually • Ensure funds budgeted for the compliance program are sufficient and appropriate, considering the health center's size, complexity, and compliance history • Review the annual compliance work plan and, during the year, monitor progress • Receive regular reports from the CEO and the Compliance Officer about compliance program activities • Receive information and reports from the Compliance Officer about investigations of non-compliance (as appropriate) – in executive session! • Periodically evaluate the performance and effectiveness of the compliance program and update, as appropriate

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The Fundamentals of Board Financial Oversight

Mary L. Hawbecker, CPA

Senior Vice President, Operations and Chief Financial Officer, NACHC

Gervean Williams

Director, Finance Training and Technical Assistance, NACHC

Virtual Participants

Chat
(use to talk with peers)

Polling/Q&A
(participate in polls, ask questions to faculty)

Objectives

- Outline the board's financial oversight role
- Outline various questions board members can ask related to financial oversight

The great health center in the finance area has…

- A well informed and engaged board
- Board committee(s) focused on finance and audit
- A knowledgeable Treasurer
- Knowledgeable highly qualified accounting/finance staff
- Strong written policies and procedures and follows them
- Good systems for capturing and reporting financial information

Fiscal Oversight

The board is responsible for ensuring that the health center is financially stable and is operating in accordance with applicable federal, state, and local laws and regulations as well as its own established policies and procedures.

Establishing Financial Priorities

- Must have a long-range financial planning process.
  - Health Center Program Compliance Manual, Chapter 19: Board Authority: *The health center governing board must provide direction for long-range planning, including but not limited to identifying health center priorities and adopting a three-year plan for financial management and capital expenditures.**

- Annually the board should discuss the center's financial priorities for the year prior to preparation of the next year's budget. Center staff should identify needs or the changing environment.

**Note: see the HRSA Health Center Compliance Manual, Chapter 19: Board Authority*
https://bphc.hrsa.gov/programrequirements/compliancemanual/chapter-19.html#titletop

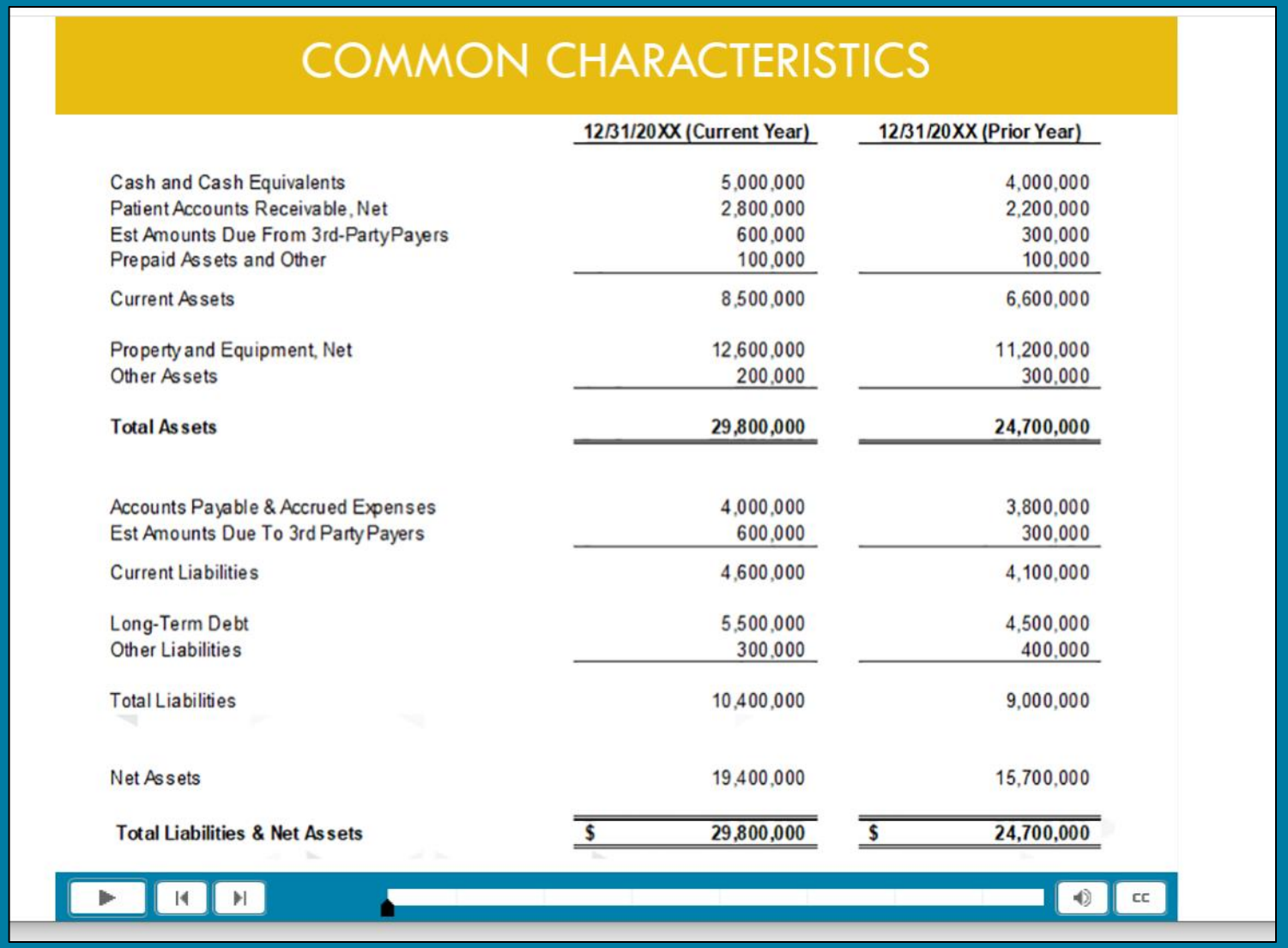
Review and Approve the Annual Budgets

Operating Budget	Grant Budget
– The board should review the budget to make sure resources follow priorities – Things to consider: • Current year's expected results • Changes in funding amounts • Changes in expenses	– Balances to zero – Submitted to HRSA annually – Represents all 330 grant activities

Monitor Financial Performance

- Monitor financial status through routine review of:
  - Statement of Financial Position (Balance Sheet)
  - Statement of Activities (Income Statement)
  - Statement of Cash Flows
  - Key Performance Indicators

Statement of Financial Position *(Balance Sheet)*



Statement of Activities *(Income Statement)*

	12/31/20XX	12/31/20XX
Patient Service Revenue	$ 25,000,000	$ 23,500,000
Grant Revenue	6,500,000	6,300,000
Contribution Revenue	600,000	550,000
Other Revenue	400,000	350,000
Operating Revenues	32,500,000	30,700,000
Salaries and Benefits	21,250,000	20,050,000
Supplies and other	9,300,000	8,835,000
Rent	350,000	350,000
Depreciation and amortization	950,000	850,000
Operating Expenses	31,850,000	30,085,000
Operating Income	$ 650,000	$ 615,000

Statement of Cash Flows

CASH FLOW

	20CY	20PY
Operating Activities		
Change in net assets	$ (1,200,000)	$ (800,000)
Items not requiring (providing) operating cash flow		
Depreciation	900,000	900,000
Loss on disposal of property and equipment	100,000	-
Changes in		
Patient accounts receivable, net	100,000	100,000
Estimated amounts due from third-party payers	1,000,000	100,000
Accounts payable and accrued expenses	300,000	(300,000)
Deferred grant revenue	(200,000)	200,000
Net cash provided by operating activities	1,000,000	200,000
Investing Activities		
Purchase of property and equipment	-	(100,000)
Net cash used in investing activities	-	(100,000)
Financing Activities		
Principal payments on long-term debt	(500,000)	(600,000)
Proceeds from issuance of notes payable to bank	-	700,000
Principal payments on notes payable to bank	(700,000)	(500,000)
Net cash used in financing activities	(1,200,000)	(400,000)
Decrease in Cash	(200,000)	(300,000)
Cash, Beginning of Year	300,000	600,000
Cash, End of Year	$ 100,000	$ 300,000
Supplemental Cash Flows Information		
Interest paid	$ 500,000	$ 600,000

Poll: You are discussing financial statements in a board meeting and have questions about some of the numbers. What would you do?

a. Speak up! It's every board member's responsibility to understand and ask questions about the financial information being presented to them.
b. Wait and see if someone else asks the question and, if not, then raise your concerns.
c. Stay quiet.
d. Talk to the Treasurer after the meeting to ask questions.

Live Content Slide

When playing as a slideshow, this slide will display live content

Poll: You are discussing financial statements in a board meeting and have questions about some of the numbers. What would you do?

Key Performance Indicators

Sample Indicators

Measure Name	What it measures	Target/desired direction
Operating Margin	Measures the performance of the health center over a period of time and is calculated by dividing operating income by total revenues.	2 to 4%, over 5% if possible
Days Cash on Hand	Measures how many days a health center can pay its expenses if income were to cease.	45 to 60 days minimum; best practice 90-120 days
Days in Accounts Receivable	Measures how long it takes for a health center to collect its patient accounts receivable.	Less than 45 days (lower number is better)

Poll: Your board receives the following information. What questions might you ask about the financial dashboard?

Measure	2019	2020		Target
Days Cash on Hand	55	25		45-60 days (minimum)
Days in Accounts Receivable	42	47		Less than 45 days
Days in Accounts Payable	30	35		Less than 45 days

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Poll: What questions might you ask about the financial dashboard?

Modules on Board Financial Oversight

English: https://www.healthcenterinfo.org/details/?id=2152
Spanish: https://www.healthcenterinfo.org/details/?id=3048

The board should ensure the establishment of:

- Internal control procedures
- A billing and collection system
- Purchasing policies and standards
- Protocols for determining eligibility for services
- Sliding Fee Discount Policy
  - See Health Center Program Compliance Manual, Chapter 9: Sliding Fee Discount Program*

**Note: see the HRSA Health Center Compliance Manual, Chapter 19: Board Authority* https://bphc.hrsa.gov/programrequirements/compliancemanual/chapter-19.html#titletop and Chapter 9: Sliding Fee Discount Program https://bphc.hrsa.gov/programrequirements/compliancemanual/chapter-9.html#titletop

Audit

- Auditor Selection as a Procurement
  - Procuring the services, selecting auditor
  - Engagement letter

- Review and approve the annual audit, ensure follow-up actions taken
  - If an entity receives over $750,000 in federal support, they are required to obtain an audit in accordance with "CFR Part 200, Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards."

- Be attentive to the Opinion

Government Auditing Standards & Uniform Guidance

- The financial review
- Internal control review
- Compliance review

Audit Reporting Package

- Opinion or Disclaimer of Opinion on Financial Statements*
- Financial Statements and Footnotes**
- Schedule of Expenditures of Federal awards**
- Report on internal control*
- Report on compliance*
- Schedule of Findings and Questioned Costs*
- Summary Schedule of Prior Audit Findings*
- Corrective Action Plan**

*Auditor's responsibility
**Auditee's responsibility

What is the IRS looking for?

- Form 990
- Form 990T

Tool: Questions a Board Can Ask

- Does the budget reflect our priorities?
- Are our expenses appropriate?
- How effectively are we collecting accounts receivable?
- What is our current cash position?
- Did we get a clean audit?
- What can we learn from the audit?
- What internal controls do we have in place?

Poll

What is the biggest financial threat or challenge to your health center?

Live Content Slide

When playing as a slideshow, this slide will display live content

Poll: What is the biggest financial threat or challenge to your health center?

Financial Oversight During COVID-19

- ✓ Monitor key indicators
- ✓ Ask questions to better understand the financial outlook
- ✓ Balance short and long-term strategy when making decisions
- ✓ Understand new funding streams
- ✓ Ask questions to ensure grants compliance
- ✓ Ensure budget reflects current realities

Resources

- Hot Topics in Finance During the Pandemic (Video)
- Strategic Planning and Strategic Financial Planning During Crisis (Video)
- Financial Oversight During COVID-19 (Video)
- Pandemic Related Budgeting Considerations (Article – English/Spanish)


Q
&
A

Key Learning & Action Planning

Consider:

- What key concepts will you take back and use with ***your board***
- What key concepts will make ***you*** a more effective board member

Poll: Short Answer

- Please consider sharing one key concept that you will take away from this segment

Live Content Slide

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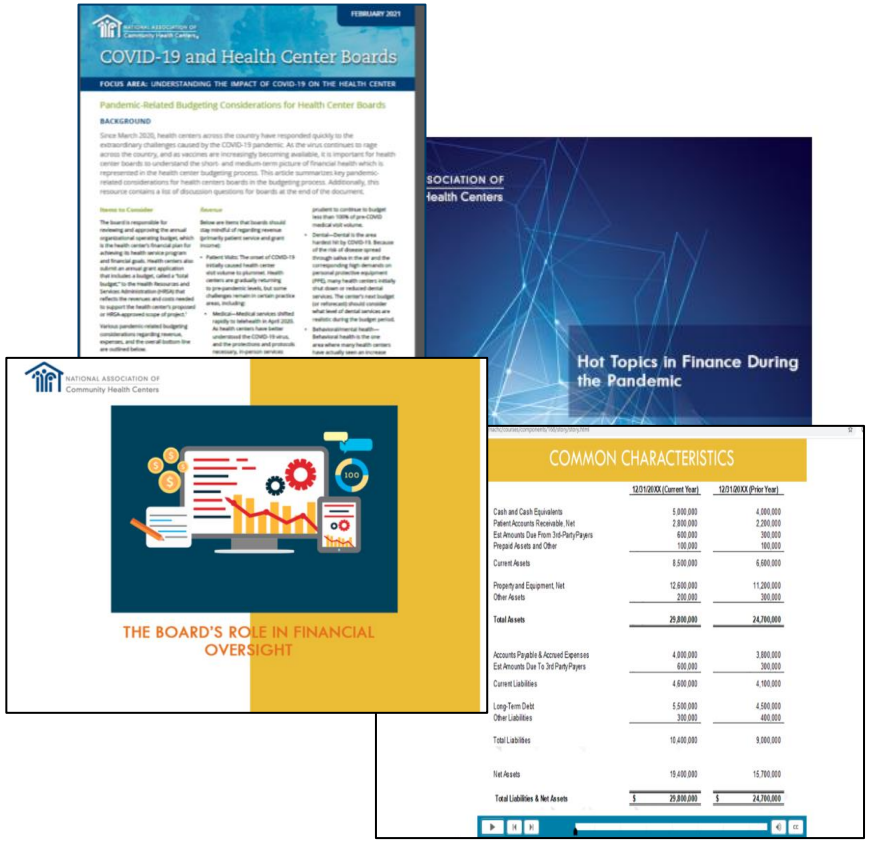
Poll: Please consider sharing one key concept that you will take away from this segment.

Board Financial Oversight Resources

- **Governance Guide for Health Center Boards**, Chapter 4: Financial Oversight

- **Modules on Board Financial Oversight**
  - English
  - Spanish

- **COVID-19 Governance Resources**
  - Hot Topics in Finance During the Pandemic (Video)
  - Strategic Planning and Strategic Financial Planning During Crisis (Video)
  - Financial Oversight During COVID-19 (Video)
  - Pandemic Related Budgeting Considerations
  - Audit Considerations Related to the Pandemic



Make sure we have a unique e-mail address to ensure you receive up to date tools and information!

NATIONAL ASSOCIATION OF Community Health Centers®

Critical Components of Health Center Governance: *Quality Oversight & Board Member Advocacy*

Audience Participation

Chat
(use to talk with peers)

Polling/Q&A
(participate in polls, ask questions to faculty)

NATIONAL ASSOCIATION OF Community Health Centers®

Quality Oversight

A. Seiji Hayashi, MD, MPH, FAAFP
Chief Transformation Officer and Medical Director, Mary's Center

Brandon L. Jones
Health Center Board Chair

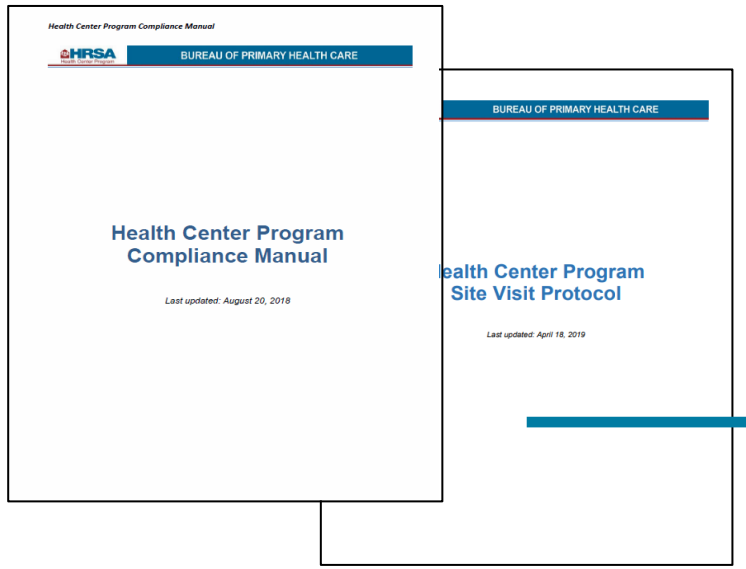
Avni Shridharani, MHS
President, Community Health Strategies LLC

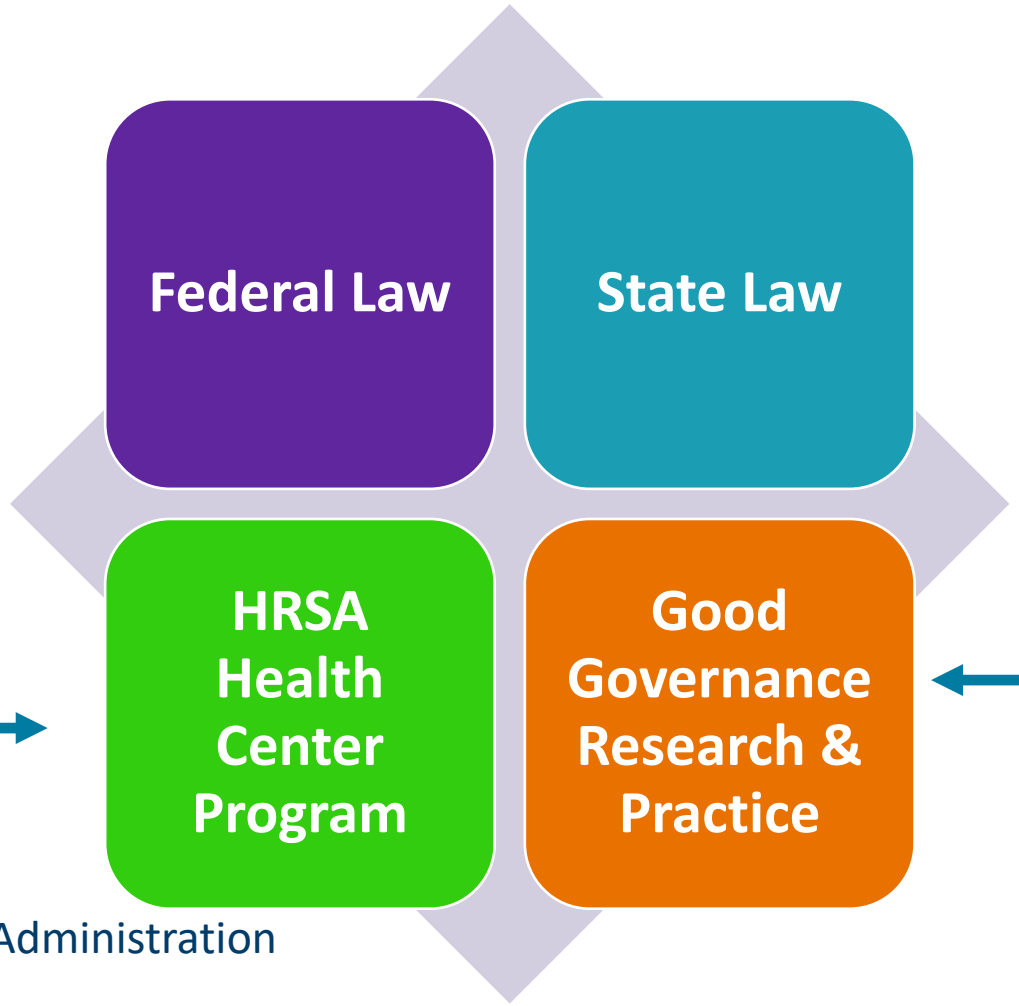
Objectives

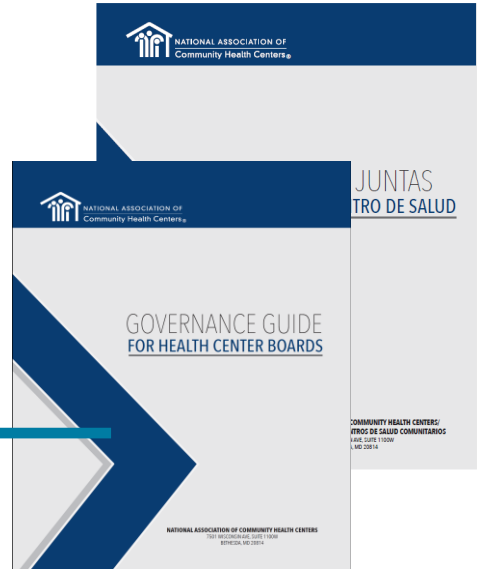
- Define quality and explore its importance for health centers
- Outline the board's role in providing oversight of quality

Health Center Governance & Quality

- Chapter 19: Board Authority;
- Chapter 10: Quality Improvement/Assurance;
- Chapter 21: Federal Tort Claims Act (FTCA) Deeming Requirements







HRSA = Health Resources and Services Administration

https://bphc.hrsa.gov/

Governance Guide for Health Center Boards(Chapter 5)

https://www.healthcenterinfo.org/details/?id=2302

Poll:

What type of experience do you want for health center patients?

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Poll: What type of experience do you want for health center patients?

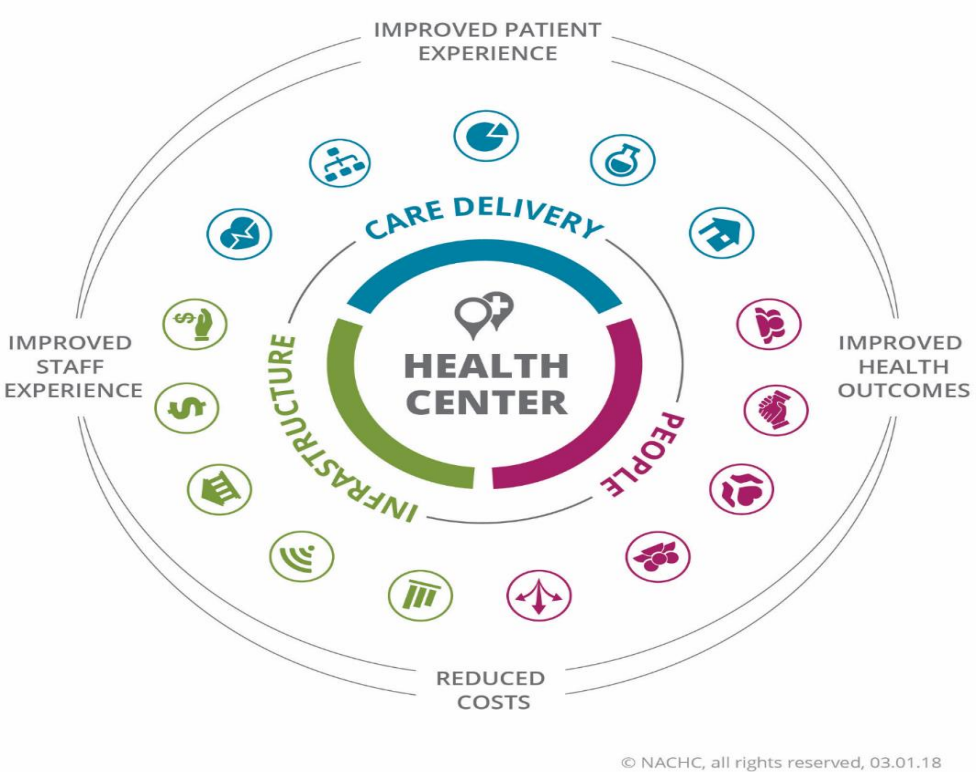
Board's Role in Quality Oversight

1. Ensure Shared Definitions and Understanding

The National Academy of Medicine describes quality as care that is **safe, effective, patient-centered, timely, efficient, and equitable.**

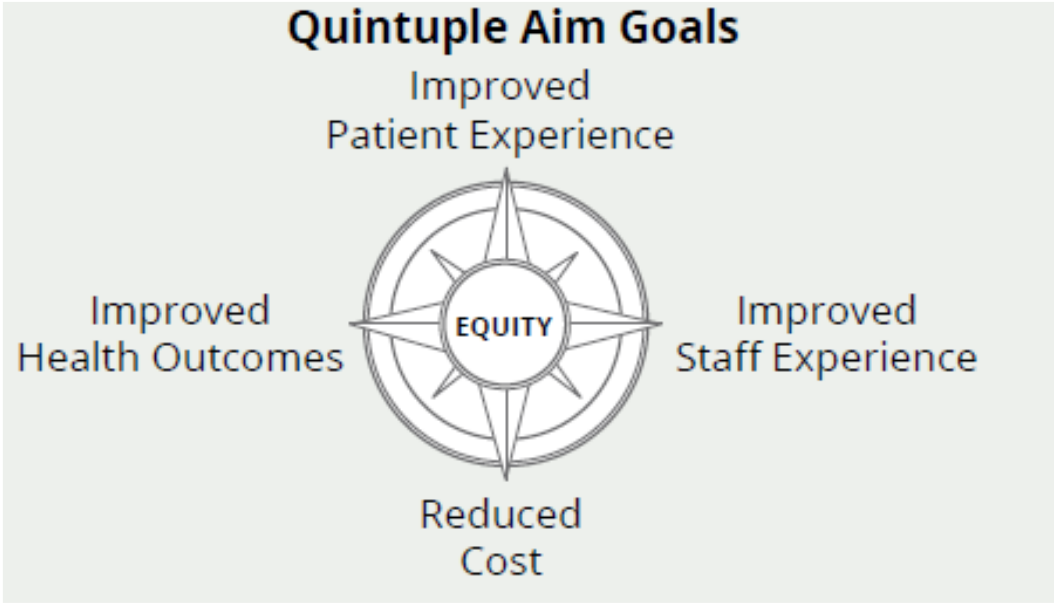
Consider Quality Frameworks

Value Transformation Framework



For more information, visit
http://www.nachc.org/clinical-matters/value-transformation-framework/

Quintuple Aim



Board's Role in Quality Oversight

2. Set Tone

3. Assure Resources

4. Approve and Revise Quality Assurance/Quality Improvement Policies

Board's Role in Quality Oversight

5. Review Measures, Understand the Forces Impacting the Data, and Ask Questions

Sample Uniform Data System (UDS) Measures

Percentage of children 2 years of age who had four diphtheria, tetanus and acellular pertussis (DTaP); three polio (IPV), one measles, mumps and rubella (MMR); three or four H influenza type B (HiB); three Hepatitis B (Hep B); one chicken pox (VZV); four pneumococcal conjugate (PCV); one Hepatitis A (Hep A); two or three rotavirus (RV); and two influenza (flu) vaccines by their second birthday

Percentage of patients 3–16 years of age with a BMI percentile ***and*** counseling on nutrition *and* physical activity documented

Percentage of patients 18–75 years of age with diabetes who had hemoglobin A1c (HbA1c) greater than 9.0 percent during the measurement period

Sample Data

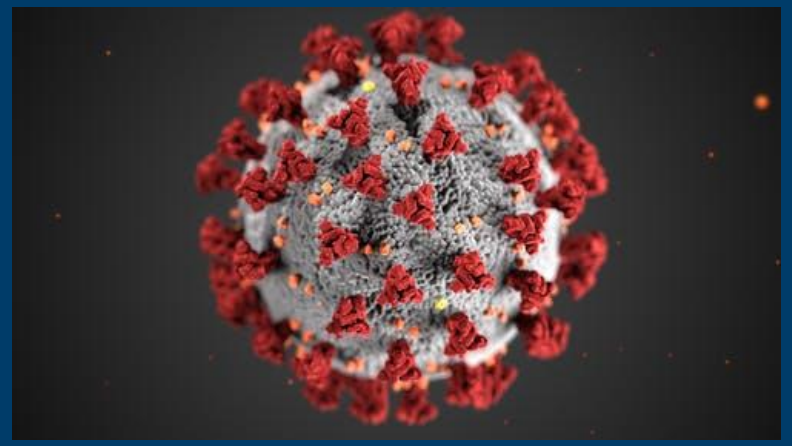
Percentage of patients 18-85 years of age who had a diagnosis of hypertension and whose blood pressure was adequately controlled (less than 140/90 mmHg) during the measurement period.

Measure	2017	2018	2019
All health centers	62.38	62.71	63.26
Healthy People Benchmark	61.2	61.2	61.2
Health Center ABC	49.2	56.2	61.3

Sample Patient Satisfaction Scores

Measure	Q2	Q3
Overall satisfaction	89.1%	90.2%
Telehealth Video – Overall Quality by Care Provider	82.3%	75.6%
Telehealth Video – Ease of Connecting with Care Team	85.9%	88.6%
In-person – Staff Courtesy and Helpfulness	77.5%	80.1%
In-person – Overall Quality by Care Provider	85.6%	87.5%

Pandemic-Related Forces Impacting Quality



- Rapid adoption of telemedicine
- Limitations on access to care
- Role of patient engagement
- Navigating constant change
- Provider and staff fatigue

Poll: Below is sample Uniform Data System data from 2020.

Clinical Data	2016	2017	2018	2019	2020
Childhood Immunization Status	78.68 %	71.59 %	75.22 %	71.74 %	77.40 %

What do you anticipate might happen to the childhood immunization data that will be reported for 2021?

a. The percentage will likely stay the same
b. The percentage will likely decrease as many parents delayed care for their children during the pandemic
c. I'm not sure

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Poll: What do you anticipate might happen to the childhood immunization data that will be reported for 2021?

Poll/Scenario

Patient satisfaction for telehealth visits were high at the start of the pandemic, but data shared with the board shows a steady decline in the last 3 months. What questions might you ask?

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Poll: Patient satisfaction for telehealth visits were high at the start of the pandemic, but data shared with the board shows a steady decline in the last 3 months. What questions might you ask?

Poll:

If you take the scenario a step further, what might a board want to ensure happens in response to the questions raised?

1. Document the discussion in the board meeting minutes.
2. Ensure there are reports during board meetings to demonstrate follow up.
3. Ensure the CEO has a plan for holding their team accountable for addressing contributing factors.
4. All of the above.

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Poll: If you take the scenario a step further, what might a board want to ensure happens in response to the questions raised?

Ask questions

FEBRUARY 2021

NATIONAL ASSOCIATION OF Community Health Centers®

COVID-19 and Health Center Boards

FOCUS AREA: UNDERSTANDING THE IMPACT OF COVID-19 ON THE HEALTH CENTER

Board Oversight of Quality During the COVID-19 Pandemic

BACKGROUND

Since the start of the health center program, health centers have prioritized the delivery of high-quality clinical care to patients. Health center providers, staff, leadership teams, and boards have invested resources to ensure that patients receive timely, evidence-based,[1] and continuous clinical care that result in healthier patients and communities.

Providing oversight of quality is an important role of a health center board. Boards are responsible for setting the tone to communicate the importance of quality, reviewing and approving the Quality Assurance/Quality Improvement plan, monitoring quality and safety indicators, and approving key policies, among other duties.[2]

Perhaps not surprisingly, the COVID-19 pandemic has challenged traditional means of providing quality care and has forced health center providers, staff, and leadership to find new and innovative ways to ensure access and meet the comprehensive needs of their patients. It is important for boards to remember their quality oversight responsibilities particularly during COVID-19 when so many other items will compete for the time, attention, and resources of health centers. This short resource outlines various factors for board consideration regarding quality oversight and mitigating risks related to quality during the pandemic. (Boards may also be interested in a related short article on "Board Oversight of Risk Management During the Pandemic.")

Items to Consider

Health center staff have been faced with immediate and ongoing challenges of needing to balance testing and treatment of patients for COVID-19, vaccine deployment, and continuing to offer primary care services to patients. Centers have been required to rapidly adapt clinical and operational processes and have rapidly adopted telehealth.[3] As a result, health centers have been placed in unfamiliar territory and many have had to make critical decisions around new models of care.

Below are some considerations for health center boards and the Quality Committee of a board (if one is in place):

- **Ensure the board continues to monitor quality**—It is important and required[4] for boards to monitor quality regularly. Consider: are we still receiving and discussing

1 Evidence-based care is an approach to decision making where a clinician uses the best evidence available, in consultation with the patient (evidence-based patient choice), to decide upon which option best suits the patient.

2 For general information on board oversight of quality, see NACHC's Governance Guide for Health Center Boards, Chapter 5: Quality Oversight (available at https://www.healthcenterinfo.org/details/?id=2802). The Health Resources and Services Administration (HRSA) has a number of requirements that health center boards must meet related to quality oversight. For details, see the HRSA Health Center Program Compliance Manual available at https://bphc.hrsa.gov/programrequirements/compliancemanual/index.html (specifically Chapter 19: Board Authority and Chapter 11: Quality Improvement/Assurance).

3 For more on telehealth, please see "Current and Future Strategic and Oversight Considerations Related to Telehealth for Health Center Boards" available on the Health Center Resource Clearinghouse (https://www.healthcenterinfo.org/) in March 2021.

4 See footnote 2 for details on where to find information on HRSA requirements.

Sources: Quality Oversight During the Pandemic and Governance Guide for Health Center Boards

- How has the pandemic impacted data? What are we learning from the data?
- Are we reducing disparities in care across all UDS measures?
- Where are there gaps?
- Are our quality goals strategically important?
- What will be different about how our health center measures quality in five years?
- Has limited access to care impacted quality?
- How do we measure staff and provider satisfaction?
- What is the current state of staff and provider satisfaction? What additional resources or investments may be needed to support staff and provider well-being?
- What technical investments need to be made to improve quality? What financial investment and approval may be needed from the board?

Board's Role in Quality Oversight

6. Ensure Follow-Up

(continued)

Board's Role in Quality Oversight

7. Recruit

8. Orient

9. Use a Quality Committee


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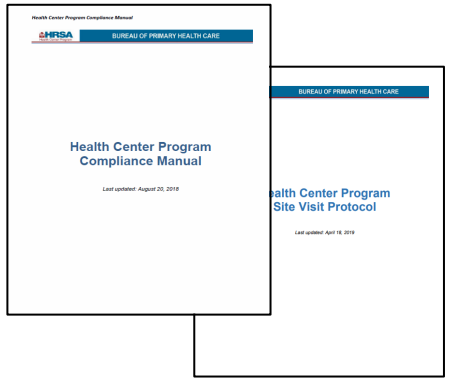
Board Quality Oversight



Health Resources and Services Administration (HRSA) Requirements – See Health Center Program Compliance Manual https://bphc.hrsa.gov/

- Chapter 19: Board Authority;
- Chapter 10: Quality Improvement/Assurance;
- Chapter 21: Federal Tort Claims Act (FTCA) Deeming Requirements

Governance Guide for Health Center Boards, Chapter 5: Quality Oversight
https://www.healthcenterinfo.org/details/?id=2302

COVID-19 Related Governance Resources
Health Center Governance and Telehealth
Board Oversight of Risk Management During the Pandemic
Board Oversight of Quality During the Pandemic

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Board Member Advocacy

Susan Greer Burton
Director, National Grassroots Advocacy, NACHC

Brandon L. Jones
Health Center Board Chair

Avni Shridharani, MHS
President, Community Health Strategies LLC

Objectives

- Understand what advocacy is and why it is important
- Discuss ways board members and the board can engage in advocacy
- Learn about tools to help you become an advocate

What is advocacy?

- Acting in support of a belief, a policy, or in recommendation of a policy
- Educating on an issue
- Amplifying the voices of others

How is advocacy carried out?

- Legislative visits (virtual during pandemic)
- Send emails
- Write op-eds
- Social media engagement
- And more!

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Poll Question

Why is advocacy important for health centers?

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Poll: Why is advocacy important for health centers?

Advocacy is *Everyone's* Responsibility!

Storytelling is at the heart of advocacy!

Poll Question

Why did ***YOU*** join the board you serve on?

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Poll: Why did YOU join the board you serve on?

Board Role in Advocacy

- Support a **"culture of advocacy"**
- **Partner with the CEO** and their staff on advocacy efforts
  - Participate in legislative visits (virtual during pandemic!)
  - Send emails
  - Write op-eds
  - And more!

Poll: What types of advocacy have you participated in?

1. Sending email to elected officials
2. In-person legislative visit
3. Virtual legislative visit
4. Social media post
5. None yet but looking forward to it!

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Poll: What types of advocacy have you participated in?

Board Role in Advocacy *(continued)*

- Pass a Board Resolution to support advocacy *(NACHC has a sample board resolution, here)*
- Consider forming a board advocacy committee

You may Advocate

Advocacy includes: sharing information about your health center, information about your patients, a story about yourself or your doctor, requesting policies and funding that benefit CHCs and health center patients…

BUT….
You may NOT

- Endorse a candidate
- Host an event for a candidate
- Invite only candidates from one party to your events (if you invite one elected official, invite them all)
- Show a preference for candidates or parties.

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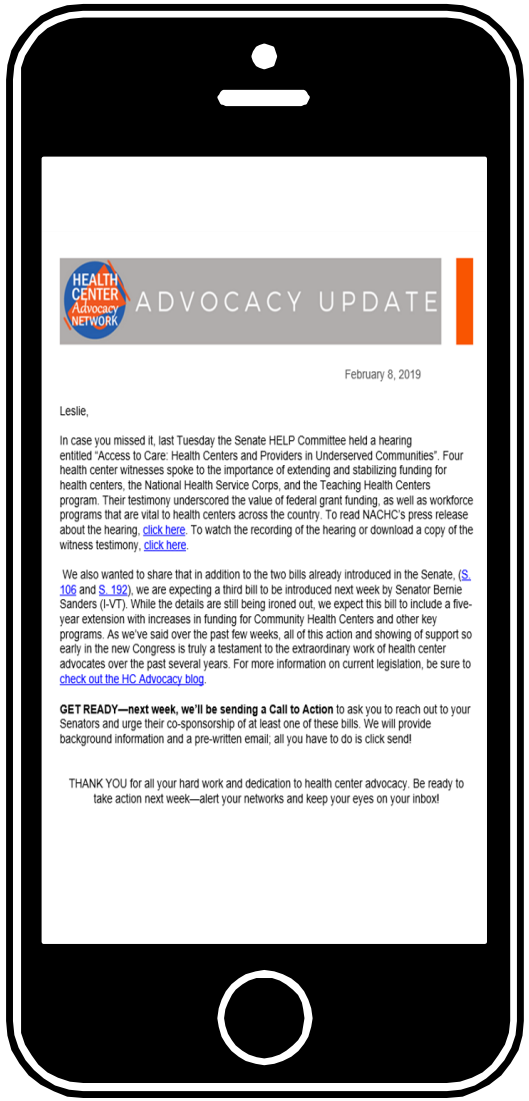
Advocacy Resources



https://www.hcadvocacy.org/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&
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Key Learning & Action Planning

As you participate in Boot Camp today, consider:

- What key concepts will you take back and use with ***your board***
- What key concepts will make ***you*** a more effective board member

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Poll

Please consider sharing one key concept that you will take away from this segment

Live Content Slide

When playing as a slideshow, this slide will display live content

Poll: Please consider sharing one key concept that you will take away from this segment

Resources for Health Center Boards

NACHC has over 50 resources (including many in Spanish) to support health center boards addressing:

- Governance Fundamentals, *including board roles, board recruitment and orientation, board meetings, CEO succession planning*
- Overall Health Care Environment & Governance, *including many resources on COVID-19 Response and Recovery*
- Strategic Planning and Thinking
- Justice, Diversity, Equity, and Inclusion
- And much more!

Short Videos and E-learning Modules are available to support new board member orientation and ongoing board education.

Learn more at https://www.nachc.org/trainings-and-conferences/governance

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Questions? Please contact Emily Heard at trainings@nachc.com

@NACHC

Poll: What delivery modes do you prefer for accessing governance training and technical assistance? (select all that apply)

a. E-learning modules or videos (to use for the board's own orientation or ongoing education)
b. "Live" training conducted **in-person**
c. "Live" training conducted **virtually**
d. "Office hours" or webinars conducted **virtually**
e. Peer to peer learning conducted **in-person**
f. Peer to peer learning conducted **virtually**
g. Podcasts
h. Toolkits, guides, or case studies

Live Content Slide

When playing as a slideshow, this slide will display live content

Poll: What delivery modes do you prefer for accessing governance training and technical assistance? (select all that apply)

Poll: What topics are of greatest interest for additional governance training and technical assistance? (select all that apply)

a. Advocacy
b. Board member engagement
c. Board meetings and committees
d. Board member recruitment and retention
e. Board Chair-CEO Partnership
f. CEO Oversight
g. Committee chair or board officer preparation
h. Diversity, equity, and inclusion and governance
i. Financial oversight “201”
j. Risk Management and Various forms of Compliance (e.g., Corporate Compliance)
k. Quality oversight “201”
l. Strategic thinking and planning

Live Content Slide

When playing as a slideshow, this slide will display live content

Poll: What topics are of greatest interest for additional governance training and technical assistance? (select all that apply)

Poll: What issues impacting health centers and healthcare would you like to learn more about from a governance perspective? (select all that apply)

a. Alternative payment models
b. Corporate consolidation (e.g., merger)
c. Expansion (geographic, service line)
d. Health equity and social determinants of health
e. Pandemic impacts
f. Telehealth
g. Value-based care
h. Workforce

Live Content Slide

When playing as a slideshow, this slide will display live content

Poll: What issues impacting health centers and healthcare would you like to learn more about from a governance perspective? (select all that apply)

Other Training and Technical Assistances needs or ideas?

Please reach out to Emily Heard, Director of Health Center Governance, eheard@nachc.com.

Resources for Health Center Boards

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