C. L. Brumback
Primary Care Clinics
Health Care District Palm Beach County

BOARD OF DIRECTORS
February 26, 2020
12:45 P.M.

Meeting Location
1515 N. Flagler Drive, Suite 101
West Palm Beach, FL 33401

If a person decides to appeal any decision made by the board, with respect to any matter at such meeting or hearing, he will need a record of the proceedings, and that, for such purpose, he may need to ensure that a verbatim record of the proceedings made, which record includes the testimony and evidence upon which the appeal is to be based.

C. L. Brumback
Primary Care Clinics
Health Care District Palm Beach County

BOARD OF DIRECTORS MEETING
AGENDA
February 26, 2020
1515 N Flagler Drive, Suite 101
West Palm Beach, FL 33401

1. Call to Order – James Elder, Chair

A. Roll Call

B. Affirmation of Mission: To provide compassionate, comprehensive health services to all Palm Beach County residents, through collaboration and partnership, in a culturally sensitive environment.

2. Agenda Approval

A. Additions/Deletions/Substitutions

B. Motion to Approve Agenda

3. Awards, Introductions and Presentations

A. Telemedicine in the C.L. Brumback Primary Care Clinics
(Dr. Courtney Rowling) [Pages 1-8]

B. Patient Access to Care- Transportation
(David Speciale) [Pages 9-21]

4. Disclosure of Voting Conflict

5. Public Comment

6. Meeting Minutes

A. **Staff recommends a MOTION TO APPROVE:**
Board Meeting Minutes of January 29, 2020. [Pages 22- 33]

7. Consent Agenda – Motion to Approve Consent Agenda Items

All matters listed under this item are considered routine and action will be taken by one motion. There will be no separate discussion of these items unless a Commissioner or person so requests, in which the item will be removed from the general order of business and considered on its normal sequence on the Agenda.

A. ADMINISTRATION

7A-1 **RECEIVE AND FILE:**
February 2020 Internet Posting of District Public Meeting.
https://www.hcdpbc.org/resources/public-meetings

7. Consent Agenda – Motion to Approve Consent Agenda Items (cont.)

7A-2 **RECEIVE AND FILE:**
Attendance tracking. [Page 34]

7A-3 **RECEIVE AND FILE:**
Credentialing and Privileging Procedure. [Page 35-41]

B. FINANCE

7B-1 **RECEIVE AND FILE:**
C. L. Brumback Primary Care Clinics Financial Report December 2019.
(Joel Snook) [Pages 42-59]

8. Regular Agenda

A. ADMINISTRATION

8A-1 **Staff Recommends a MOTION TO APPROVE:**
Sliding Fee Discount Program Policy & Federal Poverty Guidelines; Update to Sliding Fee Scales.
(Joel Snook) [Pages 60-72]

8A-2 **Staff Recommends a MOTION TO APPROVE:**
Second Amendment to Co-Applicant Agreement between HCDPBC and DCHI.
(Dr. Hyla Fritsch) [Pages 73-74]

8A-3 **Staff Recommends a MOTION TO APPROVE:**
Change in Scope - Form 5A Moving services from Column II to Column III.
(Dr. Belma Andric) [Pages 75-76]

B. EXECUTIVE

8B-1 **RECEIVE AND FILE:**
Executive Director Informational Update.
(Dr. Belma Andric) [Pages 77-78]

C. OPERATIONS

8C-1 **Staff Recommends a MOTION TO APPROVE:**
Operations Reports.
(Dr. Hyla Fritsch) [Pages 79-100]

8. Regular Agenda (cont.)

D. CREDENTIALING AND PRIVILEGING

8D-1 **Staff Recommends a MOTION TO APPROVE:**
Licensed Independent Practitioner Credentialing and Privileging.
(Sarah Gonzalez) [Pages 101-102]

8D-2 **Staff Recommends a MOTION TO APPROVE:**
Credentialing and Privileging Policy Update.
(Sarah Gonzalez) [Pages 103-106]

E. QUALITY

8E-1 **Staff Recommends a MOTION TO APPROVE:**
Quality Reports & Updated QI Plan.
(Dr. Ana Ferwerda) [Pages 107-169]

9. VP and Executive Director of Clinic Services Comments

10. Board Member Comments

11. Closed Risk Meeting [Under Separate Cover]

12. Establishment of Upcoming Meetings

March 25, 2020 (HCD Board Room)
12:45pm Board of Directors

April 29, 2020 (HCD Board Room)
12:45pm Board of Directors

May 27, 2020 (HCD Board Room)
12:45pm Board of Directors

June 24, 2020 (HCD Board Room)
12:45pm Board of Directors

July 29, 2020 (HCD Board Room)
12:45pm Board of Directors

August 26, 2020 (HCD Board Room)

12:45pm Board of Directors

September 30, 2020 (HCD Board Room)
12:45pm Board of Directors

October 28, 2020 (HCD Board Room)
12:45pm Board of Directors

November 25, 2020 (HCD Board Room)
12:45pm Board of Directors

December 16, 2020 (HCD Board Room)
12:45pm Board of Directors

13. Motion to Adjourn

Health Care District
of Palm Beach County

Dedicated to the health of our community

Telemedicine in C. L. Brumback Primary Care Clinics

February 2020

Courtney Rowling, MD
Director of Behavioral Health

Current Use of Telemedicine in Clinics

- Purpose
  - To maximize access to psychiatric services (2 psychiatrists and 10 clinic locations)
  - Decreasing barriers to psychiatric services
    - Alleviating transportation challenges
    - Providing more readily available appointment slots for psychiatric services
- Utilization
  - Implemented April 2019
  - Contracted with HIPPAA protected, cloud based software platform that does not interact with EHR (Certintell)
  - Hardware includes Ipad for patient (originating site) and HCD issued laptop with application downloaded for physician (Distant site)

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Process of Tele psychiatric Service Delivery

- Appointment scheduled in EHR and in Certintell after asking patient's permission
  - 3 open emergency Tele psych slots daily
  - Any scheduled psychiatric visit can be converted to telemedicine (excluding suboxone visits)
  - Biopsychosocial Assessment already done prior to visit
- Patient checked in at originating site and separate consent obtained
- Medical Assistant works up and rooms patient
- The Medical Assistant logs into certintell on IPad for the patient
- Physician at Distant site logs in and starts appointment.
- When connection is made, medical assistant leaves room and encounter is performed
- When encountered finished, patient opens door and notifies Medical Assistant who checks patient out

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Telemedicine Script for Referring Providers

You are being referred to telemedicine for behavioral health services. Over this HIPAA compliant web interface, you will be able to see and be assessed by a CLBPCC provider in a secure private session on the iPad in an exam room. No individuals other than you and the provider will participate. This is optional you can opt to see the provider in person if you are uncomfortable with this.

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TELEMEDICINE SESSION IN PROGRESS

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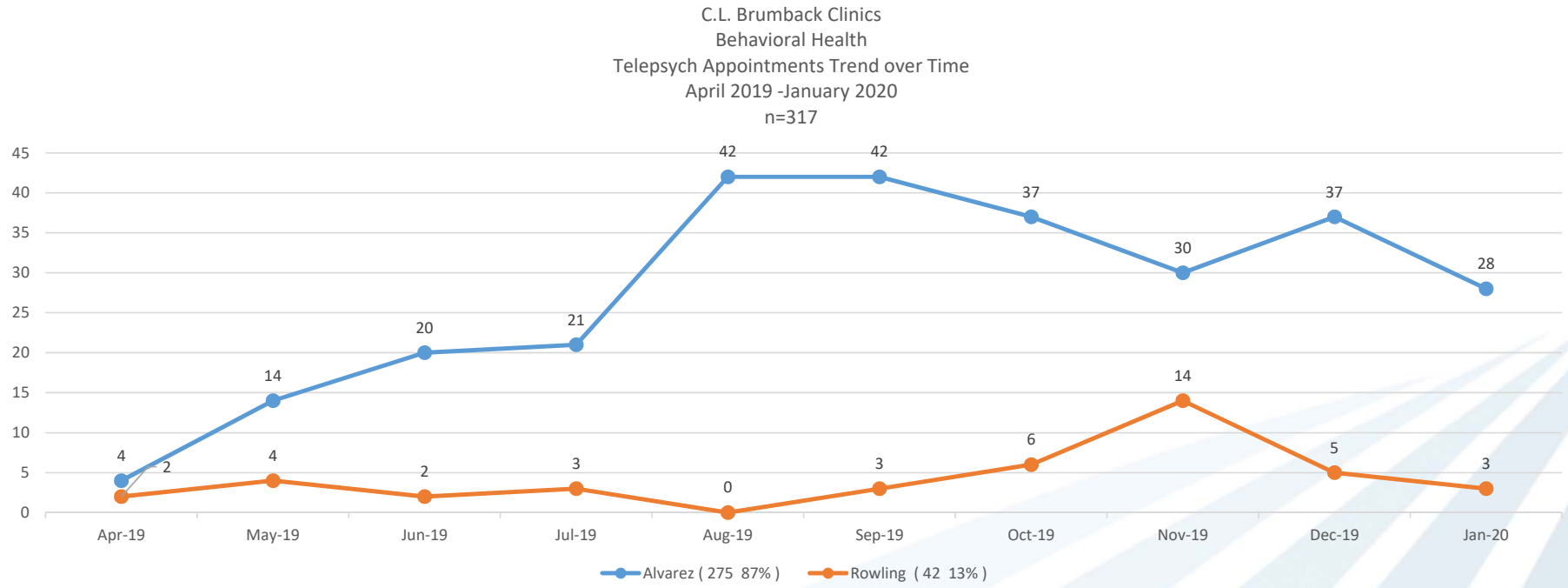
Telepsych Trended Over Time

Number of Telepsych appointments each month (excludes no shows and cancellations)											Total
	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	
Alvarez (275 87%)	4	14	20	21	42	42	37	30	37	28	**275**
Rowling (42 13%)	2	4	2	3	0	3	6	14	5	3	**42**



Summary

- Since April through mid November, 228 unique patients have utilized tele psych services at C.L. Brumback PCC
- Tele-Behavioral Health (In progress)
- Evidence: https://www.telehealthresourcecenter.org/evidence
- The Story of “Hope”

Thank you!

Disclosures: none

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C. L. Brumback Primary Care Clinics (CLBPCC)

Patient Access To Care - Transportation

Social Determinants of Health – 5 Key Areas

Neighborhood and Built Environment
- Access to Foods that Support Healthy Eating Patterns
- Crime and Violence
- Environmental Conditions
- Quality of Housing

Health and Health Care
- Access to Health Care*
- Access to Primary Care*
- Health Literacy

Social and Community Context
- Civic Participation
- Discrimination
- Incarceration
- Social Cohesion

Education
- Early Childhood Education and Development
- Enrollment in Higher Education
- High School Graduation
- Language and Literacy

Economic Stability
- Employment
- Food Insecurity
- Housing Instability
- Poverty

https://www.healthypeople.gov/2020/topics-objectives/topic/social-determinants-of-health

Access to Health Care / Primary Care

- Patients with a Primary Care Provider are more likely to receive recommended preventive services such as flu shots, blood pressure screenings, and cancer screenings.

- However, disparities in access to primary health care exist, and many people face barriers that decrease access to services and increase the risk of poor health outcomes.

- Some of these obstacles include lack of health insurance, language-related barriers, disabilities, inability to take time off work to attend appointments, ***geographic and transportation-related barriers***, and a shortage of primary care providers.

- These barriers may intersect to further reduce access to primary care.

https://www.healthypeople.gov/2020/topics-objectives/topic/social-determinants-health/interventions-resources/access-to-primary

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Access to Care - Transportation

- Since June 2013, the C. L. Brumback Primary Care Clinics have improved patients access to care by providing County bus passes.
- Team members are educated on transportation services provided by credentialed third party payers.
- In May 2018, the clinics partnered with CertintelI – a telehealth software platform and service provider.
- In November 2019, the clinics contracted with Circulation – a Non-Emergency Medical Transportation (NEMT) service provider.

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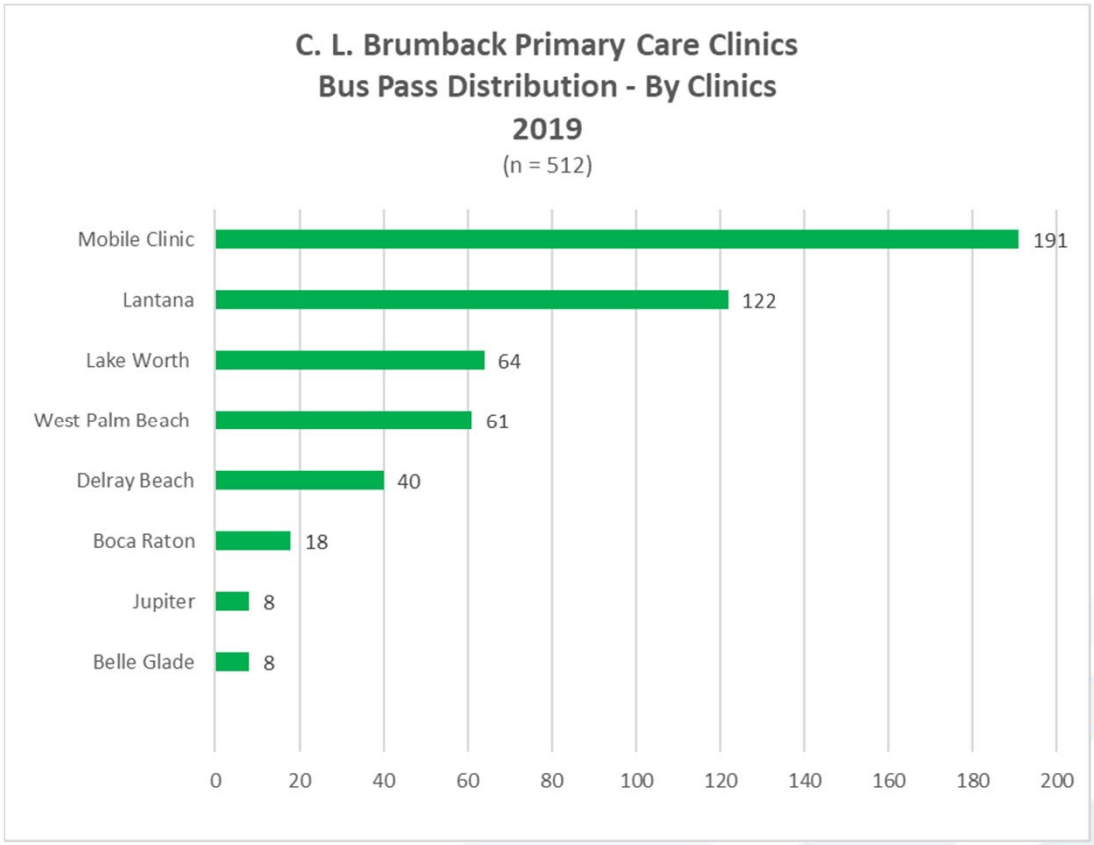
2019 Bus Pass Distribution & Utilization

In 2019, clinics provided a total of 512 bus passes to clinic patients for purposes of attending a healthcare appointment.



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Circulation - Non Emergency Medical Transportation Services (NEMT)

- Circulation - Founded in 2016, Boston-based company is the nation's largest manager of non-emergency medical transportation (NEMT) programs for state government agencies and managed care organizations.
- A HIPAA-Complaint company.
- Partnered with Lyft to improve access to quality care by providing patients with reliable and convenient transportation for non-emergency medical needs.
- Circulation's transportation exchange improves care by providing patients access to convenient, cost-effective, safe, reliable rides.
- Maintains a 99 percent complaint-free service rate while annually managing over 61 million trips and more than 24 million eligible riders in 49 states and the District of Columbia.

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Implementation of Non-Emergency Medical Transportation (NEMT)

- This transportation service is provided as a last resort for established patients to maintain compliance with medically necessary treatment as recommended by the clinic provider.
- Patients must sign a transportation consent before rides are approved and booked by a healthcare administrator using Circulation's platform.
- Rides can be booked on-demand or scheduled days, in advance of a patient's appointment.
- Circulation's transportation exchange matches the patient with a vehicle based on their needs (i.e. specialized vehicles).
- Patient NEMT rides can be one-way or round trip depending on the needs of the patient.
- NEMT rides may be combined with bus passes to successfully transport a patient to and from authorized locations.

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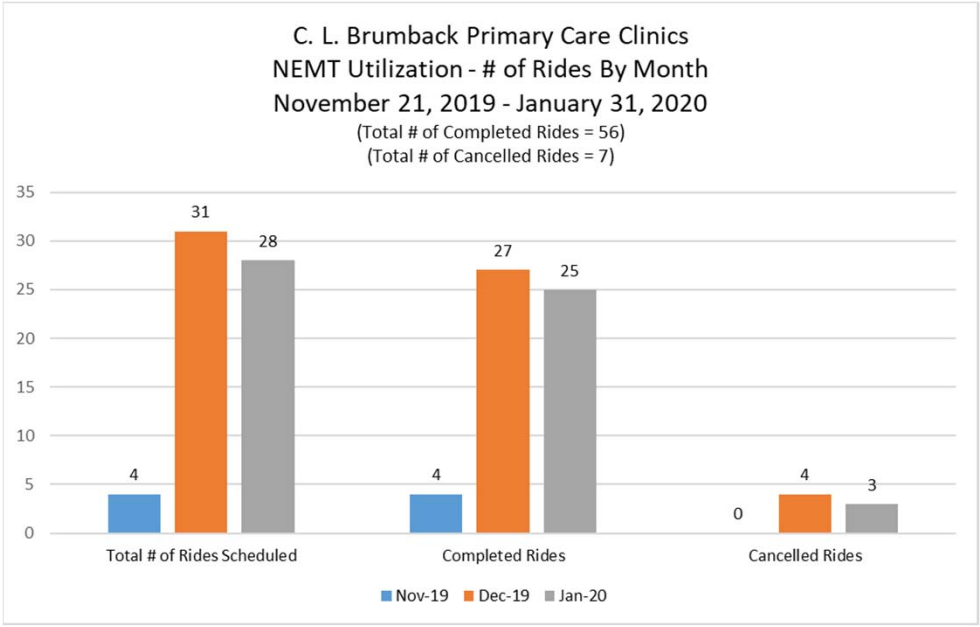
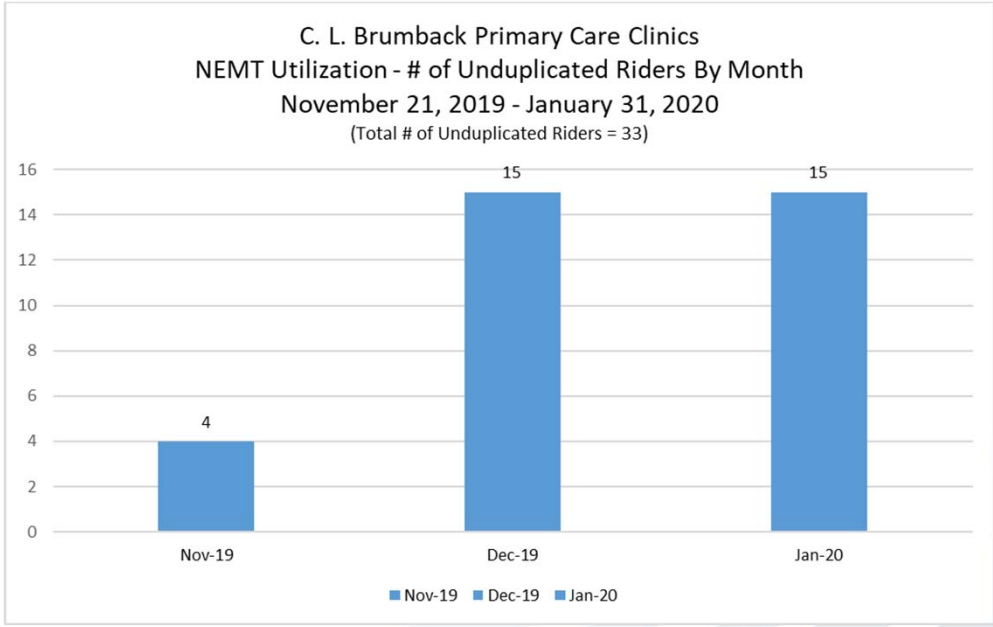
Non-Emergency Medical Transportation Services (NEMT)





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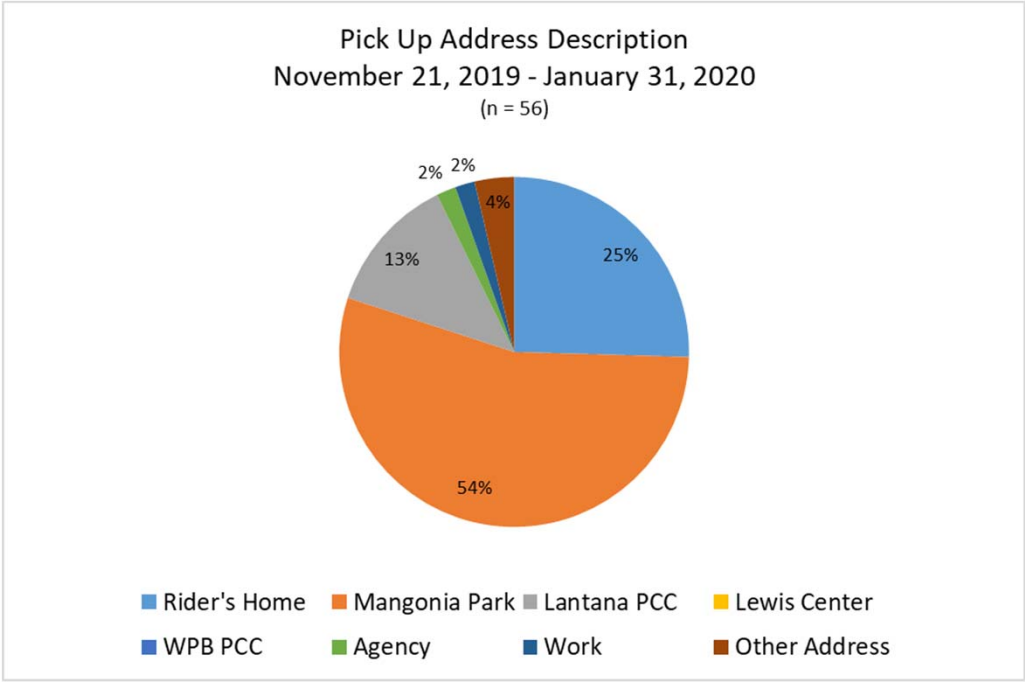
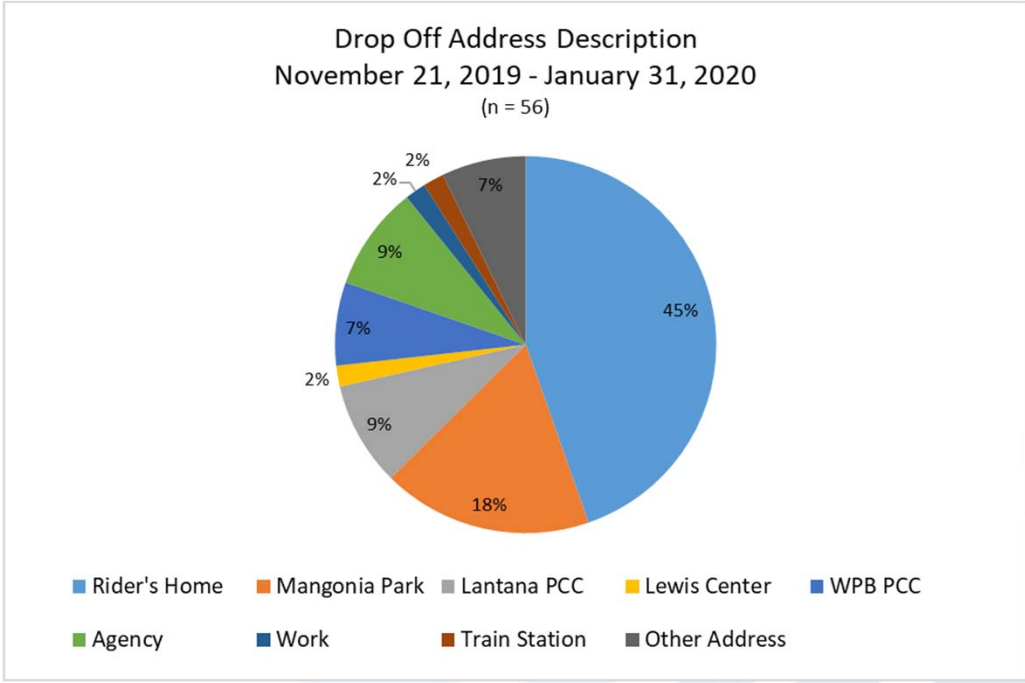
Non-Emergency Medical Transportation Services (NEMT)





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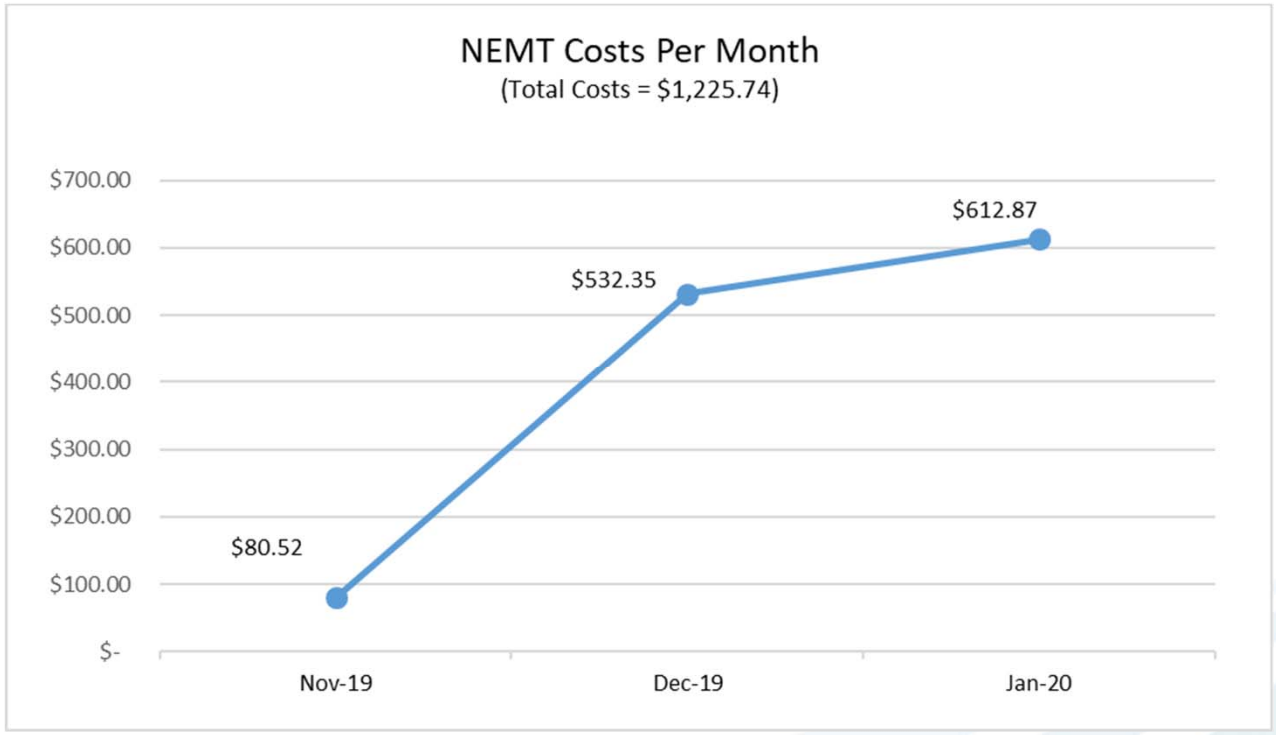
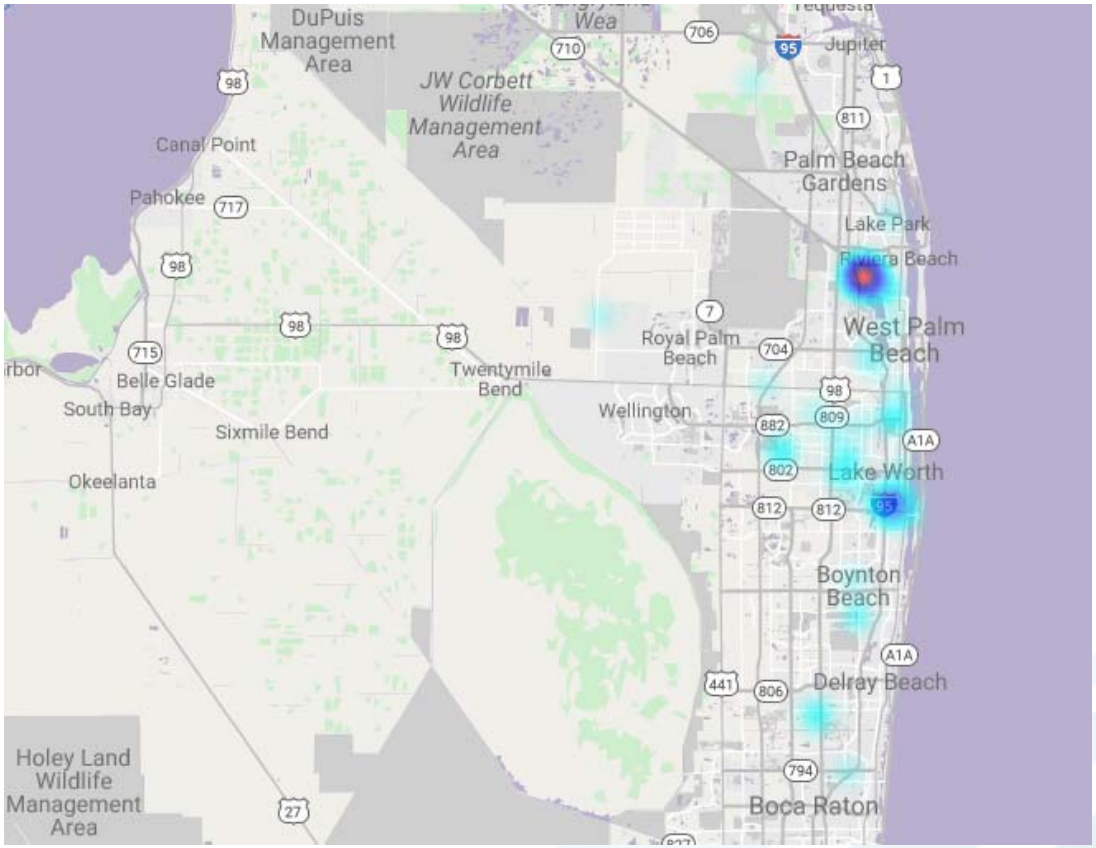


Non-Emergency Transportation Services (NEMT)



A Patient Experience

- A patient, hospitalized at the Addiction Stabilization Unit for an overdose was discharged to the Mangonia Park Clinic with severe withdrawal symptoms.
- Upon arrival to the clinic, patient was extremely agitated and wanted to leave. She was threatening to use again and was not willing to wait for her medications. Patient had no shoes but was prepared to walk home.
- The clinic team intervened and coordinated the immediate delivery of patient medications as well as booked a non-emergency medical transportation ride for the patient to return back home.
- The Pharmacy Team arrived less than 10 minutes later with the medication and within minutes patient was looking and feeling “much better”.
- Shortly thereafter, the NEMT ride arrived and transported patient back home.
- Later that afternoon the patient contacted the Clinic Coordinator to report that she was “extremely grateful for her care” and that no one judged her. She reported that her experience with the non-emergency medical transportation service was “excellent” and prevented her from using again.

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Questions?
Comments.
Thank you!

District Clinic Holdings, Inc.
d.b.a. C.L. Brumback Primary Care Clinics
Board of Directors Meeting
Summary Minutes
01/29/2020

Present: James Elder, Chairperson; Gary Butler, Vice-Chairperson, Irene Figueroa, Secretary; Mike Smith, Treasurer; John Casey Mullen; Melissa Mastrangelo; Tammy Jackson-Moore; Lisa Strickland; Julia Bullard; Marjorie Etienne
Excused:
Absent:
Staff: Dr. Belma Andric, CMO, VP & Executive Director of Clinical Services; Valerie Shahriari, General Counsel; Joel Snook, VP & Chief Financial Officer; Dr. Hyla Fritsch, Director of FQHC Practice Operations; Shauniel Brown, Risk Manager; Dr. Ana Ferwerda, Director of Women's Health & Interim Medical Director; David Speciale, Patient Experience Manager; Nancy Stockslager, CIO; Martha Hyacinthe, Director of Corporate Risk; Thomas Cleare, VP of Strategy; Sarah Gonzalez, Director of Provider Services

Minutes Transcribed By: Jonathan Dominique

Meeting Scheduled For: 12:45 PM
Meeting Began at: 12:57 PM

AGENDA ITEM	DISCUSSION	ACTION
1. Call to Order **1A. Roll Call** **1B. Affirmation of Mission**	Mr. Elder called the meeting to order. Roll call was taken. Mr. Elder Read the Affirmation of Mission	**The meeting was called to order at 12:57pm**
2. Agenda Approval **2A. Additions/Deletions/ Substitutions**	Mr. Elder called for an approval of the meeting agenda. Mr. Butler requested that there be an addition to the agenda; *Item 8A-5: Change of Venue – Staff Recommends a Motion to Approve*	**VOTE TAKEN: Ms. Jackson-Moore made a motion to approve the agenda with the addition. The motion was duly seconded by Mr. Butler. A vote was called, and the motion passed unanimously.**

2B. Motion to Approve Agenda Items	The agenda for the January 2020 meeting was approved with the addition of Item 8A-5	
3. Awards, Introductions and Presentations **3A. UDS Presentation** **3B. Risk Management Training**	 Dr. Andric Provided the Board with UDS information with which they could familiarize themselves. Shauniel Brown, Risk Manager, provided the board members with training on Risk Management and the Role the Department Plays, Patient Safety, Just Culture, Events reportable to risk management.	**No action necessary.**
4. Disclosure of Voting Conflict	None.	**No action necessary.**
5. Public Comment	None.	**No action necessary.**
6. Meeting Minutes **6A-1 Staff Recommends a MOTION TO APPROVE:** Board meeting minutes of October 30, 2019	 There were no changes or comments to the minutes dated October 30, 2019.	 **VOTE TAKEN: Ms. Jackson-Moore made a motion to approve the Board meeting minutes of October 30, 2019 as presented. The motion was duly seconded by Mr. Butler. A vote was called, and the motion passed unanimously.**
6A-2 Staff Recommends a MOTION TO APPROVE: Board meeting minutes of November 27, 2019	There were no changes or comments to the minutes dated November 27, 2019.	**VOTE TAKEN: Mr. Smith made a motion to approve the Board meeting minutes of November 27, 2019 as presented. The motion was duly seconded by Ms. Figueroa. A vote was called, and the motion passed unanimously.**
6A-3 Staff Recommends a MOTION TO APPROVE:	There were no changes or comments to the minutes dated December 11, 2019.	**VOTE TAKEN: Mr. Smith made a motion to approve the Board meeting minutes of December 11, 2019 as presented. The**

Board meeting minutes of December 11, 2019		**motion was duly seconded by Ms. Mastrangelo. A vote was called, and the motion passed unanimously.**
7. Consent Agenda – Motion to Approve Consent Agenda Items		**VOTE TAKEN: Ms. Jackson-Moore made a motion to approve the consent agenda as presented. The motion was duly seconded by Ms. Bullard. A vote was called, and the motion passed unanimously.**
7A. ADMINISTRATION		
7A-1. Receive & File: January 2019 Internet Posting of District Public Meeting	The meeting notice was posted.	**Receive & File. No further action necessary.**
7A-2. Receive & File: Attendance tracking	Attendance tracking was updated.	**Receive & File. No further action necessary.**
7A-3. Staff Recommends a MOTION TO APPROVE: Bylaws Update	The HRSA Compliance Manual requires that the Bylaws to include adoption in conflict of interest and further define a patient board member. The bylaws have been updated accordingly.	**Motion referenced above, no further action necessary.**
7B. FINANCE		
7B-1. Staff Recommends a MOTION TO APPROVE: C. L. Brumback Primary Care Clinics Update of Current Charge Master.	Per the HRSA Compliance Manual, District Clinic Holdings, Inc. must prepare a schedule of fees or payments for the provision of its services consistent with locally prevailing rates or charges and designed to cover its reasonable costs of operation. C. L. Brumback Primary Care Clinics requested and received an analysis from our Primary Care Association (FACHC) for 2018, which represents locally prevailing rates in several comparable MSA in the state of Florida. Per the attached analysis, a thorough review shows that amending the Charge Master to be at the 50th percentile would result in the smallest increase and align our organization with prevailing rates.	**Motion referenced above, no further action necessary.**

7B-2 Receive & File: C. L. Brumback Primary Care Clinics Financial Report – November 2019	The Year To Date November 2019 Financial statements for the District Clinic Holdings, Inc. are presented for Board review. Management has provided the income statements and key statistical information for DCHI. Additional management discussion and analysis is incorporated into the financial statement presentation.	**Receive & File. No further action necessary.**
8. REGULAR AGENDA		
8A. ADMINISTRATION		
8A-1. Staff Recommends a MOTION TO APPROVE: Change in Scope Form 5A	The C. L. Brumback Primary Care Clinics is respectfully requesting approval to proceed with a Change in Scope application with the Health Resources and Services Administration to add our answering service contract to Form 5A, Column II for the required service: After Hours Coverage.	**VOTE TAKEN: Mr. Smith made a motion to approve the Change in Scope in form 5A. The motion was duly seconded by Ms. Jackson-Moore. A vote was called, and the motion passed unanimously.**
8A-2. Staff Recommends a MOTION TO APPROVE: Change in Scope Form 5B	The C. L. Brumback Primary Care Clinics is respectfully requesting approval to proceed with a Change in Scope application with the Health Resources and Services Administration to update HRSA Form 5B as follows: 1. Site Id: BPS-H80-029869 (Belle Glade) a. Add zip codes 33438 and 33470 b. Update the "FQHC Site Medicare Billing Number Status" box to "this site has a Medicare billing number" c. Update the "Medicare Billing Number" box to 101189 2. Site Id: BPS-H80-018949 (Boca Raton) a. Update hours of operations to 45 3. Site Id: BPS-H80-022320 (Mobile Clinic) a. Update the months of operations to all months b. Add zip codes 33444 and 33430	**VOTE TAKEN: Mr. Smith made a motion to approve the Change in Scope in form 5B. The motion was duly seconded by Mr. Butler. A vote was called, and the motion passed unanimously.**

	c. Update the "FQHC Site Medicare Billing Number Status" box to "this site has a Medicare billing number" d. Update the "Medicare Billing Number" box to 101194 4. Site Id: BPS-H80-019120 (Jupiter) a. Update hours of operations to 45 5. Site Id: BPS-H80-029868 (Mangonia Park) a. Update hours of operations to 45 6. Site Id: BPS-H80-015089 (Lewis Center) a. Update the hours of operations to 45	
8A-3. Staff Recommends a MOTION TO APPROVE: Grant Application & Budget Updates	Although we did not receive the NAP grant, we still opened a new access point now named Mangonia Park Clinic. The original application and budget are attached for your approval. Plans are underway to order and install all new dental chairs for West Palm Beach, Lantana and Delray. The original application and budget are attached for your approval. Cherokee Health provided a 3-day on-site coaching to administrative and Behavioral Health team-members. The first progress report has been submitted to HRSA. The original application and budget are attached for your approval.	**VOTE TAKEN: Ms. Jackson-Moore made a motion to approve the Grant Application & Budget Updates. The motion was duly seconded by Ms. Etienne. A vote was called, and the motion passed unanimously.**
8A-4. Staff Recommends a MOTION TO APPROVE: Appointment of Susan Foster to the Clinic Board	Susan Foster has submitted an application for consideration for appointment to the District Clinic Holdings, Inc. Board of Directors. Ms. Foster brings prior business experience and nurse training to the Board. Ms. Foster also brings experience serving on the Board of Directors for and organization in West Palm Beach where she assists with fundraising data management. Ms. Foster also has previous experience working with Migrant and Seasonal Farm Workers and Homeless populations.	**VOTE TAKEN: Ms. Jackson-Moore made a motion to approve the appointment of Ms. Foster to the DCHI Board. The motion was duly seconded by Ms. Etienne. A vote was called, and the motion passed unanimously.**

8A-5. Staff Recommends a MOTION TO APPROVE: Change of Venue for Board Meeting.	Mr. Butler voiced concern with the new location, how it compares to the previous location (boardroom) in relations to accessibility to the public. He also felt that the room was a bit small for the number of people in attendance. He has requested that we reconsider the move to the seventh floor conference room, and revert to the boardroom location. Dr. Andric, explains that the location of the meeting is not currently set in stone, and that the change was intended to encourage more open discussion by creating a less intimidating atmosphere. Dr. Andric also points out that she has noticed in today's meetings that there has been more engagement and discussion and believes that this can possibly be attributed to said change, but we are always open to suggestions change. Mr. Smith suggested a compromise where we return to the Boardroom but maintain a set up similar to the set up in the current conference room with the board sitting around a table.	**VOTE TAKEN: Ms. Jackson-Moore made a motion to approve the Change in Venue for the DCHI Board Meeting. The motion was duly seconded by Ms. Mastrangelo. A vote was called, and the motion passed unanimously.**
8B. EXECUTIVE		
8B-1. Receive & File: Executive Director Informational Update	Dr. Belma Andric, VP& Executive Director, provided the following updates: In 2018, 1,362 Health Center Program awardees provided services to 28,379,680 patients, representing nearly 7.6% of the total U.S. population. Over a period of 5 years, the number of funded awardees has grown by 6.6%, with 24% growth in the number of total patients served and averaging an annual increase of almost 5%. The 2019 data is due 2/15/2020. HRSA Operational Site Visit is scheduled for the week of March 24-26. It is not a HRSA requirement to have a Board Member join our monthly Quality Council meeting.	**Receive & File. No further action necessary.**
8C. OPERATIONS		
8C-1. Staff Recommends a MOTION TO APPROVE: Operations Reports – December 2019	Dr. Hyla Fritsch, Director of Clinical Operations and Pharmacy Services, presented the following productivity report:	**VOTE TAKEN: Ms. Jackson-Moore made a motion to approve the December Productivity Report as presented. The motion was duly seconded by Ms. Bullard.**

<table>
<tr><td></td><td>Attached you will find the updated organizational chart for our upcoming HRSA audit. For the evening hours, the clinics completed a financial impact analysis as a result of discontinuing Delray Beach, Lantana, Lake Worth, and West Palm Beach Clinic evening hours. $6,162 - $12,877 for security services between 1.5 - 2.5 hours of regular or intermittent overtime. This analysis does not include our potential overtime impact for our clinic team. To date, there has been no impact to patients overall.</td><td>A vote was called, and the motion passed unanimously.</td></tr>
<tr><td colspan="3">8D. Credentialing and Privileging</td></tr>
<tr><td>8D-1. Staff Recommends a MOTION TO APPROVE Licensed Independent Practitioner Credentialing and Privileging – LIP(s)</td><td>The LIP(s) listed below satisfactorily completed the credentialing and privileges process and met the standards set forth within the approved Credentialing and Privileging Policy. The credentialing and privileging process ensures that all health center practitioners meet specific criteria and standards of professional qualifications. This criterion includes, but is not limited to:

• Current licensure, registration or certification
• Relevant education, training and experience
• Current clinical competence
• Health fitness, or ability to perform the requested privileges
• Malpractice history (NPDB query)
• Immunization and PPD status; and
• Life support training (BLS)

<table><tr><th>Last Name</th><th>First Name</th><th>Degree</th><th>Specialty</th><th>Credentialing</th></tr><tr><td>Bentsi-Enchill</td><td>Flora</td><td>DMD</td><td>General Dentistry</td><td>Recredentialing</td></tr></table>
Primary source and secondary source verifications were performed for credentialing and privileging elements in accordance with state, federal and HRSA requirements. A</td><td>VOTE TAKEN: Ms. Jackson-Moore made a motion to approve the re-credentialing and renewal privileges of the LIP(s) as presented. The motion was duly seconded by Ms. Bullard. A vote was called, and the motion passed unanimously.</td></tr>
</table>

	Nationally accredited Credentials Verification Organization (CVO) was utilized to verify the elements requiring primary source verification. The C.L. Brumback Primary Care Clinics utilized internal Credentialing staff and the FQHC Medical Director and Dental Director to support the credentialing and privileging process. Flora Bentsi-Enchill, DMD joined the West Palm Beach Clinic in 2018 specializing in General Dentistry. She attended the University of Louisville School of Dentistry. Dr. Bentsi-Enchill has been in practice for nearly nine years and is fluent in Twi.	
8E. Quality		
8E-1. Staff Recommends a MOTION TO APPROVE Patient Relations Report & Pediatric Survey Results	This agenda item provides the Quarterly Patient Relations Dashboard for Quarter 4, 2019 and Pediatric Survey Results. Mr. Smith asked about how referrals work in relations to Complaints. Mr. Speciale explained that the clinics have gone to a system where referral individual referral clerks are assigned to specific clinics that can help and there is cross-coverage if needed. This is to hold them accountable for having these situations handled in a timely matter. If a patient comes in and asks about their referrals, they can then be brought to the person designated to help. Dr. Andric also adds that we outsource our claims processing system to CCP which is tied out our referrals processing. This is why we have had an increase in the complaints about referrals processing. As of right now, there is a bit of a delay with our third party vendor (CCP), which we are currently in process of troubleshooting. Mr. Speciale informed the board that they have also provided their teams with more education about the have also been provided with more extensive training on the plans and what they require. Mr. Mullen states that the network of	**VOTE TAKEN: Ms. Jackson-Moore made a motion to approve the Patient Relations Report as presented. The motion was duly seconded by Ms. Bullard. A vote was called, and the motion passed unanimously.**

	physicians that the clinics has is amazing, and he received his referral immediately. The only issue was the wait time on the other end. Ms. Mastrangelo asked about a patient portal. Mr. Speciale explained that we do not currently have a patient portal open in Athena due to compliance issues. However, we should have one open soon when we switch over systems in the near future. Mr. Butler asked about internal metrics documenting patient cycle times of referrals. Mr. Speciale answered that he does not have those with him but his team does track these cycle times. Dr. Ferwerda points out that when a patient is in need of a quick turnaround with referrals there are two options. Either A: the Providers reach out to the assigned referral clerks and ask them to get the referral process turned around quickly or B: the providers would flag the referrals as STAT (less than 24 Hours). This would allow for a differentiation between regular referrals vs High priority referrals. Mr. Speciale Presented the Pediatric Hours of Operation Survey. This survey addressed the Consolidation of Pediatric operations from four clinics to two clinics, and if our patients' needs are being met.	
8E-2. Staff Recommends a MOTION TO APPROVE Quality Council Reports	Dr. Ana Ferwerda, Interim Medical Director and Director of Women's Health Presented the following: <u>PATIENT SAFETY & ADVERSE EVENTS</u> Patient safety and risk, including adverse events, peer review and chart review are brought to the board "under separate cover" on a quarterly basis. <u>PATIENT SATISFACTION AND GRIEVANCES</u> No update. <u>QUALITY ASSURANCE & IMPROVEMENT</u>	**VOTE TAKEN: Mr. Butler made a motion to approve the Quality Report as presented. The motion was duly seconded by Mr. Mullen. A vote was called, and the motion passed unanimously.**

	Of the 14 UDS Measures: 7 exceeded the HRSA Goal and 7 were short of the HRSA Goal. Several of the measures will change or be retired. "Appropriate use of medications for asthma" measure will be retired. The time allowed for linkage to care for patients with HIV will be decreased for 90 to 30 days. Changes have been made in EHR documentation and tracking in anticipation of the changes. In 2020 data for diabetes as well as screening and follow up for depression will be stratified in two categories to evaluate management of vulnerable populations. Diabetes management in migrant populations will be presented separately as will depression screening and follow up in the homeless population. Rates and screening and follow up for depression were lower for the homeless population. Data will be analyzed in order to identify what additional interventions are needed. Diabetes was better controlled in the migrant population when compared to the data for the overall universe. Attached you will find the Diabetes Performance Analysis for our upcoming HRSA audit and our goals for the diabetes measure in 2020. <u>UTILIZATION OF HEALTH CENTER SERVICES</u> No update.	
8F. Risk		
8F-1. Staff Recommends a MOTION TO APPROVE Risk Management Plan 2020	Risk management is used to safeguard the health and safety of individuals and to protect the environment by monitoring or mitigating risk. The risk management plan of CLBPCC identify, track and implement improvement	**VOTE TAKEN: Ms. Jackson-Moore made a motion to approve the Quality Report as presented. The motion was duly seconded**

	methods for the potential or identified risks by utilizing risk stratification measures that will address the eight domains of enterprise risk management. Controls will be set & periodically evaluated and limits will be analyzed to promote risk mitigation sustainability.	**by Mr. Elder. A vote was called, and the motion passed unanimously.**
9. CMO, VP and Executive Director of Clinical Services Comments	None.	**No action necessary.**
10. Board Member Comments	Ms. Strickland spoke about the disabled parking situation in Lantana. Dr. Andric informed Ms. Strickland that the building is owned by the Department of Health and she will follow up with them about these spots. Ms. Strickland also pointed out that there seems to be a lack of privacy during the Check-in process for the Lantana clinic. Dr. Andric explained that because it is a health department building, we are limited in the structural changes we can make. We are currently considering other changes we can make but cannot have less than five registration windows in that location. Ms. Strickland also pointed out that she would like to be notified when prescriptions are not filled instead of finding half empty prescription bottles when arriving at home. Dr. Fritsch explained that there is a process in place for prescriptions that are not filled and she will follow up on that.	**No action necessary.**
11. Establishment of Upcoming Meetings	<u>February 26, 2020 (HCD Board Room)</u> 12:45pm Board of Directors <u>March 25, 2020 (HCD Board Room)</u> 12:45pm Board of Directors <u>April 29, 2020 (HCD Board Room)</u> 12:45pm Board of Directors	**No action necessary.**

	May 27, 2020 (HCD Board Room) 12:45pm Board of Directors June 24, 2020 (HCD Board Room) 12:45pm Board of Directors July 29, 2020 (HCD Board Room) 12:45pm Board of Directors August 26, 2020 (HCD Board Room) 12:45pm Board of Directors September 30, 2020 (HCD Board Room) 12:45pm Board of Directors October 28, 2020 (HCD Board Room) 12:45pm Board of Directors November 25, 2020 (HCD Board Room) 12:45pm Board of Directors December 16, 2020 (HCD Board Room) 12:45pm Board of Directors	
13. Motion to Adjourn	There being no further business, the meeting was adjourned at 2:42 pm	**Ms. Jackson-Moore made a motion to adjourn and seconded by Mr. Smith. The meeting was adjourned.**

Minutes Submitted by: _____

Signature Date

C. L. Brumback Primary Care Clinics
Board of Directors

Attendance Tracking

	1/29/20	2/26/20	3/25/20	4/29/20	5/27/20	6/24/20	7/29/20	8/26/20	9/30/20	10/28/20	11/25/20	12/16/2020
James Elder	X											
Gary Butler	X											
Mike Smith	X											
Irene Figueroa	X											
John Casey Mullen	X											
Julia Bullard	X											
Marjorie Etienne	X											
Lisa Strickland	X											
Melissa Mastrangelo	X											
Tammy Jackson-Moore	X											

X= Present

C= Cancel

E= Excused

A= Absent

DISTRICT CLINIC HOLDINGS, INC.
BOARD OF DIRECTORS
February 26, 2020

1. Description: Credentialing and Privileging Procedure

2. Summary:

The agenda item represents the revised C.L. Brumback Primary Care Clinics Credentialing and Privileging Procedure.

3. Substantive Analysis:

The Credentialing and Privileging Procedure has been revised to be consistent with the revisions to the Credentialing and Privileging Policy.

This serves to orient the Board of the formalized procedure for Credentialing and Privileging.

4. Fiscal Analysis & Economic Impact Statement:

	Amount	Budget
Capital Requirements		Yes ☐ No ☒
Annual Net Revenue		Yes ☐ No ☒
Annual Expenditures		Yes ☐ No ☒

Reviewed for financial accuracy and compliance with purchasing procedure:

N/A

Joel H. Snook, CPA
Chief Financial Officer

5. Reviewed/Approved by Committee:

N/A

Committee Name

Date Approved

6. Recommendation:

Staff recommends the Board receive and file the Credentialing and Privileging Procedure as revised.

DISTRICT CLINIC HOLDINGS, INC.
BOARD OF DIRECTORS
February 26, 2020

Approved for Legal sufficiency:

Valerie Shahriari
VP & General Counsel

Sarah Gonzalez
Sarah Gonzalez, CPMSM, CPC
Director, Credentialing & Provider Services

Dr. Belma Andric
Chief Medical Officer, VP & Executive Director
of Clinic Services

C. L. Brumback
Primary Care Clinics
Health Care District Palm Beach County

Credentialing and Privileging Procedure			
Procedure #:	600-17-A	Effective Date:	4/23/2013
Business Unit:	Primary Care Clinics	Last Review Date:	1/15/2020
Approval Group:	PCC Credentialing Procedure	Document Owner(s):	Credentialing

APPLICABILITY

This procedure applies to all C.L. Brumback Primary Care Clinics practitioners, employed or contracted, volunteers and locum tenens, at all health center sites.

DEFINITIONS

1. Credentialing – the process of assessing and confirming the qualifications (e.g. licensure, certification, and/or registration) of a licensed or certified health care practitioner.

2. Privileging – the process of authorizing the specific scope and content of patient care services of a licensed or certified health care practitioner. This is performed in conjunction with an evaluation of the health care practitioner's clinical qualifications and/or performance.

3. Licensed Independent Practitioner (LIP) – an individual permitted by law to provide care and services without direction or supervision, within the scope of the individual practitioner's license and consistent with individually granted privileges.

4. Other Licensed or Certified Health Care Practitioner (OLCP) – an individual who is licensed, registered, or certified, but is not permitted by law to provide patient care services without direction or supervision.

5. Other Clinical Staff (OCS) - an individual for which licensure or certification is not required and who is not permitted by law to provide patient care services without direction or supervision.

6. Primary source verification (PSV) – verification by the original source of a specific credential to determine the accuracy of a qualification reported by an individual health care practitioner. Examples of primary source verification include, but are not limited to, direct correspondence, internet verification, and reports from Credentials Verification Organizations (CVO).

7. Secondary source verification (SSV) – verification by methods not considered acceptable for primary source verification. These methods may be used when primary source verification is not required. Examples of secondary source verification methods include, but are not limited to, the original credential, notarized copy of the credential, a copy of the credential (when the copy is made from an original by approved C.L. Brumback staff).

8. National Practitioner Data Bank (NPDB) – is an electronic information repository created by Congress. It contains information on medical malpractice claims and certain adverse actions related to health care practitioners, entities, providers and suppliers.

PROCEDURE

Initial Credentialing and Privileging of LIP's

Initial Credentialing and Privileging of LIP's involves the assessment of current competence in the specific scope or content of patient care services and the primary source verification of the following:

- Current licensure
- Relevant education, training and experience
- Current competence by a minimum of two (2) peer references
- Health fitness, or ability to perform the requested privileges
- NPDB query, as applicable
- Medicare exclusion query, as applicable

Initial Credentialing and Privileging of LIP's requires secondary source verification of the following:

- Government issued picture identification
- Drug Enforcement Administration (DEA), as applicable
- Hospital admitting privileges, as applicable
- Immunization and PPD status; and
- Life support training (BLS)

LIP's must complete a credentialing application and Delineation of Privileges form specific to the scope of services being provided and specific site the services will be performed. If not complete, the LIP's request for credentialing and privileging will be rejected. The LIP will have ten (10) days to cure, if not cured within the ten (10) days; a new application will be required. The LIP's completed credentialing application will be processed by Credentialing staff and the Delineation of Privileges will be reviewed by the appropriate service line Clinical Director. A Credentials Verification Organization (CVO) may be utilized to perform primary source verification of licensure, education, training and experience and board certification. Verification of health fitness will be obtained by self-attestation and certified by the appropriate service line Clinical Director.

The initial granting of LIP privileges' ultimate approval authority is vested in the Board based on the recommendation by the appropriate service line Clinical Director.

Supported by primary source and secondary source verifications, temporary privileges may be granted for a limited period, not to exceed sixty (60) days, by recommendation of the appropriate service line Clinical Director and approval by the CEO to fulfill an important patient care need. These temporary privileges may be granted when a LIP with a complete, clean application (no adverse history of licensure, malpractice, medical staff membership actions) is awaiting review and approval by the Board and will not be routinely used for other administrative purposes.

Recredentialing and Renewal of Privileges of LIP's

The recredentialing and renewal of privileges of LIP's will occur every two (2) years and involves the assessment of current competence in the specific scope of content of patient care services and the primary source verification of the following:

- Expiring or expired credentials
- Current competence based on overall peer review results for the two (2) year period and performance improvement data
- NPDB query, as applicable
- Medicare exclusion query, as applicable
- Immunization and PPD status; and
- Life support training (BLS)

At the time of renewal, LIP's must complete a recredentialing application and Delineation of Privileges form specific to the scope of services performed. The LIP's completed recredentialing application will be processed by Credentialing staff and the Delineation of Privileges will be reviewed by the appropriate service line Clinical Director. A Credentials Verification Organization (CVO) may be utilized to perform primary source verification of licensure and board certification. Verification of health fitness will be obtained by self-attestation and certified by the appropriate service line Clinical Director.

Similar to the initial granting of privileges, approval of subsequent privileges is vested in the Board based on the recommendation by the appropriate service line Clinical Director.

Modification and/or Removal of Privileges

Based on the outcomes of demonstrated clinical competence obtained from competency assessments and/or peer review results, delineated privileges may be recommended for modification and/or removal by the appropriate service line Clinical Director

Approval for the modification and/or removal of privileges is vested in the Board based upon the recommendation of the appropriate service line Clinical Director.

Notification of Credentialing and Privileging Decision of LIP's

The appropriate service line Clinical Director shall provide written notification of the credentialing and privileging decision to the LIP within ten (10) business days from the Board's decision. If credentialing and privileging is granted, the written notification shall include the next credentialing and renewal of privileges date, which shall be two (2) years from the date of the Board's decision.

If an adverse privileging decision is rendered, the LIP may appeal the determination to the Board in writing within ten (10) business days from receipt of the notification. The Board shall review the written appeal and any documentation provided for reconsideration of the LIP's credentialing and privileging request. Written notification of the appeal decision and final determination will be made by the appropriate service line Clinical Director within ten (10) days of the Board's decision.

Failure of the LIP to submit a written request for appeal within the ten (10) business days' period shall be deemed as a waiver of the practitioner's right to appeal.

Initial Credentialing and Privileging of OLCP's and OCS

Initial Credentialing and Privileging of OLCP's and OCS involves the assessment of current competence in the specific scope or content of patient care services and the primary source verification of the following:

- Current license, registration or certification, as applicable
- Current competence by a thorough review of clinical qualifications and supervisory evaluation per the job description by their appropriate supervisor
- Health fitness
- NPDB query, as applicable
- Medicare exclusion query, as applicable

Initial Credentialing and Privileging of OLCP's and OCS requires secondary source verification of the following:

- Relevant education, training and experience
- Government issued picture identification
- Immunization and PPD status; and

- Life support training (BLS)

OLCP's and OCS must complete a credentialing application processed by Credentialing staff and reviewed by the appropriate service line Clinical Director. A Credentials Verification Organization (CVO) may be utilized to perform primary source verification of licensure and education. For OLCP's and OCS, verification of competence is completed during the orientation process via supervisory evaluation based on the job description. Verification of health fitness will be obtained by self-attestation and certified by the appropriate service line Clinical Director.

The credentialing and privileging of other licensed or certified health care practitioners will be completed prior to an individual being allowed to provide patient care services.

Recredentialing and Renewal of Privileges of OLCP's and OCS

The recredentialing and renewal of OLCP and OCS privileges will occur every two (2) years and involves the assessment of current competence in the specific scope of content of patient care services and the primary source verification of the following:

- Expiring or expired credentials
- Current competence based on performance evaluations that assures the practitioner is competent to perform the duties in the job description by the appropriate supervisor
- Health fitness
- NPDB query, as applicable
- Medicare exclusion query, as applicable
- Immunization and PPD status; and
- Life support training (BLS)

At the time of renewal OLCP's and OCS will complete a recredentialing application processed by Credentialing staff and reviewed by the appropriate service line Clinical Director. Verification of current competence shall be based on clinical competencies and supervisory performance evaluation. Verification of health fitness will be obtained by self-attestation and certified by the appropriate service line Clinical Director.

Notification of Credentialing Decision of OLCP's and OCS

The appropriate service line Clinical Director shall provide written notification of the credentialing completion to the OLCP and OCS within ten (10) business days from credentialing review.

RELATED DOCUMENTS	
Related Policy Document(s)	Credentialing and Privileging Policy
Related Forms	Health Fitness For Duty, Tuberculosis Screening, Peer Reference, Conflict Interest and Managed Care Affiliation
Reference(s)	HRSA FTCA Program Assistance Letter (PAL)
Last Revision	1/15/2020
Revision Information/Changes	
Next Review Date	1/15/2023

This procedure is only intended to serve as a general guideline to assist staff in the delivery of patient care; it does not create standard(s) of care or standard(s) of practice. The final decision(s) as to patient management shall be based on the professional judgement of the health care providers(s) involved with the patient, taking into account the circumstances at that time. Any references are to sources, some parts of which were reviewed in connection with formulation of the procedure. The references are not adopted in whole or in part by the hospital(s) or clinic(s) / provider(s).

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DISTRICT CLINIC HOLDINGS, INC
BOARD OF DIRECTORS
February 26, 2020

1. Description: District Clinic Holdings, Inc. Financial Report December 2019

2. Summary:

The Year To Date December 2019 financial statements for the District Clinic Holdings, Inc. are presented for Board review.

3. Substantive Analysis:

Management has provided the income statements and key statistical information for District Clinic Holdings, Inc. Additional Management discussion and analysis are incorporated into the financial statement presentation.

4. Fiscal Analysis & Economic Impact Statement:

	Amount	Budget
Capital Requirements	**N/A**	Yes ☐ No ☐
Annual Net Revenue	**N/A**	Yes ☐ No ☐
Annual Expenditures	**N/A**	Yes ☐ No ☐

Reviewed for financial accuracy and compliance with purchasing procedure:

Joel H. Snook
VP & Chief Financial Officer

5. Reviewed/Approved by Committee:

Finance Committee	2/26/2020
Committee Name	Date Approved

6. Recommendation:

Staff recommends the Board receive and file the YTD December 2019 District Clinic Holdings, Inc. financial statements.

Approved for Legal sufficiency:

Valerie Shahriari
VP & General Counsel

Joel H. Snook
VP & Chief Financial Officer

Dr. Belma Andric
Chief Medical Officer, VP & Executive Director of Clinic Services

C. L. Brumback
Primary Care Clinics
Health Care District Palm Beach County

MEMO

To: Finance Committee

From: Joel H. Snook
VP & Chief Financial Officer

Date: 1/17/2020

Subject: Management Discussion and Analysis of December 2019 C.L. Brumback Primary Care Clinics Financial Statements

The December statements represent the financial performance for the third month of the 2020 fiscal year for C.L. Brumback Primary Care Clinics. Total revenue is favorable to budget by $258k due to an increase in actual visits of 33,756 versus projected visits of 30,714 or 9.9%. Expenses before depreciation are over budget by ($249k) or (3.9%) mostly due to salaries, wages and benefits ($181k), purchases services of ($27k), repair and maintenance ($26k), and lease and rental ($40k).

Within the medical clinics, revenue is ahead of budget by $356k YTD. This favorable variance is mostly a result of higher than expected visits to budget of 3,401 or 14.6%. Positive variance in other revenue is a result of bonus incentive revenue of $19k. Total operating expenses of $5.6M are unfavorable to budget of $5.3M by ($321k) or (6.1%). This negative variance is attributable to higher than expected salaries, wages and benefits expenses ($215k). Purchased services has a negative variance of ($21k); primarily due to higher collection fees from Athena. Repairs and maintenance is unfavorable by ($32k) due to higher than anticipated repairs and software maintenance costs. Lease and rental is unfavorable to budget by ($39k) due to delayed relocation of the Belle Glade clinic.
The dental clinics gross revenue is in line with budget, resulting in a slightly unfavorable variance of ($7k) or (0.7%). Patient volume YTD of 7,098 was under budget by (359) or (4.8%). Total revenue of $599k is under budget of $696k by ($97k) or (14.0%). YTD revenue in unfavorable to budget due to increased charity care of ($33k), as well as reduction patient volume compared to budget. Total operating expenses of $1.1M are favorable to budget by $71k due mainly to salaries, wages, benefits, and medical supplies of $33k, and $32k respectively.

On the Comparative Statement of Net Position, due from other governments increased to $1.4M as result of LIP anticipated payment of approximately $1.3M from AHCA State Fiscal Year 2019-2020. The District subsidy year to date for the clinics is $4.8M.

DISTRICT CLINIC HOLDINGS, INC.
COMPARATIVE STATEMENT OF NET POSITION

	Dec 31, 2019	Nov 30, 2019	Increase (Decrease)
Assets			
Cash and Cash Equivalents	48,167	346,839	$ (298,673)
Accounts Receivable, net	1,728,713	1,631,447	97,266
Due From Other Funds	-	-	-
Due from Other Governments	1,365,468	1,174,028	191,440
Other Current Assets	86,282	137,243	(50,960)
Net Investment in Capital Assets	2,126,343	1,920,009	206,335
Total Assets	$ 5,354,973	$ 5,209,566	$ 145,407
Liabilities			
Accounts Payable	226,961	459,032	(232,071)
Due To Other Governments	-	-	-
Deferred Revenue	46,406	46,406	-
Other Current Liabilities	2,094,209	1,595,688	498,521
Non-Current Liabilities	800,884	800,884	-
Total Liabilities	3,168,460	2,902,010	266,450
Deferred Inflows of Resources			
Deferred Inflows- Other Post Employment Benefits	$ 543	$ 543	$ -
Net Position			
Net Investment in Capital Assets	2,126,343	1,920,009	206,335
Unrestricted	59,627	387,005	(327,378)
Total Net Position	2,185,970	2,307,014	(121,043)
Total Liabilities, Deferred Inflows of Resources and Net Position	$ 5,354,973	$ 5,209,566	$ 145,407

Note: Amounts may not foot due to rounding.

District Clinics Holdings, Inc. Statement of Revenues and Expenses

FOR THE THIRD MONTH ENDED DECEMBER 31, 2019

Current Month								Fiscal Year To Date							
Actual	Budget	Variance	%	Prior Year	Variance	%		Actual	Budget	Variance	%	Prior Year	Variance	%	
$ 1,899,323	$ 1,740,232	$ 159,091	9.1%	$ 2,006,898	$ (107,575)	(5.4%)	Outpatient Revenue	$ 5,804,051	$ 5,350,980	$ 453,071	8.5%	$ 5,445,259	$ 358,791	6.6%	
1,899,323	**1,740,232**	**159,091**	**9.1%**	**2,006,898**	**(107,575)**	**(5.4%)**	**Gross Patient Revenue**	**5,804,051**	**5,350,980**	**453,071**	**8.5%**	**5,445,259**	**358,791**	**6.6%**	
271,867	290,610	18,743	6.4%	955,352	683,485	71.5%	Contractual Allowances	1,062,062	884,247	(177,815)	(20.1%)	2,109,040	1,046,977	49.6%	
715,762	716,377	615	0.1%	411,855	(303,906)	(73.8%)	Charity Care	2,255,101	2,203,284	(51,817)	(2.4%)	1,304,575	(950,526)	(72.9%)	
306,448	295,608	(10,840)	(3.7%)	187,946	(118,501)	(63.1%)	Bad Debt	841,620	922,492	80,872	8.8%	533,590	(308,030)	(57.7%)	
1,294,076	1,302,595	8,519	0.7%	1,555,153	261,077	16.8%	Total Contractuals and Bad Debts	4,158,784	4,010,023	(148,761)	(3.7%)	3,947,205	(211,579)	(5.4%)	
341,366	380,319	(38,953)	(10.2%)	346,606	(5,240)	(1.5%)	Other Patient Revenue	1,113,006	1,140,957	(27,951)	(2.4%)	992,787	120,219	12%	
946,612	**817,956**	**128,656**	**15.7%**	**798,350**	**148,262**	**18.6%**	**Net Patient Revenue**	**2,758,273**	**2,481,914**	**276,359**	**11.1%**	**2,490,841**	**267,432**	**10.7%**	
49.84%	47.00%			39.78%			Collection %	47.52%	46.38%			45.74%			
28,234	57,154	(28,920)	(50.6%)	690,034	(661,800)	(95.9%)	Grant Funds	129,890	171,462	(41,572)	(24.2%)	1,871,266	(1,741,375)	(93.1%)	
6,897	2,442	4,455	182.4%	24,768	(17,871)	(72.2%)	Other Revenue	30,834	7,326	23,508	320.9%	38,234	(7,400)	(19.4%)	
35,130	59,596	(24,466)	(41.1%)	714,802	(679,671)	(95.1%)	Total Other Revenues	160,724	178,788	(18,064)	(10.1%)	1,909,499	(1,748,775)	(91.6%)	
981,742	**877,552**	**104,190**	**11.9%**	**1,513,151**	**(531,409)**	**(35.1%)**	**Total Revenues**	**2,918,997**	**2,660,702**	**258,295**	**9.7%**	**4,400,340**	**(1,481,343)**	**(33.7%)**	
							Direct Operational Expenses:								
1,427,860	1,360,118	(67,742)	(5.0%)	1,317,029	(110,831)	(8.4%)	Salaries and Wages	4,245,988	4,080,340	(165,648)	(4.1%)	3,894,897	(351,091)	(9.0%)	
365,616	369,399	3,783	1.0%	314,881	(50,735)	(16.1%)	Benefits	1,123,941	1,108,192	(15,749)	(1.4%)	976,571	(147,370)	(15.1%)	
43,837	65,753	21,916	33.3%	50,770	6,933	13.7%	Purchased Services	224,876	197,259	(27,617)	(14.0%)	184,412	(40,464)	(21.9%)	
33,103	36,001	2,898	8.0%	14,573	(18,530)	(127.2%)	Medical Supplies	113,805	108,003	(5,802)	(5.4%)	83,706	(30,099)	(36.0%)	
1,026	19,686	18,660	94.8%	2,672	1,646	61.6%	Other Supplies	28,782	59,058	30,276	51.3%	40,767	11,985	29.4%	
-	-	-	0.0%	-	-	0.0%	Contracted Physician Expense	-	-	-	0.0%	-	-	0.0%	
53,733	60,707	6,974	11.5%	19,144	(34,589)	(180.7%)	Medical Services	165,407	184,589	19,182	10.4%	77,492	(87,915)	(113.5%)	
85,786	78,781	(7,005)	(8.9%)	36,129	(49,658)	(137.4%)	Drugs	257,250	241,718	(15,532)	(6.4%)	121,217	(136,033)	(112.2%)	
19,935	13,887	(6,048)	(43.6%)	32,150	12,215	38.0%	Repairs & Maintenance	68,034	41,661	(26,373)	(63.3%)	98,587	30,553	31.0%	
121,087	106,377	(14,710)	(13.8%)	104,526	(16,562)	(15.8%)	Lease & Rental	358,954	319,131	(39,823)	(12.5%)	318,291	(40,663)	(12.8%)	
4,724	6,682	1,958	29.3%	5,313	589	11.1%	Utilities	18,463	20,046	1,583	7.9%	16,439	(2,024)	(12.3%)	
33,567	28,941	(4,626)	(16.0%)	24,682	(8,886)	(36.0%)	Other Expense	90,327	86,823	(3,504)	(4.0%)	39,632	(50,695)	(127.9%)	
2,377	2,236	(141)	(6.3%)	2,170	(207)	(9.5%)	Insurance	7,131	6,708	(423)	(6.3%)	6,764	(366)	(5.4%)	
2,192,652	2,148,568	(44,084)	(2.1%)	1,924,039	(268,614)	(14.0%)	Total Operational Expenses	6,702,958	6,453,528	(249,430)	(3.9%)	5,858,775	(844,183)	(14.4%)	
(1,210,910)	**(1,271,016)**	**60,106**	**(4.7%)**	**(410,887)**	**(800,023)**	**194.7%**	**Net Performance before Depreciation & Overhead Allocations**	**(3,783,960)**	**(3,792,826)**	**8,866**	**(0.2%)**	**(1,458,434)**	**(2,325,526)**	**159.5%**	

District Clinics Holdings, Inc. Statement of Revenues and Expenses

FOR THE THIRD MONTH ENDED DECEMBER 31, 2019

Current Month								Fiscal Year To Date						
Actual	Budget	Variance	%	Prior Year	Variance	%		Actual	Budget	Variance	%	Prior Year	Variance	%
26,292	13,280	(13,012)	(98.0%)	5,158	(21,134)	(409.7%)	Depreciation	49,816	39,840	(9,976)	(25.0%)	39,671	(10,145)	(25.6%)
							Overhead Allocations:							
1,990	2,255	265	11.8%	8,246	6,257	75.9%	Risk Mgt	5,702	6,764	1,063	15.7%	33,660	27,958	83.1%
69,757	96,913	27,155	28.0%	124,187	54,430	43.8%	Rev Cycle	217,131	290,738	73,607	25.3%	309,150	92,019	29.8%
5,435	5,506	71	1.3%	5,120	(315)	(6.2%)	Internal Audit	17,699	16,519	(1,180)	(7.1%)	15,360	(2,339)	(15.2%)
20,918	21,420	503	2.3%	16,141	(4,777)	(29.6%)	Home Office Facilities	58,188	64,261	6,072	9.4%	49,442	(8,746)	(17.7%)
37,093	36,548	(546)	(1.5%)	21,164	(15,929)	(75.3%)	Administration	103,532	109,643	6,111	5.6%	72,262	(31,270)	(43.3%)
66,995	40,465	(26,529)	(65.6%)	34,863	(32,131)	(92.2%)	Human Resources	140,309	121,395	(18,913)	(15.6%)	102,615	(37,694)	(36.7%)
19,536	18,543	(993)	(5.4%)	8,094	(11,442)	(141.4%)	Legal	46,827	55,629	8,801	15.8%	26,465	(20,362)	(76.9%)
7,687	8,410	723	8.6%	6,067	(1,620)	(26.7%)	Records	20,840	25,230	4,390	17.4%	19,039	(1,802)	(9.5%)
11,403	11,534	131	1.1%	3,605	(7,798)	(216.3%)	Compliance	21,452	34,602	13,150	38.0%	16,578	(4,874)	(29.4%)
-	-	-	0.0%	1,209	1,209	100.0%	Planning/Research	-	-	-	0.0%	3,830	3,830	100.0%
28,393	31,318	2,925	9.3%	22,630	(5,763)	(25.5%)	Finance	89,756	93,953	4,198	4.5%	79,601	(10,155)	(12.8%)
11,021	11,356	335	3.0%	8,336	(2,685)	(32.2%)	Public Relations	36,055	34,069	(1,986)	(5.8%)	21,179	(14,876)	(70.2%)
94,710	109,427	14,718	13.4%	97,329	2,620	2.7%	Information Technology	237,365	328,282	90,917	27.7%	246,981	9,616	3.9%
2,876	1,447	(1,429)	(98.7%)	2,150	(726)	(33.7%)	Corporate Quality	7,109	4,342	(2,767)	(63.7%)	9,900	2,791	28.2%
6,754	4,999	(1,755)	(35.1%)	-	(6,754)	0.0%	Project MGMT Office	16,718	14,996	(1,722)	(11.5%)	-	(16,718)	0.0%
2,822	3,755	933	24.9%	3,039	217	7.1%	Managed Care Contract	9,658	11,266	1,608	14.3%	10,479	821	7.8%
387,389	403,897	16,508	4.1%	362,180	(25,209)	(7.0%)	Total Overhead Allocations	1,028,341	1,211,690	183,349	15.1%	1,016,541	(11,800)	(1.2%)
2,606,333	**2,565,745**	**(40,589)**	**(1.6%)**	**2,291,377**	**(314,956)**	**(13.7%)**	**Total Expenses**	**7,781,114**	**7,705,058**	**(76,056)**	**(1.0%)**	**6,914,987**	**(866,128)**	**(12.5%)**
$ (1,624,591)	**$ (1,688,193)**	**$ 63,602**	**(3.8%)**	**$ (778,226)**	**$ (846,365)**	**108.8%**	**Net Margin**	**$ (4,862,117)**	**$ (5,044,356)**	**$ 182,239**	**(3.6%)**	**$ (2,514,646)**	**$ (2,347,471)**	**93.4%**
(81,965)	3,988	85,953	2,155.3%	(13,581)	68,384	(503.5%)	**Capital**	-	11,964	11,964	100.0%	(13,581)	(13,581)	100.0%
$ 1,421,583	**$ 1,681,071**	**$ 259,488**	**15.4%**	**$ 930,086**	**$ (491,497)**	**(52.8%)**	**General Fund Support/ Transfer In**	**$ 4,812,301**	**$ 5,022,991**	**$ 210,690**	**4.2%**	**$ 2,627,860**	**$ (2,184,441)**	**(83.1%)**

District Clinics Holdings, Inc. Statement of Revenues and Expenses by Month

	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Year to Date
Gross Patient Revenue	**2,170,266**	**1,734,463**	**1,899,323**	-	-	-	-	-	-	-	-	-	**5,804,051**
Contractual Allowances	453,586	336,609	271,867	-	-	-	-	-	-	-	-	-	1,062,062
Charity Care	811,861	727,479	715,762	-	-	-	-	-	-	-	-	-	2,255,101
Bad Debt	341,494	193,678	306,448	-	-	-	-	-	-	-	-	-	841,620
Other Patient Revenue	385,820	385,820	341,366	-	-	-	-	-	-	-	-	-	1,113,006
Net Patient Revenue	**949,144**	**862,516**	**946,612**	-	-	-	-	-	-	-	-	-	**2,758,273**
Collections %	43.73%	49.73%	49.84%										47.52%
Grant Funds	53,241	48,416	28,234	-	-	-	-	-	-	-	-	-	129,890
Other Revenue	21,291	2,647	6,897	-	-	-	-	-	-	-	-	-	30,834
Total Other Revenues	74,531	51,063	35,130	-	-	-	-	-	-	-	-	-	160,724
Total Revenues	**1,023,676**	**913,579**	**981,742**	-	-	-	-	-	-	-	-	-	**2,918,997**
Direct Operational Expenses:													
Salaries and Wages	1,489,724	1,328,404	1,427,860	-	-	-	-	-	-	-	-	-	4,245,988
Benefits	380,176	378,148	365,616	-	-	-	-	-	-	-	-	-	1,123,941
Purchased Services	101,033	80,005	43,837	-	-	-	-	-	-	-	-	-	224,876
Medical Supplies	15,280	65,422	33,103	-	-	-	-	-	-	-	-	-	113,805
Other Supplies	8,043	19,713	1,026	-	-	-	-	-	-	-	-	-	28,782
Contracted Physician Expense	-												-
Medical Services	67,974	43,699	53,733	-	-	-	-	-	-	-	-	-	165,407
Drugs	65,352	106,112	85,786	-	-	-	-	-	-	-	-	-	257,250
Repairs & Maintenance	36,932	11,167	19,935	-	-	-	-	-	-	-	-	-	68,034
Lease & Rental	117,472	120,395	121,087	-	-	-	-	-	-	-	-	-	358,954
Utilities	6,959	6,781	4,724	-	-	-	-	-	-	-	-	-	18,463
Other Expense	19,578	37,182	33,567	-	-	-	-	-	-	-	-	-	90,327
Insurance	2,377	2,377	2,377	-	-	-	-	-	-	-	-	-	7,131
Total Operational Expenses	2,310,900	2,199,405	2,192,652	-	-	-	-	-	-	-	-	-	6,702,958
Net Performance before Depreciation & Overhead Allocations	**(1,287,225)**	**(1,285,826)**	**(1,210,910)**	-	-	-	-	-	-	-	-	-	**(3,783,960)**
Depreciation	13,167	10,357	26,292	-	-	-	-	-	-	-	-	-	49,816
Overhead Allocations:													
Risk Mgt	1,623	2,089	1,990	-	-	-	-	-	-	-	-	-	5,702
Rev Cycle	62,997	84,377	69,757	-	-	-	-	-	-	-	-	-	217,131
Internal Audit	5,281	6,983	5,435	-	-	-	-	-	-	-	-	-	17,699
Home Office Facilities	18,086	19,184	20,918	-	-	-	-	-	-	-	-	-	58,188
Administration	28,448	37,990	37,093	-	-	-	-	-	-	-	-	-	103,532
Human Resources	35,210	38,104	66,995	-	-	-	-	-	-	-	-	-	140,309
Legal	11,308	15,984	19,536	-	-	-	-	-	-	-	-	-	46,827
Records	6,516	6,638	7,687	-	-	-	-	-	-	-	-	-	20,840
Compliance	3,902	6,147	11,403	-	-	-	-	-	-	-	-	-	21,452
Planning/Research	-												-
Finance	27,070	34,293	28,393	-	-	-	-	-	-	-	-	-	89,756
Public Relations	9,057	15,976	11,021	-	-	-	-	-	-	-	-	-	36,055
Information Technology	80,822	61,834	94,710	-	-	-	-	-	-	-	-	-	237,365
Corporate Quality	1,964	2,269	2,876	-	-	-	-	-	-	-	-	-	7,109
Project MGMT Office	4,280	5,685	6,754	-	-	-	-	-	-	-	-	-	16,718
Managed Care Contract	3,150	3,685	2,822	-	-	-	-	-	-	-	-	-	9,658
Total Overhead Allocations	299,713	341,238	387,389	-	-	-	-	-	-	-	-	-	1,028,341
Total Expenses	**2,623,781**	**2,551,001**	**2,606,333**	-	-	-	-	-	-	-	-	-	**7,781,114**
Net Margin	**$ (1,600,105)**	**$ (1,637,421)**	**$ (1,624,591)**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ (4,862,117)**
Capital	-	81,965	(81,965)	-	-	-	-	-	-	-	-	-	-
General Fund Support/ Transfer In	1,726,629	1,664,089	1,421,583	-	-	-	-	-	-	-	-	-	**$ 4,812,301**

District Clinics Holdings, Inc.- Medical Statement of Revenues and Expenses by Location

FOR THE THIRD MONTH ENDED DECEMBER 31, 2019

	Clinic Administration	West Palm Beach Clinic	Lantana Clinic	Delray Clinic	Belle Glade Clinic	Lewis Center	Lake Worth Clinic	Jupiter Clinic	West Boca Clinic	Subxone Clinic	Mobile Van	Total
Gross Patient Revenue	-	897,800	1,040,426	598,990	468,057	71,628	657,432	274,980	397,919	147,371	214,144	**4,768,747**
Contractual Allowances	-	176,525	197,957	119,386	123,666	17,921	111,587	54,247	105,823	854	17,038	925,002
Charity Care	-	343,794	392,546	128,249	125,770	20,044	283,516	94,062	98,957	53,975	108,526	1,649,438
Bad Debt	-	118,496	198,210	169,172	112,094	25,710	62,480	20,376	26,340	2,498	64,544	799,921
Total Contractual Allowances and Bad Debt	-	638,815	788,713	416,807	361,530	63,674	457,582	168,685	231,120	57,327	190,108	3,374,360
Other Patient Revenue	-	177,872	178,260	79,636	57,339	38,784	98,886	32,438	49,132	26,472	26,438	765,258
Net Patient Revenue	**-**	**436,857**	**429,974**	**261,820**	**163,867**	**46,738**	**298,736**	**138,733**	**215,931**	**116,516**	**50,474**	**2,159,644**
Collection %	0.00%	48.66%	41.33%	43.71%	35.01%	65.25%	45.44%	50.45%	54.27%	79.06%	23.57%	45.29%
Grant Funds	16,162	-	-	-	28,541	-	-	-	-	60,193	24,995	129,890
Other Revenue	3,892	6,261	7,743	3,107	3,793	538	2,500	1,097	1,475	274	154	30,834
Total Other Revenues	20,053	6,261	7,743	3,107	32,334	538	2,500	1,097	1,475	60,467	25,150	160,724
Total Revenues	**20,053**	**443,118**	**437,717**	**264,926**	**196,201**	**47,275**	**301,236**	**139,830**	**217,405**	**176,983**	**75,624**	**2,320,369**
Direct Operational Expenses:												
Salaries and Wages	689,976	500,281	471,930	394,847	286,361	108,257	406,281	176,544	234,647	180,982	76,014	3,526,122
Benefits	163,080	129,285	127,284	113,617	75,819	25,388	116,083	48,616	54,184	47,062	27,176	927,594
Purchased Services	10,300	25,910	22,929	21,108	21,891	2,418	33,891	16,534	21,185	15,537	3,335	195,039
Medical Supplies	-	16,920	22,140	5,095	8,025	758	6,450	1,963	2,199	15,775	336	79,662
Other Supplies	945	2,490	6,660	2,926	5,644	162	1,407	(674)	756	3,142	1,270	24,729
Contracted Physician Expense	-	-	-	-	-	-	-	-	-	-	-	-
Medical Services	-	29,137	17,182	22,897	27,657	3,551	31,226	5,220	28,537	-	-	165,407
Drugs	-	90,900	69,156	43,019	22,450	126	10,296	8,945	3,503	8,817	39	257,250
Repairs & Maintenance	-	9,699	6,880	6,659	9,304	2,131	8,951	1,745	4,061	2,237	4,768	56,435
Lease & Rental	-	34,400	39,679	23,105	62,598	1,008	60,284	20,167	29,438	10,096	-	280,775
Utilities	-	378	2,385	472	4,324	756	3,855	1,960	1,585	-	-	15,716
Other Expense	54,081	2,033	4,410	2,220	5,191	1,071	6,534	581	2,642	2,902	1,449	83,113
Insurance	-	1,394	949	1,269	413	-	668	45	40	-	2,258	7,038
Total Operational Expenses	918,382	842,828	791,584	637,234	529,678	145,627	685,927	281,647	382,776	286,550	116,646	5,618,879
Net Performance before Depreciation & Overhead Allocations	**(898,329)**	**(399,709)**	**(353,867)**	**(372,308)**	**(333,478)**	**(98,352)**	**(384,691)**	**(141,817)**	**(165,370)**	**(109,567)**	**(41,022)**	**(3,298,510)**
Depreciation	2,155	1,443	1,179	449	9,416	322	1,418	1,084	1,199	83	18,750	37,498
Overhead Allocations:												
Risk Mgt	631	672	690	511	406	122	717	245	354	246	96	4,689
Rev Cycle	-	29,205	29,995	22,188	17,638	5,297	31,162	10,634	15,374	10,694	4,189	176,377
Internal Audit	1,958	2,086	2,142	1,585	1,260	378	2,226	760	1,098	764	299	14,555
Home Office Facilities	52,004	-	-	-	-	-	-	-	-	-	-	52,004
Administration	11,451	12,202	12,532	9,270	7,369	2,213	13,020	4,443	6,424	4,468	1,750	85,143
Human Resources	12,897	18,424	17,906	13,818	9,788	2,303	17,272	5,757	8,060	6,333	2,303	114,861
Legal	5,179	5,519	5,668	4,193	3,333	1,001	5,889	2,009	2,905	2,021	792	38,510
Records	2,305	2,456	2,523	1,866	1,483	446	2,621	894	1,293	899	352	17,139
Compliance	2,373	2,528	2,597	1,921	1,527	459	2,698	921	1,331	926	363	17,642
Planning/Research	-	-	-	-	-	-	-	-	-	-	-	-
Finance	9,927	10,579	10,865	8,037	6,389	1,919	11,287	3,852	5,569	3,874	1,517	73,814
Public Relations	3,988	4,249	4,364	3,228	2,566	771	4,534	1,547	2,237	1,556	609	29,651
Information Technology	26,252	27,976	28,733	21,254	16,896	5,074	29,850	10,186	14,727	10,244	4,013	195,205
Budget & Decision Support	-	-	-	-	-	-	-	-	-	-	-	-
Corporate Quality	786	838	861	637	506	152	894	305	441	307	120	5,846
Project MGMT Office	1,849	1,970	2,024	1,497	1,190	357	2,102	717	1,037	722	283	13,749
Managed Care Contract	-	1,299	1,334	987	785	236	1,386	473	684	476	186	7,845
Total Overhead Allocations	131,598	120,005	122,234	90,991	71,136	20,728	125,657	42,742	61,535	43,530	16,872	847,028
Total Expenses	**1,052,135**	**964,276**	**914,998**	**728,674**	**610,230**	**166,677**	**813,002**	**325,474**	**445,509**	**330,163**	**152,268**	**6,503,405**
Net Margin	**$ (1,032,082)**	**$ (521,157)**	**$ (477,281)**	**$ (463,748)**	**$ (414,029)**	**$ (119,401)**	**$ (511,766)**	**$ (185,644)**	**$ (228,103)**	**$ (153,180)**	**$ (76,644)**	**$ (4,183,036)**
Capital	-	-	-	-	-	-	-	-	-	-	-	-
General Fund Support/ Transfer In	**$ 3,825,712**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ 3,825,712**

District Clinic Holdings, Inc.- Medical Statement of Revenue and Expenses

FOR THE THIRD MONTH ENDED DECEMBER 31, 2019

Current Month								Fiscal Year To Date						
Actual	Budget	Variance	%	Prior Year	Variance	%		Actual	Budget	Variance	%	Prior Year	Variance	%
1,569,594	1,401,663	167,931	12.0%	1,748,762	(179,168)	(10.2%)	Gross Patient Revenue	4,768,747	4,308,736	460,011	10.7%	4,519,332	249,415	5.5%
225,053	248,978	23,925	9.6%	869,005	643,952	74.1%	Contractual Allowances	925,002	756,878	(168,124)	(22.2%)	1,863,659	938,657	50.4%
535,851	528,177	(7,674)	(1.5%)	300,323	(235,529)	(78.4%)	Charity Care	1,649,438	1,621,886	(27,552)	(1.7%)	880,834	(768,604)	(87.3%)
286,428	276,895	(9,533)	(3.4%)	189,154	(97,273)	(51.4%)	Bad Debt	799,921	864,425	64,504	7.5%	519,537	(280,384)	(54.0%)
1,047,332	1,054,050	6,718	0.6%	1,358,482	311,150	22.9%	Total Contractuals and Bad Debts	3,374,360	3,243,189	(131,171)	(4.0%)	3,264,030	(110,330)	(3.4%)
240,125	244,640	(4,515)	(1.8%)	232,242	7,883	3.4%	Other Patient Revenue	765,258	733,920	31,338	4.3%	671,495	93,763	14.0%
762,387	**592,253**	**170,134**	**28.7%**	**622,522**	**139,865**	**22.5%**	**Net Patient Revenue**	**2,159,644**	**1,799,467**	**360,177**	**20.0%**	**1,926,797**	**232,848**	**12.1%**
48.57%	42.25%			35.60%			Collection %	45.29%	41.76%			42.63%		
28,234	52,614	(24,380)	(46.3%)	552,339	(524,106)	(94.9%)	Grant Funds	129,890	157,842	(27,952)	(17.7%)	1,508,227	(1,378,337)	(91.4%)
6,897	2,442	4,455	182.4%	24,768	(17,871)	(72.2%)	Other Revenue	30,834	7,326	23,508	320.9%	38,001	(7,167)	(18.9%)
35,130	55,056	(19,926)	(36.2%)	577,107	(541,977)	(93.9%)	Total Other Revenues	160,724	165,168	(4,444)	(2.7%)	1,546,228	(1,385,504)	(89.6%)
797,517	**647,309**	**150,208**	**23.2%**	**1,199,629**	**(402,112)**	**(33.5%)**	**Total Revenues**	**2,320,369**	**1,964,635**	**355,734**	**18.1%**	**3,473,025**	**(1,152,656)**	**(33.2%)**
							Direct Operational Expenses:							
1,173,987	1,114,249	(59,738)	(5.4%)	1,083,982	(90,005)	(8.3%)	Salaries and Wages	3,526,122	3,342,739	(183,383)	(5.5%)	3,174,028	(352,093)	(11.1%)
300,793	298,753	(2,040)	(0.7%)	254,861	(45,932)	(18.0%)	Benefits	927,594	896,257	(31,337)	(3.5%)	782,253	(145,341)	(18.6%)
36,181	58,128	21,947	37.8%	41,480	5,299	12.8%	Purchased Services	195,039	174,384	(20,655)	(11.8%)	156,540	(38,499)	(24.6%)
15,735	13,917	(1,818)	(13.1%)	6,682	(9,053)	(135.5%)	Medical Supplies	79,662	41,751	(37,911)	(90.8%)	38,838	(40,824)	(105.1%)
(1,962)	18,159	20,121	110.8%	8,573	10,535	122.9%	Other Supplies	24,729	54,477	29,748	54.6%	23,259	(1,470)	(6.3%)
-	-	-	0.0%	-	-	0.0%	Contracted Physician Expense	-	-	-	0.0%	-	-	0.0%
53,733	60,707	6,974	11.5%	19,144	(34,589)	(180.7%)	Medical Services	165,407	184,589	19,182	10.4%	77,492	(87,915)	(113.5%)
85,786	78,556	(7,230)	(9.2%)	36,054	(49,732)	(137.9%)	Drugs	257,250	241,043	(16,207)	(6.7%)	120,603	(136,647)	(113.3%)
15,523	8,235	(7,288)	(88.5%)	28,281	12,758	45.1%	Repairs & Maintenance	56,435	24,705	(31,730)	(128.4%)	89,856	33,421	37.2%
94,941	80,599	(14,342)	(17.8%)	74,267	(20,674)	(27.8%)	Lease & Rental	280,775	241,797	(38,978)	(16.1%)	233,314	(47,460)	(20.3%)
4,571	4,632	61	1.3%	4,340	(231)	(5.3%)	Utilities	15,716	13,896	(1,820)	(13.1%)	13,625	(2,090)	(15.3%)
31,554	25,242	(6,312)	(25.0%)	20,454	(11,099)	(54.3%)	Other Expense	83,113	75,726	(7,387)	(9.8%)	35,828	(47,285)	(132.0%)
2,346	2,205	(141)	(6.4%)	2,105	(241)	(11.4%)	Insurance	7,038	6,615	(423)	(6.4%)	6,559	(478)	(7.3%)
1,813,187	1,763,382	(49,805)	(2.8%)	1,580,223	(232,964)	(14.7%)	Total Operational Expenses	5,618,879	5,297,979	(320,900)	(6.1%)	4,752,196	(866,682)	(18.2%)
(1,015,670)	**(1,116,073)**	**100,403**	**(9.0%)**	**(380,594)**	**(635,076)**	**166.9%**	**Net Performance before Depreciation & Overhead Allocations**	**(3,298,510)**	**(3,333,344)**	**34,834**	**(1.0%)**	**(1,279,172)**	**(2,019,338)**	**157.9%**

District Clinic Holdings, Inc.- Medical Statement of Revenue and Expenses

FOR THE THIRD MONTH ENDED DECEMBER 31, 2019

Current Month								Fiscal Year To Date						
Actual	Budget	Variance	%	Prior Year	Variance	%		Actual	Budget	Variance	%	Prior Year	Variance	%
18,790	9,840	(8,950)	(91.0%)	9,900	(8,890)	(89.8%)	Depreciation	37,498	29,520	(7,978)	(27.0%)	29,268	(8,230)	(28.1%)
							Overhead Allocations:							
1,636	1,854	218	11.8%	6,630	4,993	75.3%	Risk Mgt	4,689	5,563	874	15.7%	27,060	22,371	82.7%
56,664	78,723	22,058	28.0%	98,452	41,788	42.4%	Rev Cycle	176,377	236,168	59,792	25.3%	245,086	68,709	28.0%
4,470	4,528	59	1.3%	4,116	(354)	(8.6%)	Internal Audit	14,555	13,585	(970)	(7.1%)	12,348	(2,207)	(17.9%)
18,694	19,144	449	2.3%	14,360	(4,335)	(30.2%)	Home Office Facilities	52,004	57,431	5,427	9.4%	43,986	(8,018)	(18.2%)
30,505	30,056	(449)	(1.5%)	17,014	(13,491)	(79.3%)	Administration	85,143	90,168	5,026	5.6%	58,094	(27,049)	(46.6%)
54,844	33,126	(21,718)	(65.6%)	27,940	(26,904)	(96.3%)	Human Resources	114,861	99,378	(15,483)	(15.6%)	82,236	(32,625)	(39.7%)
16,066	15,249	(817)	(5.4%)	6,507	(9,559)	(146.9%)	Legal	38,510	45,748	7,238	15.8%	21,276	(17,234)	(81.0%)
6,322	6,916	595	8.6%	4,877	(1,444)	(29.6%)	Records	17,139	20,749	3,610	17.4%	15,306	(1,833)	(12.0%)
9,378	9,485	108	1.1%	2,898	(6,480)	(223.6%)	Compliance	17,642	28,456	10,815	38.0%	13,328	(4,314)	(32.4%)
-	-	-	0.0%	972	972	100.0%	Planning/Research	-	-	-	0.0%	3,079	3,079	100.0%
23,350	25,755	2,406	9.3%	18,193	(5,157)	(28.3%)	Finance	73,814	77,266	3,452	4.5%	63,993	(9,820)	(15.3%)
9,064	9,339	276	3.0%	6,701	(2,362)	(35.3%)	Public Relations	29,651	28,018	(1,633)	(5.8%)	17,026	(12,624)	(74.1%)
77,887	89,991	12,104	13.4%	78,246	359	0.5%	Information Technology	195,205	269,973	74,768	27.7%	198,556	3,351	1.7%
2,365	1,190	(1,175)	(98.7%)	1,729	(637)	(36.8%)	Corporate Quality	5,846	3,571	(2,276)	(63.7%)	7,959	2,113	26.5%
5,554	4,111	(1,443)	(35.1%)	-	(5,554)	0.0%	Project MGMT Office	13,749	12,333	(1,416)	(11.5%)	-	(13,749)	0.0%
2,292	3,051	758	24.9%	2,409	117	4.8%	Managed Care Contract	7,845	9,152	1,307	14.3%	8,307	462	5.6%
319,091	332,519	13,428	4.0%	291,044	(28,047)	(9.6%)	Total Overhead Allocations	847,028	997,557	150,529	15.1%	817,641	(29,387)	(3.6%)
2,151,068	**2,105,741**	**(45,327)**	**(2.2%)**	**1,881,166**	**(269,902)**	**(14.3%)**	**Total Expenses**	**6,503,405**	**6,325,056**	**(178,348)**	**(2.8%)**	**5,599,105**	**(904,300)**	**(16.2%)**
$ (1,353,551)	**$ (1,458,432)**	**$ 104,881**	**(7.2%)**	**$ (681,537)**	**$ (672,014)**	**98.6%**	**Net Margin**	**$ (4,183,036)**	**$ (4,360,421)**	**$ 177,385**	**(4.1%)**	**$ (2,126,080)**	**$ (2,056,956)**	**96.7%**
(81,965)	-	81,965	0.0%	-	81,965	0.0%	**Capital**	-	-	-	0.0%	-	-	0.0%
$ 854,968	**$ 1,448,762**	**$ 593,794**	**41.0%**	**$ 930,086**	**$ 75,118**	**8.1%**	**General Fund Support/ Transfer In**	**$ 3,825,712**	**$ 4,331,411**	**$ 505,699**	**11.7%**	**$ 2,627,860**	**$ (1,197,852)**	**(45.6%)**

District Clinics Holdings, Inc.- Dental Statement of Revenues and Expenses by Location

FOR THE THIRD MONTH ENDED DECEMBER 31, 2019

	Dental Clinic Administration	West Palm Beach Dental Clinic	Lantana Dental Clinic	Delray Dental Clinic	Belle Glade Dental Clinic	Total
Gross Patient Revenue	**-**	**370,670**	**284,360**	**264,746**	**115,529**	**1,035,304**
Contractual Allowances	-	52,252	36,477	24,601	23,730	137,060
Charity Care	-	217,073	151,065	184,554	52,973	605,664
Bad Debt	-	2,750	35,299	2,176	1,475	41,699
Total Contractual Allowances and Bad Debt	-	272,074	222,842	211,330	78,178	784,423
Other Patient Revenue	-	130,510	84,130	70,020	63,088	347,748
Net Patient Revenue	**-**	**229,106**	**145,648**	**123,436**	**100,439**	**598,629**
Collection %	-	61.81%	51.22%	46.62%	86.94%	57.82%
Grant Funds	-	-	-	-	-	-
Other Revenue	-	-	-	-	-	-
Total Other Revenues	-	-	-	-	-	-
Total Revenues	**-**	**229,106**	**145,648**	**123,436**	**100,439**	**598,629**
Direct Operational Expenses:						
Salaries and Wages	69,066	222,616	196,277	147,260	84,647	719,866
Benefits	15,672	57,135	54,831	44,573	24,135	196,346
Purchased Services	-	6,941	5,606	5,568	11,722	29,837
Medical Supplies	-	10,623	9,451	7,287	6,782	34,143
Other Supplies	-	440	287	231	3,096	4,054
Contracted Physician Expense	-	-	-	-	-	-
Medical Services	-	-	-	-	-	-
Drugs	-	-	-	-	-	-
Repairs & Maintenance	-	2,747	2,671	2,426	3,755	11,599
Lease & Rental	-	28,750	16,420	15,405	17,605	78,180
Utilities	-	1,060	629	198	860	2,748
Other Expense	143	1,127	1,920	2,487	1,537	7,214
Insurance	-	-	-	-	93	93
Total Operational Expenses	84,881	331,439	288,092	225,435	154,232	1,084,079
Net Performance before Depreciation & Overhead Allocations	**(84,881)**	**(102,334)**	**(142,444)**	**(101,999)**	**(53,792)**	**(485,450)**
Depreciation	-	1,835	1,853	1,827	6,804	12,318
Overhead Allocations:						
Risk Mgt	75	348	248	217	125	1,013
Rev Cycle	-	15,110	10,759	9,443	5,442	40,754
Internal Audit	233	1,079	768	674	389	3,144
Home Office Facilities	6,184	-	-	-	-	6,184
Administration	1,362	6,313	4,495	3,945	2,274	18,389
Human Resources	1,151	8,060	7,024	6,333	2,879	25,448
Legal	616	2,855	2,033	1,785	1,028	8,317
Records	274	1,271	905	794	458	3,702
Compliance	282	1,308	931	818	471	3,810
Finance	1,180	5,473	3,897	3,420	1,971	15,942
Public Relations	474	2,199	1,565	1,374	792	6,404
Information Technology	3,122	14,474	10,306	9,046	5,213	42,161
Corporate Quality	94	433	309	271	156	1,263
Project MGMT Office	220	1,019	726	637	367	2,969
Managed Care Contract	-	672	479	420	242	1,813
Total Overhead Allocations	15,267	60,615	44,445	39,178	21,808	181,313
Total Expenses	**100,148**	**393,889**	**334,390**	**266,439**	**182,843**	**1,277,710**
Net Margin	**$ (100,148)**	**$ (164,784)**	**$ (188,742)**	**$ (143,003)**	**$ (82,404)**	**$ (679,081)**
Capital	-	-	-	-	-	-
General Fund Support/ Transfer In	**$ 986,589**	**-**	**-**	**-**	**-**	**986,589**

District Clinics Holdings, Inc.- Dental Statement of Revenues and Expenses

FOR THE THIRD MONTH ENDED DECEMBER 31, 2019

Current Month								Fiscal Year To Date						
Actual	**Budget**	**Variance**	**%**	**Prior Year**	**Variance**	**%**		**Actual**	**Budget**	**Variance**	**%**	**Prior Year**	**Variance**	**%**
329,729	338,569	(8,840)	(2.6%)	258,136	71,594	27.7%	Gross Patient Revenue	1,035,304	1,042,244	(6,940)	(0.7%)	925,928	109,377	11.8%
46,815	41,632	(5,183)	(12.4%)	86,347	39,532	45.8%	Contractual Allowances	137,060	127,369	(9,691)	(7.6%)	245,380	108,320	44.1%
179,910	188,200	8,290	4.4%	111,533	(68,378)	(61.3%)	Charity Care	605,664	581,398	(24,266)	(4.2%)	423,742	(181,922)	(42.9%)
20,020	18,713	(1,307)	(7.0%)	(1,208)	(21,228)	1,757.2%	Bad Debt	41,699	58,067	16,368	28.2%	14,053	(27,646)	(196.7%)
246,745	248,545	1,800	0.7%	196,671	(50,073)	(25.5%)	Total Contractuals and Bad Debts	784,423	766,834	(17,589)	(2.3%)	683,175	(101,248)	(14.8%)
101,241	135,679	(34,438)	(25.4%)	114,364	(13,123)	(11.5%)	Other Patient Revenue	347,748	407,037	(59,289)	(14.6%)	321,292	26,456	8.2%
184,225	**225,703**	**(41,478)**	**(18.4%)**	**175,828**	**8,397**	**4.8%**	**Net Patient Revenue**	**598,629**	**682,447**	**(83,818)**	**(12.3%)**	**564,044**	**34,584**	**6.1%**
55.87%	66.66%			68.11%			Collection %	57.82%	65.48%			60.92%		
-	4,540	(4,540)	(100.0%)	137,695	(137,695)	(100.0%)	Grant Funds	-	13,620	(13,620)	(100.0%)	363,038	(363,038)	(100.0%)
-	-	-	0.0%	-	-	0.0%	Other Revenue	-	-	-	0.0%	233	(233)	(100.0%)
-	4,540	(4,540)	(100.0%)	137,695	(137,695)	(100.0%)	Total Other Revenues	-	13,620	(13,620)	(100.0%)	363,271	(363,271)	(100.0%)
184,225	**230,243**	**(46,018)**	**(20.0%)**	**313,523**	**(129,297)**	**(41.2%)**	**Total Revenues**	**598,629**	**696,067**	**(97,438)**	**(14.0%)**	**927,316**	**(328,687)**	**(35.4%)**
							Direct Operational Expenses:							
253,873	245,869	(8,004)	(3.3%)	233,047	(20,826)	(8.9%)	Salaries and Wages	719,866	737,601	17,735	2.4%	720,868	1,002	0.1%
64,823	70,646	5,823	8.2%	60,021	(4,803)	(8.0%)	Benefits	196,346	211,935	15,589	7.4%	194,318	(2,029)	(1.0%)
7,656	7,625	(31)	(0.4%)	9,290	1,634	17.6%	Purchased Services	29,837	22,875	(6,962)	(30.4%)	27,872	(1,965)	(7.1%)
17,368	22,084	4,716	21.4%	7,891	(9,477)	(120.1%)	Medical Supplies	34,143	66,252	32,109	48.5%	44,868	10,725	23.9%
2,988	1,527	(1,461)	(95.7%)	(5,902)	(8,890)	150.6%	Other Supplies	4,054	4,581	527	11.5%	17,509	13,455	76.8%
-	-	-	0.0%	-	-	0.0%	Contracted Physician Expense	-	-	-	0.0%	-	-	0.0%
-	-	-	0.0%	-	-	0.0%	Medical Services	-	-	-	0.0%	-	-	0.0%
-	225	225	100.0%	74	74	100.0%	Drugs	-	675	675	100.0%	614	614	100.0%
4,412	5,652	1,240	21.9%	3,870	(542)	(14.0%)	Repairs & Maintenance	11,599	16,956	5,357	31.6%	8,731	(2,869)	(32.9%)
26,146	25,778	(368)	(1.4%)	30,259	4,113	13.6%	Lease & Rental	78,180	77,334	(846)	(1.1%)	84,977	6,797	8.0%
153	2,050	1,897	92.5%	973	820	84.3%	Utilities	2,748	6,150	3,402	55.3%	2,814	67	2.4%
2,014	3,699	1,685	45.6%	4,227	2,214	52.4%	Other Expense	7,214	11,097	3,883	35.0%	3,804	(3,410)	(89.6%)
31	31	0	0.1%	65	34	52.3%	Insurance	93	93	0	0.1%	205	112	54.6%
379,465	385,186	5,721	1.5%	343,816	(35,649)	(10.4%)	Total Operational Expenses	1,084,079	1,155,549	71,470	6.2%	1,106,578	22,499	2.0%
(195,240)	**(154,943)**	**(40,297)**	**26.0%**	**(30,293)**	**(164,947)**	**544.5%**	**Net Performance before Depreciation & Overhead Allocations**	**(485,450)**	**(459,482)**	**(25,968)**	**5.7%**	**(179,262)**	**(306,188)**	**170.8%**

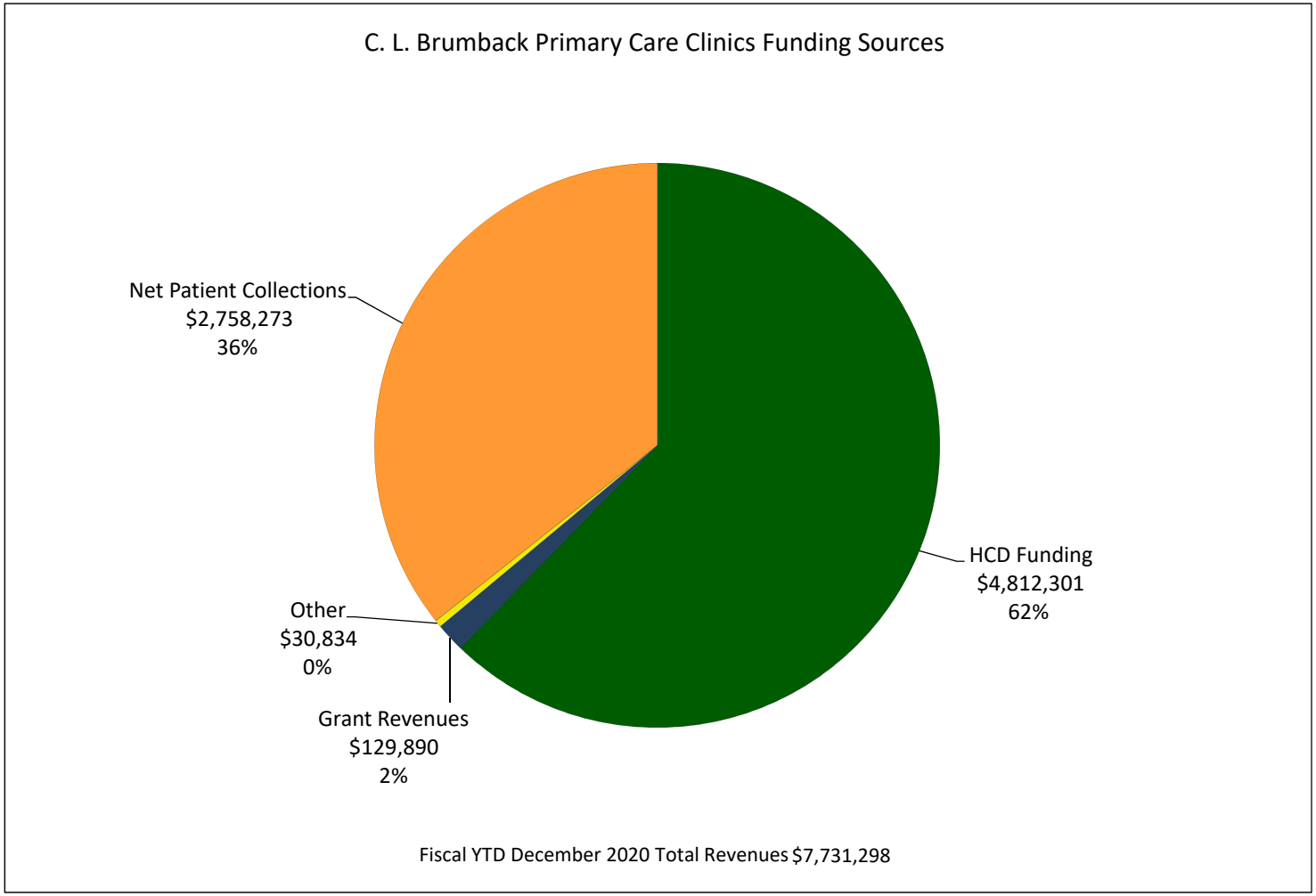
District Clinics Holdings, Inc.- Dental Statement of Revenues and Expenses

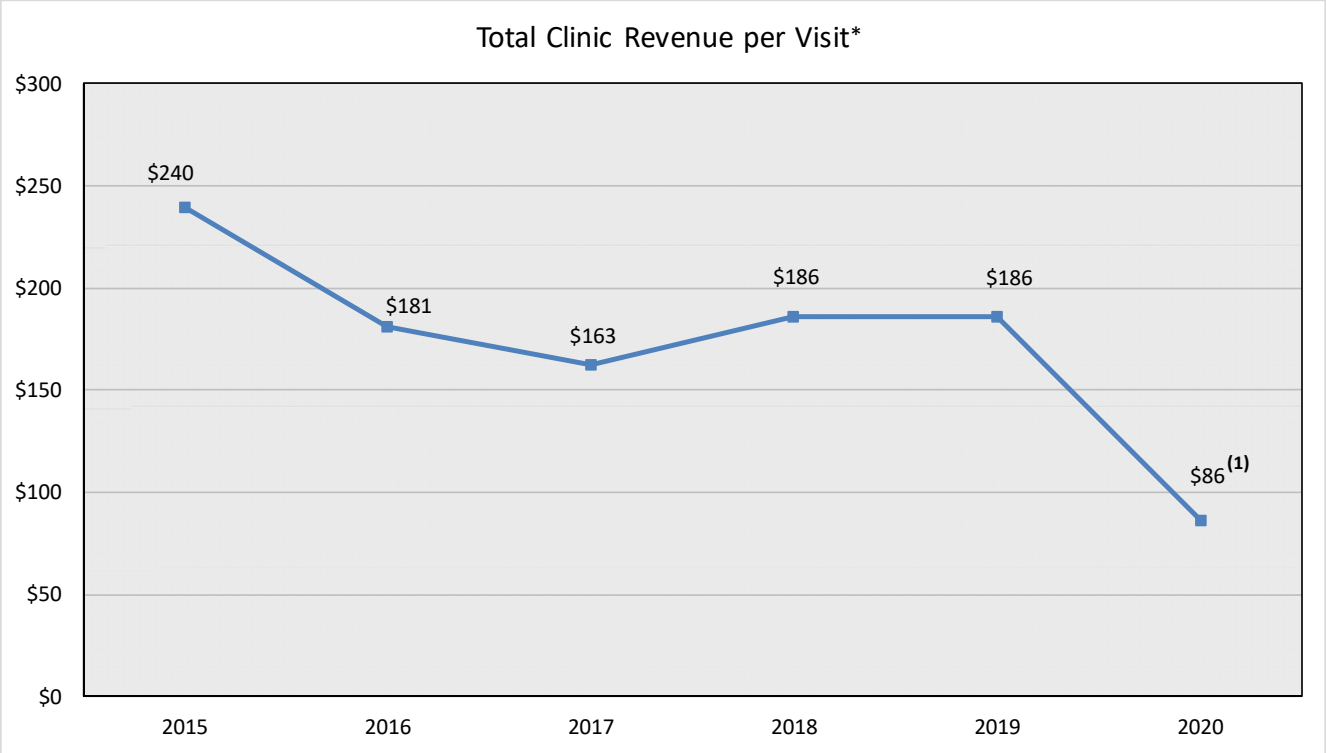
FOR THE THIRD MONTH ENDED DECEMBER 31, 2019

Current Month								Fiscal Year To Date						
Actual	Budget	Variance	%	Prior Year	Variance	%		Actual	Budget	Variance	%	Prior Year	Variance	%
7,502	3,440	(4,062)	(118.1%)	(4,741)	(12,243)	258.2%	Depreciation	12,318	10,320	(1,998)	(19.4%)	10,403	(1,915)	(18.4%)
							Overhead Allocations:							
353	401	47	11.8%	1,617	1,263	78.1%	Risk Mgt	1,013	1,202	189	15.7%	6,600	5,587	84.7%
13,093	18,190	5,097	28.0%	25,735	12,642	49.1%	Rev Cycle	40,754	54,570	13,816	25.3%	64,065	23,311	36.4%
965	978	13	1.3%	1,004	38	3.8%	Internal Audit	3,144	2,934	(210)	(7.1%)	3,012	(132)	(4.4%)
2,223	2,277	53	2.3%	1,781	(442)	(24.8%)	Home Office Facilities	6,184	6,830	645	9.4%	5,457	(728)	(13.3%)
6,588	6,492	(97)	(1.5%)	4,150	(2,439)	(58.8%)	Administration	18,389	19,475	1,085	5.6%	14,168	(4,221)	(29.8%)
12,151	7,339	(4,812)	(65.6%)	6,924	(5,227)	(75.5%)	Human Resources	25,448	22,018	(3,430)	(15.6%)	20,379	(5,069)	(24.9%)
3,470	3,294	(176)	(5.4%)	1,587	(1,883)	(118.7%)	Legal	8,317	9,881	1,563	15.8%	5,189	(3,128)	(60.3%)
1,365	1,494	128	8.6%	1,189	(176)	(14.8%)	Records	3,702	4,481	780	17.4%	3,733	31	0.8%
2,025	2,049	23	1.1%	707	(1,319)	(186.5%)	Compliance	3,810	6,146	2,336	38.0%	3,250	(560)	(17.2%)
-	-	-	0.0%	237	237	100.0%	Planning/Research	-	-	-	0.0%	751	751	100.0%
5,043	5,563	520	9.3%	4,437	(606)	(13.7%)	Finance	15,942	16,688	746	4.5%	15,607	(335)	(2.1%)
1,958	2,017	60	3.0%	1,634	(323)	(19.8%)	Public Relations	6,404	6,051	(353)	(5.8%)	4,153	(2,251)	(54.2%)
16,822	19,436	2,614	13.4%	19,083	2,261	11.8%	Information Technology	42,161	58,309	16,149	27.7%	48,425	6,265	12.9%
511	257	(254)	(98.7%)	422	(89)	(21.2%)	Corporate Quality	1,263	771	(491)	(63.7%)	1,941	678	35.0%
1,200	888	(312)	(35.1%)	-	(1,200)	0.0%	Project MGMT Office	2,969	2,664	(306)	(11.5%)	-	(2,969)	0.0%
530	705	175	24.8%	630	100	15.9%	Managed Care Contract	1,813	2,115	302	14.3%	2,172	359	16.5%
68,298	71,378	3,080	4.3%	71,137	2,839	4.0%	Total Overhead Allocations	181,313	214,133	32,820	15.3%	198,901	17,588	8.8%
455,265	**460,004**	**4,738**	**1.0%**	**410,211**	**(45,054)**	**(11.0%)**	**Total Expenses**	**1,277,710**	**1,380,002**	**102,292**	**7.4%**	**1,315,882**	**38,172**	**2.9%**
$ (271,040)	**$ (229,761)**	**$ (41,279)**	**18.0%**	**$ (96,689)**	**$ (174,351)**	**180.3%**	**Net Margin**	**$ (679,081)**	**$ (683,935)**	**$ 4,854**	**(0.7%)**	**$ (388,566)**	**$ (290,515)**	**74.8%**
-	3,988	3,988	100.0%	(13,581)	(13,581)	100.0%	**Capital**	-	11,964	11,964	100.0%	(13,581)	(13,581)	100.0%
$ 566,615	**$ 232,309**	**$ (334,306)**	**(143.9%)**	**$ -**	**$ (566,615)**	**0.0%**	**General Fund Support/ Transfer In**	**$ 986,589**	**$ 691,580**	**$ (295,009)**	**(42.7%)**	**$ -**	**$ (986,589)**	**0.0%**

C. L. Brumback
Primary Care Clinics
Health Care District Palm Beach County

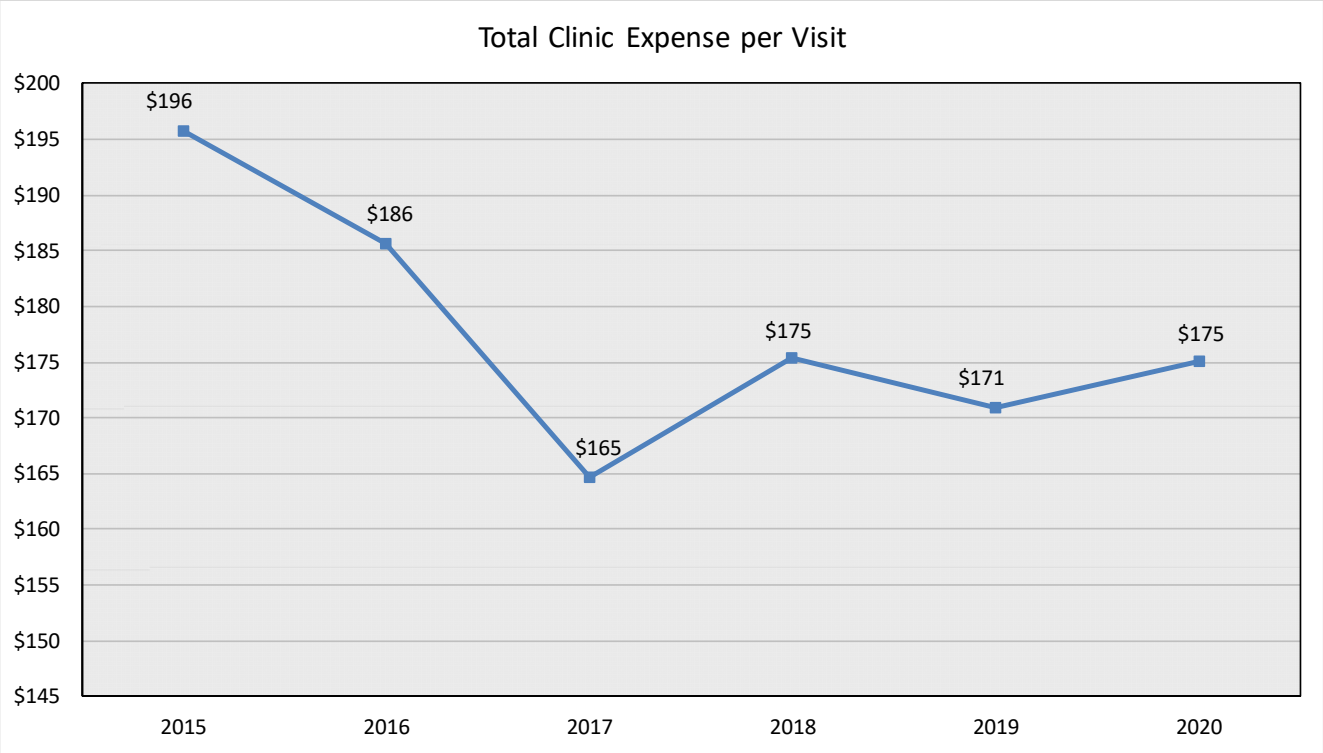
Clinic Visits - Adults and Pediatrics	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Current Year Total	Current YTD Budget	%Var to Budget	Prior Year Total
West Palm Beach	1,929	1,472	1,653										5,054	4,358	16.0%	4,262
Delray	1,429	957	1,019										3,405	2,500	36.2%	3,651
Lantana	1,752	1,489	1,664										4,905	3,946	24.3%	3,981
Belle Glade	950	746	912										2,608	2,553	2.2%	2,659
Lewis Center	296	213	241										750	676	10.9%	729
Lake Worth & Women's Health Care	1,553	1,161	1,303										4,017	4,219	(4.8%)	3,865
Jupiter Clinic	609	471	417										1,497	1,338	11.9%	1,296
West Boca & Women's Health Care	997	680	745										2,422	1,873	29.3%	2,651
Mobile Van	156	136	132										424	593	(28.5%)	544
Mangonia Park	-	67	58										125			
Mangonia Park-Substance	499	497	455										1,451	1,201	20.8%	872
Total Clinic Visits	**10,170**	**7,889**	**8,599**	-	-	-	-	-	-	-	-	-	**26,658**	**23,257**	**14.6%**	**24,510**
Dental Visits																
West Palm Beach	975	776	778										2,529	2,360	7.2%	2,344
Lantana	733	570	541										1,844	2,430	(24.1%)	1,629
Delray	628	547	596										1,771	1,685	5.1%	1,644
Belle Glade	360	251	343										954	982	(2.9%)	896
Total Dental Visits	**2,696**	**2,144**	**2,258**	-	-	-	-	-	-	-	-	-	**7,098**	**7,457**	**(4.8%)**	**6,513**
Total Medical and Dental Visits	**12,866**	**10,033**	**10,857**	-	-	-	-	-	-	-	-	-	**33,756**	**30,714**	**9.9%**	**31,023**
Mental Health Counselors (non-billable)																
West Palm Beach	178	101	164										443	248	78.6%	327
Delray	139	119	41										299	353	(15.3%)	357
Lantana	611	440	496										1,547	657	135.5%	1,249
Belle Glade	53	95	149										297	65	356.9%	60
Mangonia Park	53	150	296										499	752	(33.6%)	-
Lewis Center	240	173	215										628	570	10.2%	679
Lake Worth	204	146	163										513	426	20.4%	345
Jupiter	-	-	-										-	-	0.0%	-
West Boca	3	1	-										4	-	0.0%	-
Mobile Van	96	71	76										243	235	3.4%	-
Total Mental Health Screenings	**1,577**	**1,296**	**1,600**	-	-	-	-	-	-	-	-	-	**4,473**	**3,306**	**35.3%**	**3,017**


C. L. Brumback Primary Care Clinics Funding Sources
Net Patient Collections
$2,758,273
36%
HCD Funding
$4,812,301
62%
Other
$30,834
0%
Grant Revenues
$129,890
2%
Fiscal YTD December 2020 Total Revenues $7,731,298

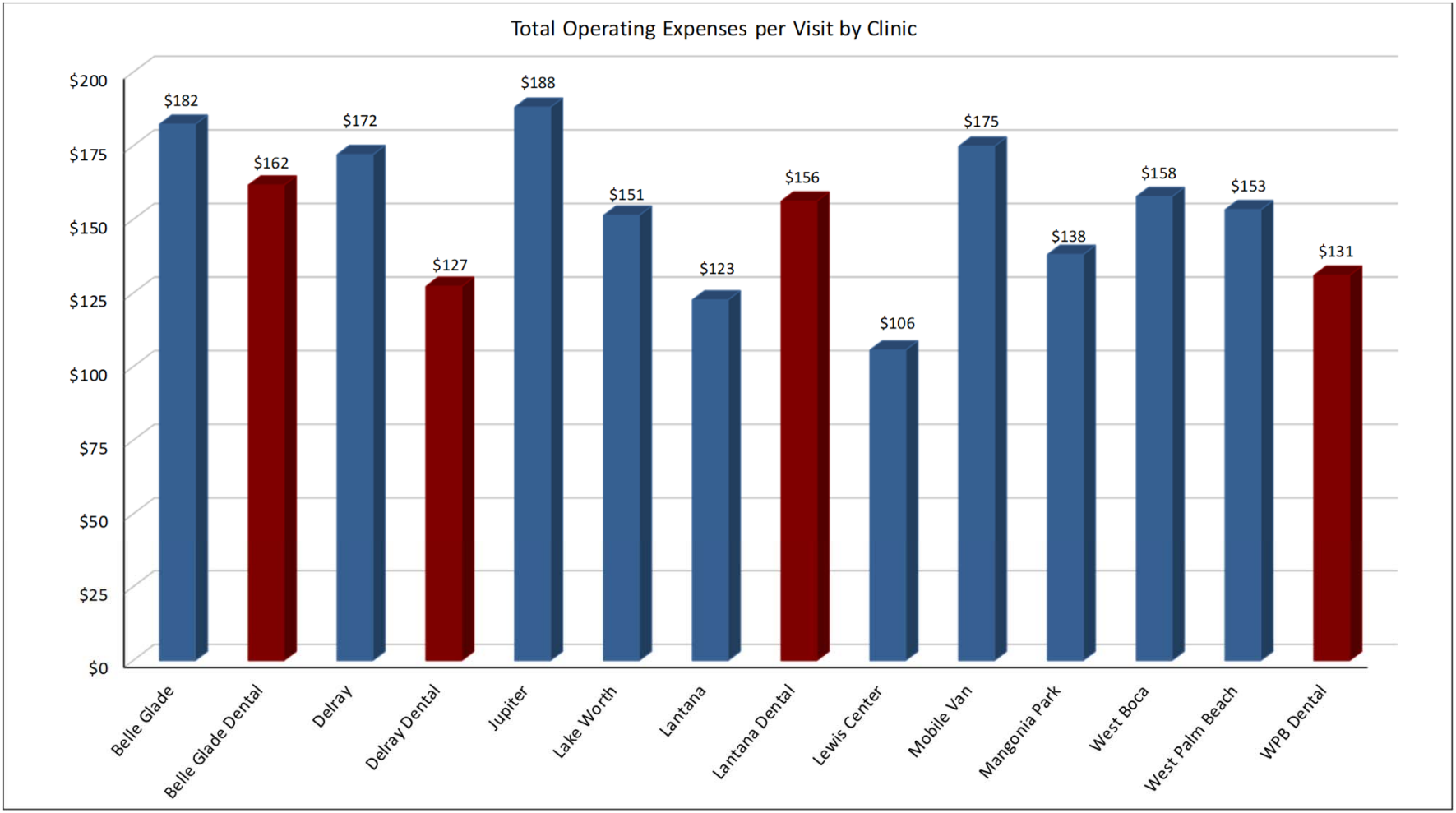


(1) The calendar year 2019 HRSA base grant and the Belle Glade construction grant were fully recognized in FY 2019, resulting in a significant reduction in total clinic revenue per visit in FY 2020.

*Based on total medical and dental visits.



*Based on total medical, dental, and mental health visits.



*Based on Fiscal Year-to-Date December 2020 total operating expenses.
** Visits for the medical clinics include medical and mental health visits.

DISTRICT CLINIC HOLDINGS, INC.
BOARD OF DIRECTORS
February 26, 2020

1. Description: Sliding Fee Discount Program Policy & Federal Poverty Guidelines; Update to Sliding Fee Scales

2. Summary:

This agenda item provides the updated C. L. Brumback Primary Care Clinics Sliding Fee Discount Program Policy and Federal Poverty Guideline Updates and corresponding scales.

3. Substantive Analysis:

The Sliding Fee Discount Program Policy is updated to reflect the HRSA Compliance Manual requirements.

The updated Federal Poverty Guidelines and corresponding updated scales are also included.

4. Fiscal Analysis & Economic Impact Statement:

	Amount	Budget
Capital Requirements	**N/A**	Yes ☐ No ☒
Annual Net Revenue	**N/A**	Yes ☐ No ☒
Annual Expenditures	**N/A**	Yes ☐ No ☒

Reviewed for financial accuracy and compliance with purchasing procedure:

N/A

Joel Snook
VP & Chief Financial Officer

5. Reviewed/Approved by Committee:

N/A

Committee Name

Date Approved

6. Recommendation:

Staff recommends the Board Approve the updated Sliding Fee Discount Program Policy and corresponding Sliding Fee Scales.

Approved for Legal sufficiency:

Valerie Shahriari
VP & General Counsel

Yolanda Ogle
Director of Revenue Cycle

Dr. Belma Andric
Chief Medical Officer, VP & Executive Director of Clinic Services

C. L. Brumback
Primary Care Clinics
Health Care District Palm Beach County

Sliding Fee Discount Program Policy

Policy #:	501-13	Effective Date:	2/26/2020
Business Unit:	Primary Care Clinics	Last Review Date:	12/31/2019
Approval Group:	HCD Rev Cycle Policy Board Approval	Document Owner(s):	Primary Care Clinics and Finance
Board Approval Date:	2/26/2020		

PURPOSE

This program is designed to provide discounted care to those who have no means, or limited means, to pay for services (Uninsured or Underinsured). In addition to quality healthcare, patients are entitled to financial counseling by someone who can understand and offer possible solutions for those who cannot pay in full.

C. L. Brumback Primary Care Clinics (CLBPCC) will offer a Sliding Fee Discount Program uniformly to all patients. CLBPCC will base program eligibility on a person's ability to pay and family size. CLBPCC will not discriminate on the basis of age, gender, race, creed, disability or national origin. The Federal Poverty Guidelines, http://aspe.hhs.gov/poverty, are used in creating and annually updating the Sliding Fee Schedule (SFS) to determine eligibility.

Individuals and families with annual incomes at or below 100 percent of the Federal Poverty Guidelines will be charged a nominal fee. No sliding fee discount will be available for individuals and families with annual incomes above 200 percent of the Federal Poverty Guidelines. CLBPCC SFS will apply for every service, including ancillary services, within CLBPCC's HRSA approved scope of project.

SCOPE

Primary Care Clinics; Finance; Revenue Cycle

POLICY

It is the policy of the CLBPCC to assess and evaluate a patient's ability to pay for all in-scope clinic services as well as services by paid referral and to make available discount services to those in need. All clinic patients will be assessed for income level unless they refuse. Discounts are determined based on household income and family size as defined in this policy. A sliding fee discount scale is used to calculate the applicable discount and is updated annually when the Federal Poverty Guidelines change. Discounts that are approved will be honored for six months, after which the patient must be reassessed. No patients will be denied health care services due to an individual's inability to pay for services of the health center.

It is the policy of CLBPCC to maintain a standard procedure to qualifying patients for sliding fee scale discounts for services provided. Sliding fee scale discounts are available to patients with all incomes at or below 200% of the Federal Poverty Guidelines. All services included within the scope of federal project, including all services provided directly and by referral will comply with HRSA sliding fee requirement. Patients with insurance are eligible to apply for the Sliding Fee Discount Program, and those who qualify will be charged the lesser of the patient liability or what they would be charged as an uninsured sliding fee patient unless prohibited by the applicable insurance contract. Patients that do not wish to apply for a sliding fee scale discount will be asked to attest to income and household size to be compliant with UDS reporting. Patients that refuse to be assessed may be billed full charges for their services.

It is the policy of the CLBPCC to post visible notices at all clinic sites, websites, and in printed material which state that no one will be denied access to services due to inability to pay, and that there is a Sliding Fee Discount Program available. This statement will be translated into the appropriate language/dialect and provided to patients upon request.

It is the policy of CLBPCC to ensure that when charging a nominal fee, the ability of the patient to pay is considered. Designated staff will periodically conduct a brief survey to those patients who were charged a nominal fee that allows patients to provide feedback about their charges.

The Board of Directors will review the Sliding Fee Discount Program Policy once every three years to ensure the policy in effect does not create a barrier to care, and if so, corrective action will be taken to eliminate those barriers. The evaluation will consider the perspective of all sliding fee patients through the use of tools such as patient surveys, focus groups and similar methods. The evaluation will also analyze patient and visit use data to ensure that the sliding fee patients of all classes are accessing services.

The following guidelines are to be followed in providing the Sliding Fee Discount Program.

1. **Notification**: CLBPCC will notify patients of the Sliding Fee Discount Program by:
    a. A “Welcome Packet” (brochure) will be available to all patients at the time of service.
    b. Notification of the Sliding Fee Discount Program will be offered to each patient upon registration.
    c. An explanation of our Sliding Fee Discount Program and our application form are available on CLBPCC’s website.
    d. CLBPCC places notification of the Sliding Fee Discount Program in the clinics’ waiting area.

2. All patients seeking healthcare services at CLBPCC are assured that they will be served regardless of ability to pay. **No one is refused service because of lack of financial means to pay.**

3. **Request for discount**: Requests for discounted services may be made by patients, family members, social services staff or others who are aware of existing financial hardship. The Sliding Fee Discount Program will only be made available for clinic visits. Information and forms can be obtained from the Front Desk.

4. **Administration**: The Sliding Fee Scale Discount Program Policy and Procedure will be administered through the FQHC Clinic Coordinator. Information about the Sliding Fee Discount Program Policy and Procedure are available upon request and assistance offered for completion of the application. Dignity and confidentiality will be respected for all who seek and/or are provided services.

5. **Completion of Application**: The patient/responsible party must complete the Sliding Fee Discount Program application in its entirety. By signing the Sliding Fee Discount Program application, persons authorize CLBPCC access in confirming income as disclosed on the application form. Providing false information on the Sliding Fee Discount Program application will result in all Sliding Fee Discount Program discounts being revoked and the full balance of the account(s) restored and payable immediately.

   If an application is unable to be processed due to the need for additional information, the applicant has two (2) weeks from the date of notification to supply the necessary information without having the date on their application adjusted. If a patient does not provide the requested information within the two-week time period, their application will be re-dated to the date on which they supply the requested information. CLBPCC will work all patient accounts as detailed in its Billing and Collections Policy.

6. **Eligibility:** Discounts will be based on income and family size only. CLBPCC uses the Census Bureau definitions of each.
   a. **Family** is defined as a group of two people or more (one of whom is the householder) related by birth, marriage, or adoption and residing together; all such people (including related subfamily members) are considered as members of one family.

b. **Income** includes earnings, unemployment compensation, workers' compensation, Social Security, Supplemental Security income, public assistance, veterans' payments, survivor benefits, pension or retirement income, interest, dividends, rents, royalties, income from estates, trusts, educational assistance, alimony, child support, assistance from outside the household, and other miscellaneous sources. *Noncash benefits (such as food stamps and housing subsidies)* ***do not*** *count.*

7. **Income verification:** Applicants must provide one of the following: prior year W-2, two most recent pay stubs, letter from employer, or Form 4506-T (if W-2 not filed). Self-employed individuals will be required to submit detail of the most recent three months of income and expenses for the business. Adequate information must be made available to determine eligibility for the program.

8. **Self-declaration of income** may only be used in special circumstances. Specific examples include participants who are living in unsheltered locations (such as streets, parks, temporary housing) coupled with an inability to pay. Patients who are unable to provide written verification must provide a signed statement of income, and why (s)he is unable to provide independent verification. This statement will be presented to CLBPCC's Executive Director or his/her designee for review and final determination as to the sliding fee percentage. Self-declared patients will be responsible for 100% of their charges until management determines the appropriate category.

9. **Discounts:** Those with incomes at or below 100% of poverty will asked to pay a nominal fee. Partial discounts are provided for patients with incomes above 100% of the Federal Poverty Guidelines (FPG) and at or below 200% of the FPG. These discounts adjust based on gradations in income levels and include four discount pay classes. Those with incomes at or below 100% of poverty will not pay more than those with incomes above 100% of poverty. The sliding fee schedule will be updated during the first quarter of every calendar year with the latest federal poverty guidelines (FPG), http://aspe.hhs.gov/poverty. The primary care medical and dental sliding fee schedules are attached as a part of the policy.

10. **Nominal Fee:** Patients at or below 100% FPG will be assessed a nominal fee per visit. However, patients will not be denied services due to an inability to pay. The nominal fee is not a threshold for receiving care and thus, is not a minimum fee or co-payment. The nominal charge is a flat fee, nominal from the patient's perspective, and is not based on actual cost of service.

11. Waiving of Charges: In certain situations, patients may not be able to pay the nominal or discount fee. Waiving of charges may only be used in special circumstances and must be approved by CLBPCC's Executive Director of Clinic Operations or their designee. Any waiving of charges should be documented in the patient's file along with an explanation (e.g., ability to pay, good will, health promotion event). Patients who demonstrate financial hardship may request assistance by completing a Waiver of Fees Exemption Application. The Clinic Coordinator will review the application and forward to the Executive Director of Clinic Operations or designee for approval. Criteria reviewed includes, but not limited to:

1. Living in unsheltered locations (such as streets/parks/temporary home)
2. Eviction or facing eviction or foreclosure
3. Shut-off notices from a utility company
4. Experiencing domestic violence
5. Death of a close family member resulting in extreme financial constraints
6. Experiencing a fire, hurricane, flood or other natural or human-caused disaster that caused substantial damage to patient property
7. Filing bankruptcy
8. Medical expenses the patient could not pay that resulted in substantial debt
9. Unexpected increases in necessary expenses due to caring for an ill, disabled or aging family member
10. External medical crisis requiring frequent visits that make it challenging for the patient to pay
11. Other hardships that may prevent a patient from affording health care services subject to Executive Director of Clinic Operations or designee approval

11. Applicant notification: The Sliding Fee Discount Program determination will be provided to the applicant(s) in writing, and will include the Sliding Fee Discount Program Discount, or, if applicable, the reason for denial. If the application is approved for less than a 100% discount or denied, the patient and/or responsible party must immediately establish payment arrangements with CLBPCC. Sliding Fee Discount Program applications cover outstanding patient balances for six months prior to the application date and any balances incurred within six months after the approved date, unless their financial situation changes significantly. The applicant has the option to reapply after the six months have expired or anytime there has been a significant change in family income. When the applicant reapplies, the look back period will be the lesser of six months or the expiration of their last Sliding

Fee Discount Program applications.

12. **Refusal to Pay:** CLBPCC does not refuse services to patients.

13. **Record keeping:** Information related to Sliding Fee Discount Program decision will be scanned by the Front Desk staff and maintained electronically in the CLBPCC's Electronic Health Record in an effort to preserve the dignity of those receiving free or discounted care.
    a. Applicants that have been approved for the Sliding Fee Discount Program will be annotated in CLBPCC's Electronic Practice Management system.

14. **Policy and procedure review**: Annually, the amount of Sliding Fee Discount Program provided will be reviewed by the CEO and CFO and submitted to the Board for approval. The SFS will be updated based on the current Federal Poverty Guidelines. Pertinent information comparing the amount budgeted and actual community care provided shall serve as a guideline for future planning. This will also serve as a discussion base for reviewing possible changes in the policy and procedures and for examining institutional practices, which may serve as barriers preventing eligible patients from having access to our community care provisions.

15. **Third Party Insurance.** Patients with third party insurance are subject to any limitations on further discounting amounts required by the insurer due to applicable Federal and state law, Medicare and Medicaid and / or terms and conditions of private payor contracts. Patients with insurance that are eligible for the SFS Program are charged no more than they would have owed under the SFS Program.

16. **Evaluation:** At a minimum, once every three years, the Sliding Fee Discount Program will be reviewed from the perspective of reducing patient financial barriers to care. CLBPCC shall include input from patients in various forms including, but not limited to, patient focus groups, patient surveys, and input from board members that are also patients of CLBPCC.

EXCEPTIONS

N/A

C. L. Brumback
Primary Care Clinics
Health Care District Palm Beach County

RELATED DOCUMENTS	
Related Policy Document(s)	522-19
Related Forms	Sliding Fee Discount Program Application, Waiver of Fees Exemptic Application
Reference(s)	
Last Revision	05/23/2013,08/12/2013,05/24/2017,06/28/2017, 2/12/2019, 12/31/2019
Revision Information/Changes	
Next Review Date	

This policy is only intended to serve as a general guideline to assist staff in the delivery of patient care; it does not create standard(s) of care or standard(s) of practice. The final decision(s) as to patient management shall be based on the professional judgement of the health care providers(s) involved with the patient, taking into account the circumstances at that time. Any references are to sources, some parts of which were reviewed in connection with formulation of the policy/procedure. The references are not adopted in whole or in part by the hospital(s) or clinic(s) / provider(s).

The master document is controlled electronically. Printed copies of this document are not controlled. Document users are responsible for ensuring printed copies are valid prior to use.

TOTAL ESTIMATED ANNUALIZED BURDEN—HOURS—Continued

Form name	Number of respondents	Number of responses per respondent	Total responses	Average burden per response (in hours)	Total burden hours
Program Implementation Semi-Structured Interview	28	1	28	1.00	28
Total	17,256		51,712		9,842

Maria G. Button,

Director, Executive Secretariat.

[FR Doc. 2020–00736 Filed 1–16–20; 8:45 am]

BILLING CODE 4165–15–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Office of the Secretary

Annual Update of the HHS Poverty Guidelines

AGENCY: Department of Health and Human Services.

ACTION: Notice.

SUMMARY: This notice provides an update of the Department of Health and Human Services (HHS) poverty guidelines to account for last calendar year's increase in prices as measured by the Consumer Price Index.

DATES: *Applicable Date:* January 14, 2020 unless an office administering a program using the guidelines specifies a different effective date for that particular program.

ADDRESSES: Office of the Assistant Secretary for Planning and Evaluation, Room 404E, Humphrey Building, Department of Health and Human Services, Washington, DC 20201.

FOR FURTHER INFORMATION CONTACT: For information about how the guidelines are used or how income is defined in a particular program, contact the Federal, state, or local office that is responsible for that program. For information about poverty figures for immigration forms, the Hill-Burton Uncompensated Services Program, and the number of people in poverty, use the specific telephone numbers and addresses given below.

For general questions about the poverty guidelines themselves, contact Kendall Swenson, Office of the Assistant Secretary for Planning and Evaluation, Room 422F.5, Humphrey Building, Department of Health and Human Services, Washington, DC 20201—telephone: (202) 795–7309—or visit *http://aspe.hhs.gov/poverty/.*

For information about the percentage multiple of the poverty guidelines to be used on immigration forms such as USCIS Form I–864, Affidavit of Support, contact U.S. Citizenship and Immigration Services at 1–800–375–5283. You also may visit *https://www.uscis.gov/i-864.*

For information about the Hill-Burton Uncompensated Services Program (free or reduced-fee health care services at certain hospitals and other facilities for persons meeting eligibility criteria involving the poverty guidelines), contact the Health Resources and Services Administration Information Center at 1–800–638–0742. You also may visit *https://www.hrsa.gov/get-health-care/affordable/hill-burton/index.html.*

For information about the number of people in poverty, visit the Poverty section of the Census Bureau's website at *https://www.census.gov/topics/income-poverty/poverty.html* or contact the Census Bureau's Customer Service Center at 1–800–923–8282 (toll-free) or visit *https://ask.census.gov* for further information.

SUPPLEMENTARY INFORMATION:

Background

Section 673(2) of the Omnibus Budget Reconciliation Act (OBRA) of 1981 (42 U.S.C. 9902(2)) requires the Secretary of the Department of Health and Human Services to update the poverty guidelines at least annually, adjusting them on the basis of the Consumer Price Index for All Urban Consumers (CPI–U). The poverty guidelines are used as an eligibility criterion by Medicaid and a number of other Federal programs. The *poverty guidelines* issued here are a simplified version of the *poverty thresholds* that the Census Bureau uses to prepare its estimates of the number of individuals and families in poverty.

As required by law, this update is accomplished by increasing the latest published Census Bureau poverty thresholds by the relevant percentage change in the Consumer Price Index for All Urban Consumers (CPI–U). The guidelines in this 2020 notice reflect the 1.8 percent price increase between calendar years 2018 and 2019. After this inflation adjustment, the guidelines are rounded and adjusted to standardize the differences between family sizes. In rare circumstances, the rounding and standardizing adjustments in the formula result in small decreases in the poverty guidelines for some household sizes even when the inflation factor is not negative. In cases where the year-to-year change in inflation is not negative and the rounding and standardizing adjustments in the formula result in reductions to the guidelines from the previous year for some household sizes, the guidelines for the affected household sizes are fixed at the prior year's guidelines. As in prior years, these 2020 guidelines are roughly equal to the poverty thresholds for calendar year 2019 which the Census Bureau expects to publish in final form in September 2020.

The poverty guidelines continue to be derived from the Census Bureau's current official poverty thresholds; they are not derived from the Census Bureau's Supplemental Poverty Measure (SPM).

The following guideline figures represent annual income.

2020 POVERTY GUIDELINES FOR THE 48 CONTIGUOUS STATES AND THE DISTRICT OF COLUMBIA

Persons in family/household	Poverty guideline
1	$12,760
2	17,240
3	21,720
4	26,200
5	30,680
6	35,160
7	39,640
8	44,120

For families/households with more than 8 persons, add $4,480 for each additional person.

2020 POVERTY GUIDELINES FOR ALASKA

Persons in family/household	Poverty guideline
1	$15,950
2	21,550
3	27,150
4	32,750
5	38,350

2020 POVERTY GUIDELINES FOR ALASKA—Continued

Persons in family/household	Poverty guideline
6	43,950
7	49,550
8	55,150

For families/households with more than 8 persons, add $5,600 for each additional person.

2020 POVERTY GUIDELINES FOR HAWAII

Persons in family/household	Poverty guideline
1	$14,680
2	19,830
3	24,980
4	30,130
5	35,280
6	40,430
7	45,580
8	50,730

For families/households with more than 8 persons, add $5,150 for each additional person.

Separate poverty guideline figures for Alaska and Hawaii reflect Office of Economic Opportunity administrative practice beginning in the 1966–1970 period. (Note that the Census Bureau poverty thresholds—the version of the poverty measure used for statistical purposes—have never had separate figures for Alaska and Hawaii.) The poverty guidelines are not defined for Puerto Rico or other outlying jurisdictions. In cases in which a Federal program using the poverty guidelines serves any of those jurisdictions, the Federal office that administers the program is generally responsible for deciding whether to use the contiguous-states-and-DC guidelines for those jurisdictions or to follow some other procedure.

Due to confusing legislative language dating back to 1972, the poverty guidelines sometimes have been mistakenly referred to as the ''OMB'' (Office of Management and Budget) poverty guidelines or poverty line. In fact, OMB has never issued the guidelines; the guidelines are issued each year by the Department of Health and Human Services. The poverty guidelines may be formally referenced as ''the poverty guidelines updated periodically in the **Federal Register** by the U.S. Department of Health and Human Services under the authority of 42 U.S.C. 9902(2).''

Some Federal programs use a percentage multiple of the guidelines (for example, 125 percent or 185 percent of the guidelines), as noted in relevant authorizing legislation or program regulations. Non-Federal organizations that use the poverty guidelines under their own authority in non-federally-funded activities also may choose to use a percentage multiple of the guidelines.

The poverty guidelines do not make a distinction between farm and non-farm families, or between aged and non-aged units. (Only the Census Bureau poverty thresholds have separate figures for aged and non-aged one-person and two-person units.)

This notice does not provide definitions of such terms as ''income'' or ''family'' as there is considerable variation of these terms among programs that use the poverty guidelines. The legislation or regulations governing each program define these terms and determine how the program applies the poverty guidelines. In cases where legislation or regulations do not establish these definitions, the entity that administers or funds the program is responsible to define such terms as ''income'' and ''family.'' Therefore questions such as net or gross income, counted or excluded income, or household size should be directed to the entity that administers or funds the program.

Dated: January 14, 2020.

Alex M. Azar II,

Secretary, Department of Health and Human Services.

[FR Doc. 2020–00858 Filed 1–15–20; 4:15 pm]

BILLING CODE 4150–05–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

[Document Identifier: OS–0990–0001]

Agency Information Collection Request; 30-Day Public Comment Request

AGENCY: Office of the Secretary, HHS.

ACTION: Notice.

SUMMARY: In compliance with the requirement of the Paperwork Reduction Act of 1995, the Office of the Secretary (OS), Department of Health and Human Services, is publishing the following summary of a proposed collection for public comment.

DATES: Comments on the ICR must be received on or before February 18, 2020.

ADDRESSES: Submit your comments to *OIRA_submission@omb.eop.gov* or via facsimile to (202) 395–5806.

FOR FURTHER INFORMATION CONTACT: Sherrette Funn, *Sherrette.Funn@hhs.gov* or (202) 795–7714. When submitting comments or requesting information, please include the document identifier 0990–0001–30D and project title for reference.

SUPPLEMENTARY INFORMATION: Interested persons are invited to send comments regarding this burden estimate or any other aspect of this collection of information, including any of the following subjects: (1) The necessity and utility of the proposed information collection for the proper performance of the agency's functions; (2) the accuracy of the estimated burden; (3) ways to enhance the quality, utility, and clarity of the information to be collected; and (4) the use of automated collection techniques or other forms of information technology to minimize the information collection burden.

Information Collection Request Title: Application for waiver of the two- year foreign residence requirement of the Exchange Visitor Program.

OMB No.: 0990–0001.

Abstract: The HHS program deals with both research and clinical care waivers. Applicant institutions apply to this Department to request a waiver on behalf of research scientists or foreign medical graduates to work as clinicians in HHS designated health shortage areas doing primary care in medical facilities. The instructions request a copy of Form G–28 from applicant institutions represented by legal counsel outside of the applying institution. United States Department of Justice Form G–28 ascertains that legal counsel represents both the applicant organization and the exchange visitor.

Need and Proposed Use of the Information: Required as part of the application process to collect basic information such as name, address, family status, sponsor and current visa information.

Likely Respondents: Research scientists and research facilities.

C. L. Brumback
Primary Care Clinics
Health Care District Palm Beach County

C.L. Brumback Primary Care Clinic
2020 SLIDING FEE SCALE - MEDICAL

Family Size	≤ 100%	101% to 150%	151% to 175%	176% to 200%	Over 200%
1	$12,760.00	$12,760.01 - $15,950.00	$15,950.01 - $19,140.00	$19,140.01 - $25.520.00	$25,520.01
2	$17,240.00	$17,240.01 - $21,550.00	$21,550.01 - $25,860.00	$25,860.01 - $34,480.00	$34,480.01
3	$21,720.00	$21,720.01 - $27,150.00	$27,150.01 - $32,580.00	$32,580.01 - $43,440.00	$43,440.01
4	$26,200.00	$26,200.01 - $32,750.00	$32,750.01 - $39,300.00	$39,300.01 - $52,400.00	$52,400.01
5	$30,680.00	$30,680.01 - $38,350.00	$38,350.01 - $46,020.00	$46,020.01 - $61,360.00	$61,360.01
6	$35,160.00	$35,160.01 - $43,950.00	$43,950.01 - $52,740.00	$52,740.01 - $70,320.00	$70,320.01
7	$39,640.00	$39,640.01 - $49,550.00	$49,550.01 - $59,460.00	$59,460.01 - $79,280.00	$79,280.01
8	$44,120.00	$44,120.01 - $55,150.00	$55,150.01 - $66,180.00	$66,180.01 - $88,240.00	$88,240.01
For families/households with more than 8 persons, add $4480 for each additional person					

Federal Poverty Level	Price
100% or below	$20.00
Between 101% to 150%	$40.00
Between 151% to 175%	$60.00
Between 176% to 200%	$80.00
Over 200%	No Discount

Based on 2020 Federal Poverty Guidelines published in the Federal Register- January 17, 2020

Discounted charges are per visit and will include lab orders and pharmacy.

C. L. Brumback
Primary Care Clinics
Health Care District Palm Beach County

C.L. Brumback Primary Care Clinic
2020 SLIDING FEE SCALE - DENTAL

Family Size	≤ 100%	101% to 150%	151% to 175%	176% to 200%	Over 200%
1	$12,760.00	$12,760.01 - $15,950.00	$15,950.01 - $19,140.00	$19,140.01 - $25.520.00	$25,520.01
2	$17,240.00	$17,240.01 - $21,550.00	$21,550.01 - $25,860.00	$25,860.01 - $34,480.00	$34,480.01
3	$21,720.00	$21,720.01 - $27,150.00	$27,150.01 - $32,580.00	$32,580.01 - $43,440.00	$43,440.01
4	$26,200.00	$26,200.01 - $32,750.00	$32,750.01 - $39,300.00	$39,300.01 - $52,400.00	$52,400.01
5	$30,680.00	$30,680.01 - $38,350.00	$38,350.01 - $46,020.00	$46,020.01 - $61,360.00	$61,360.01
6	$35,160.00	$35,160.01 - $43,950.00	$43,950.01 - $52,740.00	$52,740.01 - $70,320.00	$70,320.01
7	$39,640.00	$39,640.01 - $49,550.00	$49,550.01 - $59,460.00	$59,460.01 - $79,280.00	$79,280.01
8	$44,120.00	$44,120.01 - $55,150.00	$55,150.01 - $66,180.00	$66,180.01 - $88,240.00	$88,240.01
For families/households with more than 8 persons, add $4480 for each additional person					

Federal Poverty Level	Price
100% or below	$30.00
Between 101% to 150%	$50.00
Between 151% to 175%	$70.00
Between 176% to 200%	$90.00
Over 200%	No Discount

Based on 2020 Federal Poverty Guidelines published in the Federal Register- January 17, 2020

Discounted charges are per visit and will include lab orders and pharmacy.

DISTRICT CLINIC HOLDINGS, INC.
BOARD OF DIRECTORS
February 26, 2020

1. Description: Second Amendment to Agreement between Health Care District of Palm Beach County and District Clinic Holdings, Inc.

2. Summary:

This agenda item represents the Second Amendment to the Co-Applicant agreement between Health Care District and District Clinic Holdings, Inc. d/b/a C.L. Brumback Primary Care Clinics.

3. Substantive Analysis:

The Parties entered into the agreement initially on November 28, 2012 and the First Amendment on January 27, 2017. The District proposed amending the following sections and language:

Amend Section 2 by adding the following language at the end of the section:

- District retains the authority to adopt and approve the financial management policies.

Amend Section 4(a) by deleting in its entirety and replacing with the following:

- a. The DCHI Board shall cause the Clinics to be operated in accordance with the terms and conditions of the HRSA Compliance Manual requirements.

Amend Section 4(d) by adding the following language at the end of the section:

- District retains the authority to adopt and approve the financial management policies.

Amend Section 16 Notice by replacing the contact information with the following:

If to the District addressed to:
Chief Executive Officer
Health Care District of Palm Beach County
1515 N. Flagler Dr., Suite 101
West Palm Beach, FL 33401

With a copy to:
General Counsel
Health Care District of Palm Beach County
1515 N. Flagler Dr., Suite 101
West Palm Beach, FL 33401

If to DCHI addressed to:
James Elder
c/o District Clinic Holdings, Inc. d/b/a C.L. Brumback Primary Care Clinics
1515 N. Flagler Drive, Suite 101
West Palm Beach, FL 33401

DISTRICT CLINIC HOLDINGS, INC.
BOARD OF DIRECTORS
February 26, 2020

4. Fiscal Analysis & Economic Impact Statement:

	Amount	Budget
Capital Requirements	**N/A**	Yes ☐ No ☐
Annual Net Revenue	**N/A**	Yes ☐ No ☐
Annual Expenditures	**N/A**	Yes ☐ No ☐

Reviewed for financial accuracy and compliance with purchasing procedure:

Joel H. Snook
VP & Chief Financial Officer

5. Reviewed/Approved by Committee:

N/A
Committee Name

Date Approved

6. Recommendation:

Staff recommends the Board Approve the Second Amendment to Agreement between Health Care District of Palm Beach County and District Clinic Holdings, Inc. and forward to the Health Care District Board for approval.

Approved for Legal sufficiency:

Valerie Shahriari
VP & General Counsel

Dr. Belma Andric
Chief Medical Officer, VP &Executive Director of Clinic Services

Dr. Belma Andric
Chief Medical Officer, VP & Executive Director of Clinic Services

DISTRICT CLINIC HOLDINGS, INC.
BOARD OF DIRECTORS
February 26, 2020

1. Description: Change In Scope – Form 5A, Moving services from Column II to Column III.

2. Summary:

We respectfully request the authorization to move services currently listed in Column II of Form 5A, to Column III.

3. Substantive Analysis:

The following items currently listed in Column II of Form 5a need to be moved to Column III: Screenings, Voluntary Family Planning, Case Management, Infectious Disease, Health Education, Gynecological Care, Prenatal Care, Intrapartum Care, and Postpartum Care.

4. Fiscal Analysis & Economic Impact Statement:

	Amount	Budget
Capital Requirements		Yes ☐ No ☒
Annual Net Revenue		Yes ☐ No ☒
Annual Expenditures		Yes ☐ No ☒

Reviewed for financial accuracy and compliance with purchasing procedure:

N/A

Joel Snook
Chief Financial Officer

5. Reviewed/Approved by Committee:

N/A

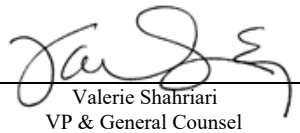
Committee Name

Date Approved

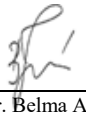
6. Recommendation:

Staff recommends the Board approve the request for Change in Scope to Move the listed services from Column II to Column III.

Approved for Legal sufficiency:



Valerie Shahriari
VP & General Counsel



Dr. Belma Andric
Chief Medical Officer, VP & Executive Director of Clinic Services

DISTRICT CLINIC HOLDINGS, INC.
BOARD OF DIRECTORS
February 26, 2019

1. Description: Executive Director Informational Update

2. Summary:

Updates on key changes within C. L. Brumback Primary Care Clinics:

- HRSA Operational Site Visit
- Addiction Stabilization Unit Grand Opening

3. Substantive Analysis:

HRSA Operational Site Visit
HRSA Operational Site Visit is scheduled for the week of March 24-26.

Addiction Stabilization Unit Grand Opening
The longstanding community efforts to create an Addiction Stabilization Unit were finally realized when the ASU held its Grand Opening on February 5, 2020.

4. Fiscal Analysis & Economic Impact Statement:

	Amount	Budget
Capital Requirements	**N/A**	Yes ☐ No ☒
Annual Net Revenue	**N/A**	Yes ☐ No ☒
Annual Expenditures	**N/A**	Yes ☐ No ☒

Reviewed for financial accuracy and compliance with purchasing procedure:

N/A

Joel Snook
Chief Financial Officer

DISTRICT CLINIC HOLDINGS, INC.
BOARD OF DIRECTORS
February 26, 2019

5. Reviewed/Approved by Committee:

N/A	
Committee Name	Date Approved

6. Recommendation:

Staff recommends Board receive and file the Executive Director Informational Update.

Approved for Legal sufficiency:

Valerie Shahriari
General Counsel

Dr. Belma Andric
Chief Medical Officer, VP & Executive Director
of Clinic Services

DISTRICT CLINIC HOLDINGS, INC.
BOARD OF DIRECTORS
February 26, 2020

1. Description: Operations Reports – December 2019

2. Summary:

This agenda item provides the following operations reports for December 2019:

- Productivity Summary Report
- Productivity Detail Report by Clinic
- Update on Referral & Lab Order process

3. Substantive Analysis:

Overall visits from 1/1/19 – 12/31/19 totaled 149,848. The total number of encounters in December across all categories is slightly higher than the previous month.

Pediatric programs in Lantana and West Palm Beach are showing increases in productivity, with 110% in Lantana and 93% in West Palm Beach.

After two full months of operation, Mangonia Park continues to show growth with an increase in patients seen from 393 in November 2019, to 525 in December 2019.

As of January 1, 2020, the Referral Department was transitioned from the Clinics Administration to the Revenue Cycle Department. Since this time, patient referral cycle data has been uploaded into Tableau which will provide more robust data on referrals and lab orders. Referral processing benchmarks have been established and include 7 days for a standard referral and 3 days for a stat referral.

4. Fiscal Analysis & Economic Impact Statement:

	Amount	Budget
Capital Requirements	**N/A**	Yes ☐ No ☒
Annual Net Revenue	**N/A**	Yes ☐ No ☒
Annual Expenditures	**N/A**	Yes ☐ No ☒

Reviewed for financial accuracy and compliance with purchasing procedure:

N/A

Joel H. Snook, CPA
Chief Financial Officer

DISTRICT CLINIC HOLDINGS, INC.
BOARD OF DIRECTORS
February 26, 2020

5. Reviewed/Approved by Committee:

N/A	
Committee Name	Date Approved

6. Recommendation:

Staff recommends the Board Approve the Operations Reports for December 2019.

Approved for Legal sufficiency:

Valerie Shahriari
General Counsel

Dr. Hyla Fritsch
Director of Clinic Operations and Pharmacy Services

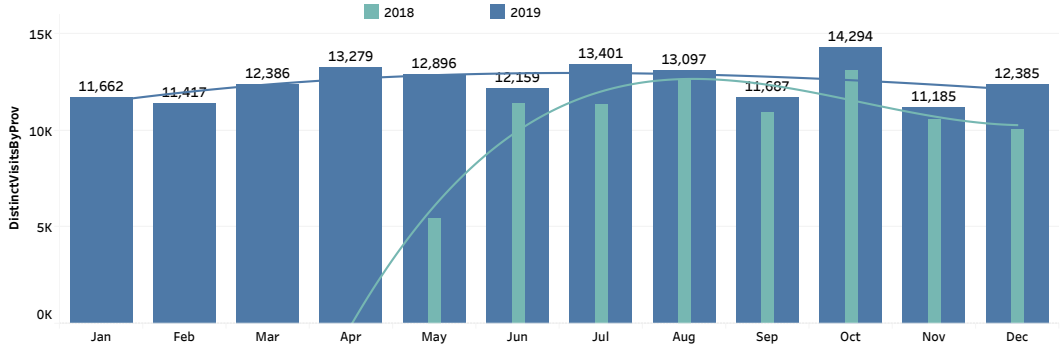
Dr. Belma Andric
Chief Medical Officer, VP & Executive Director of Clinic Services

C. L. Brumback
Primary Care Clinics
Health Care District Palm Beach County

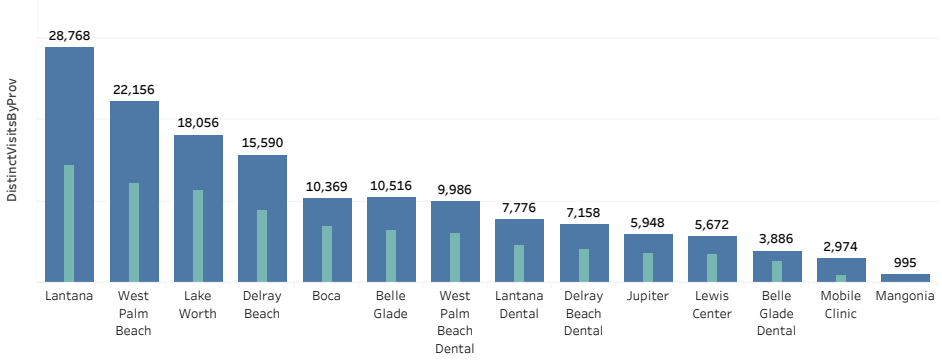
2019 Visits

149,848

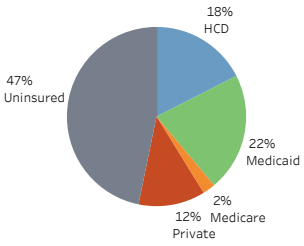
Service Date
5/15/2018 to 12/31/2019



Category
- ☑ Adult Care
- ☑ Dental
- ☑ Dental Hygiene
- ☑ Mental Health
- ☑ Other
- ☑ Pediatric Care
- ☑ Substance Abuse
- ☑ Women's Care

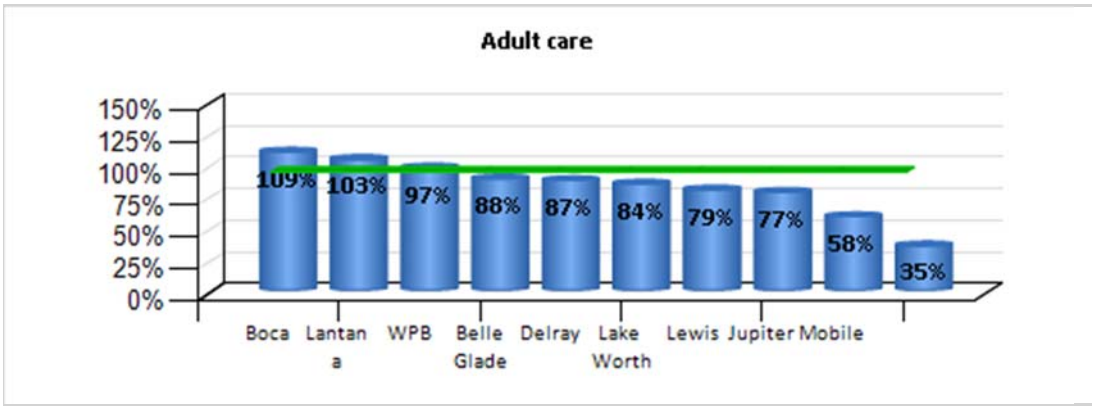


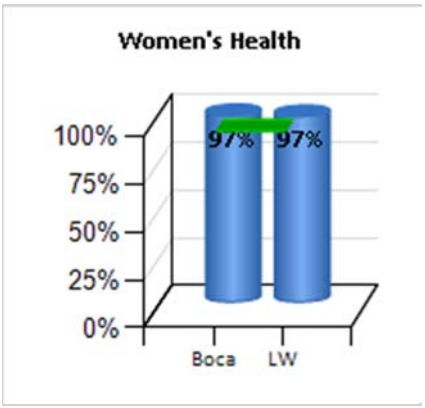
Payer Mix

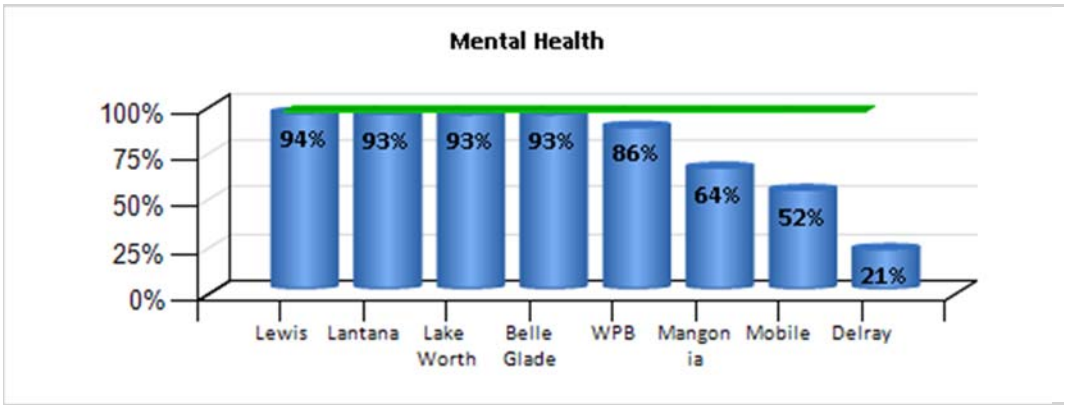


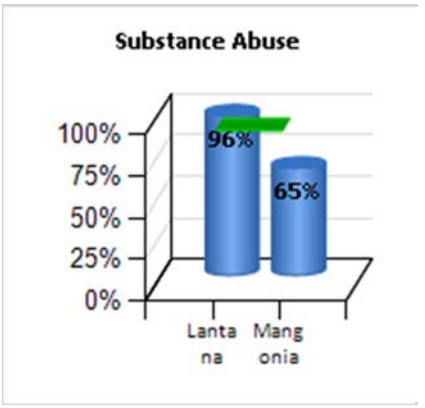
ALL CLINICS PRODUCTIVITY DECEMBER 2019

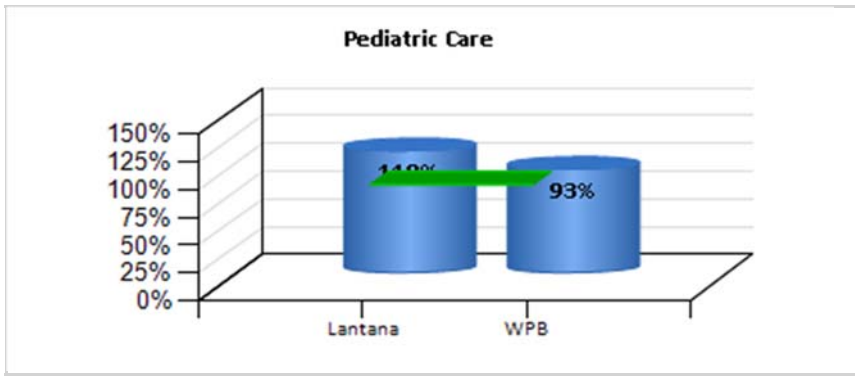
	Target	Total seen	% Monthly Target	New Patients	% of New Patients
ADULT CARE	7103	6293	89%	862	14%
DENTAL	2091	1885	90%	261	14%
DENTAL HYGIENE	584	373	64%		
MENTAL HEALTH	2086	1600	77%		
PEDIATRIC CARE	1358	1394	103%	244	18%
SUBSTANCE ABUSE	560	455	81%		
WOMEN'S HEALTH CARE	472	457	97%	90	20%

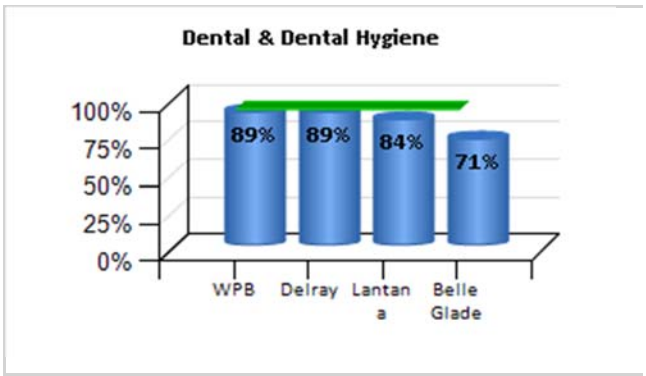


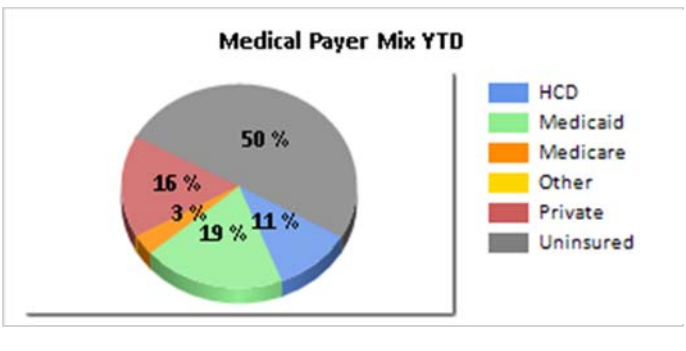


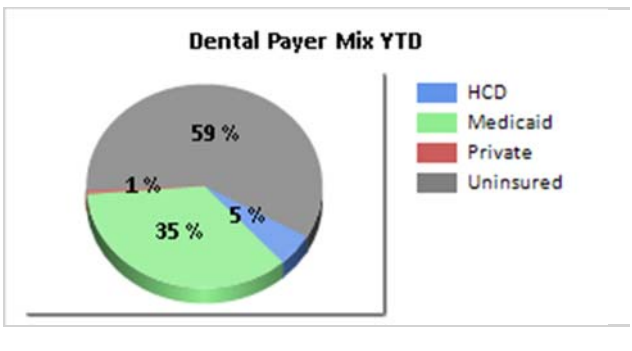








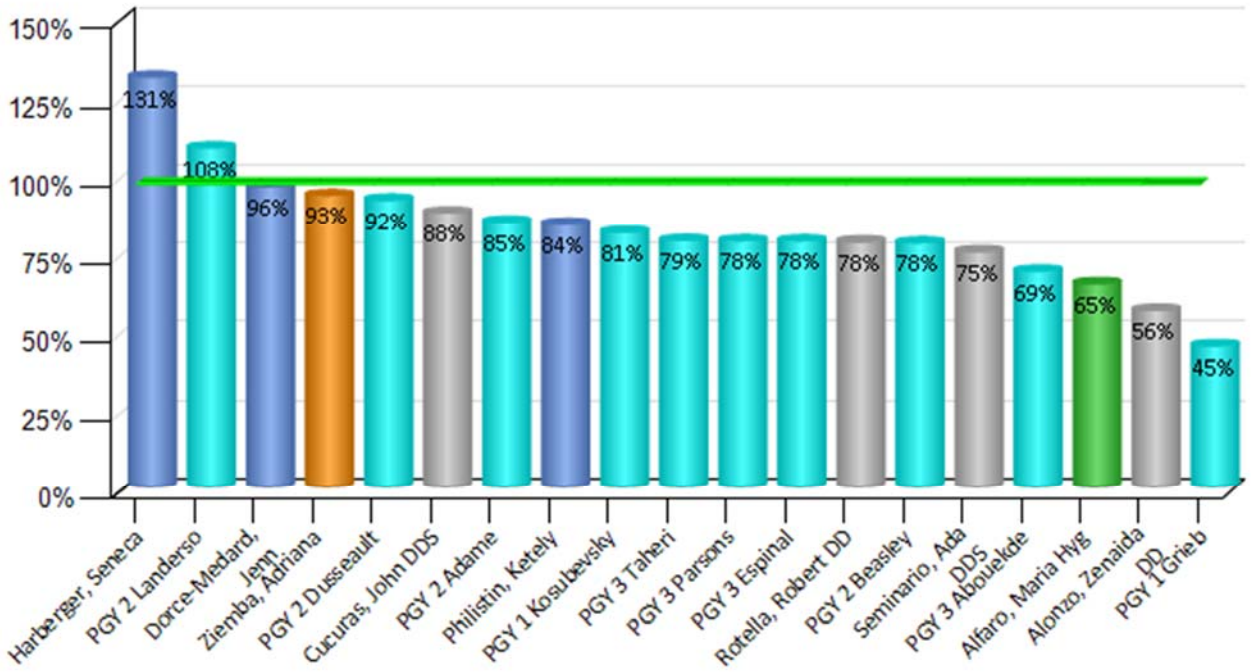


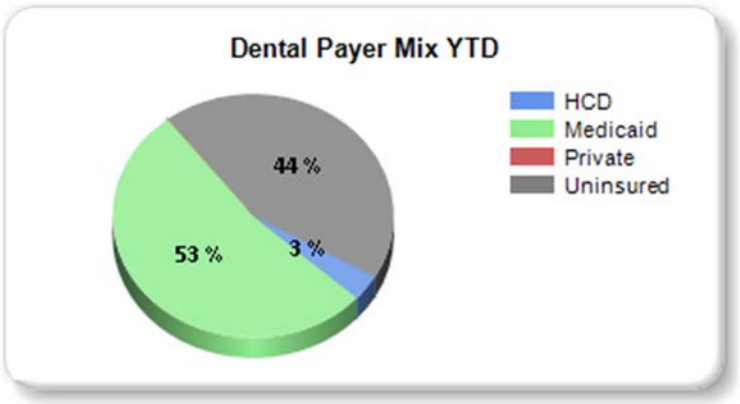


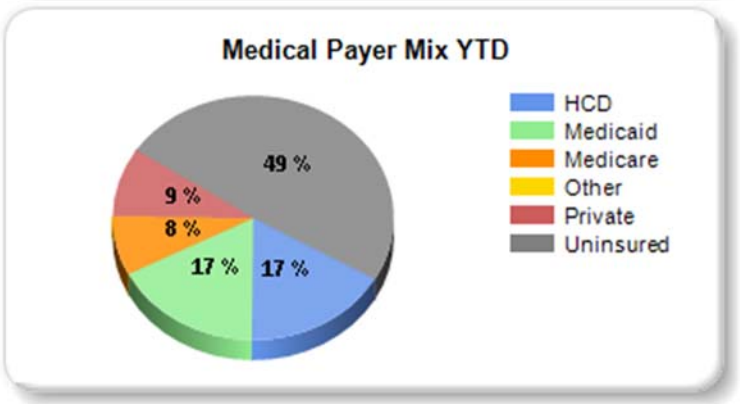
BELLE GLADE TOTALS FOR DECEMBER 2019

	Daily Target	Days Worked	Target for the month	Total for month seen	% Monthly Target Achieved	Daily Average
RESIDENT						
PGY 2 Landerso	12	1.0	12	13	108%	13.0
PGY 2 Dusseault	12	1.0	12	11	92%	11.0
PGY 2 Adame	12	7.0	84	71	85%	10.1
PGY 1 Kosubevsky	8	2.0	16	13	81%	6.5
PGY 3 Taheri	16	3.5	56	44	79%	12.6
PGY 3 Parsons	16	5.5	88	69	78%	12.5
PGY 3 Espinal	16	11.0	176	138	78%	12.5
PGY 2 Beasley	12	3.0	36	28	78%	9.3
PGY 3 Abouekde	16	2.0	32	22	69%	11.0
PGY 1 Grieb	8	2.5	20	9	45%	3.6
BELLE GLADE RESIDENT TOTALS		**38.5**	**532**	**418**	**79%**	
ADULT CARE						
Harberger, Seneca MD Resident Preceptor	7	20.0	140	183	131%	9.2
Dorce-Medard, Jennifer DO Resident Preceptor	3	12.5	38	36	96%	2.9
Philistin, Ketely ARNP	16	20.5	328	275	84%	13.4
BELLE GLADE ADULT CARE TOTALS		**53.0**	**506**	**494**	**98%**	
MENTAL HEALTH						
Ziemba, Adriana	8	20.0	160	149	93%	7.5
BELLE GLADE MENTAL HEALTH TOTALS		**20.0**	**160**	**149**	**93%**	
DENTAL						
Cucuras, John DDS	16	0.5	8	7	88%	14.0
Rotella, Robert DDS	16	2.0	32	25	78%	12.5
Seminario, Ada DDS	16	16.0	256	192	75%	12.0
Alonzo, Zenaida DDS	16	2.0	32	18	56%	9.0
BELLE GLADE DENTAL TOTALS		**20.5**	**328**	**242**	**74%**	
DENTAL HYGIENE						
Alfaro, Maria Hyg	8	19.5	156	101	65%	5.2
BELLE GLADE DENTAL HYGIENE TOTALS		**19.5**	**156**	**101**	**65%**	
BELLE GLADE TOTALS		**151.5**	**1682**	**1404**	**83%**	

BELLE GLADE PROVIDER PRODUCTIVITY DECEMBER 2019



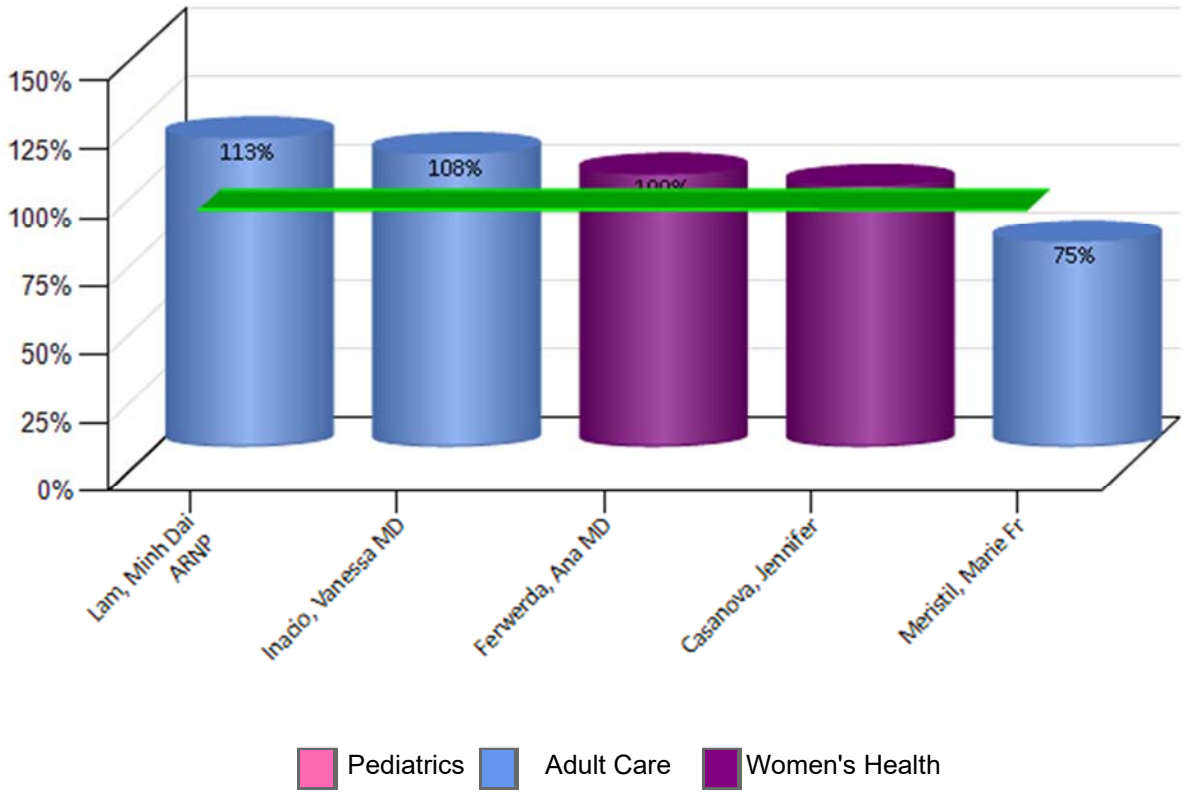


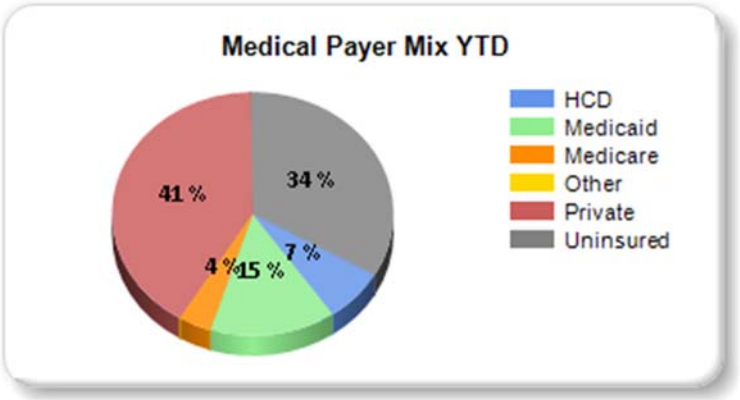


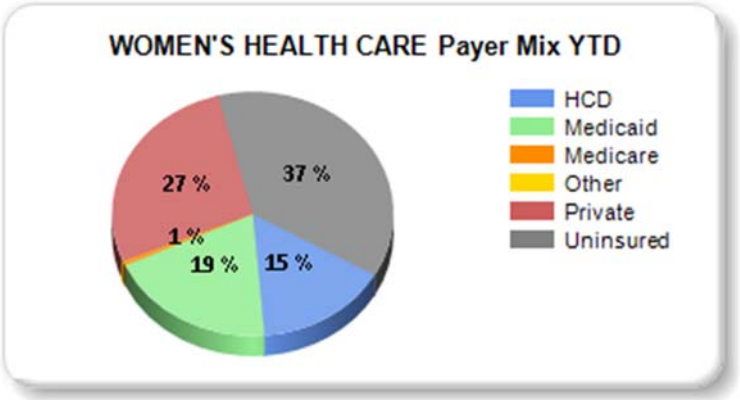
BOCA TOTALS FOR DECEMBER 2019

	Daily Target	Days Worked	Target for the month	Total for month seen	% Monthly Target Achieved	Daily Average
ADULT CARE						
Lam, Minh Dai ARNP	16	16.5	264	299	113%	18.1
Inacio, Vanessa MD	18	17.0	306	329	108%	19.4
Meristil, Marie Frantzcia ARNP	16	1.0	16	12	75%	12.0
BOCA ADULT CARE TOTALS		**34.5**	**586**	**640**	**109%**	
WOMEN'S HEALTH CARE						
Ferwerda, Ana MD	18	2.0	36	36	100%	18.0
Casanova, Jennifer, ARNP	16	4.5	72	69	96%	15.3
BOCA WOMEN'S HEALTH CARE TOTALS		**6.5**	**108**	**105**	**97%**	
BOCA TOTALS		**41.0**	**694**	**745**	**107%**	

BOCA PROVIDER PRODUCTIVITY DECEMBER 2019



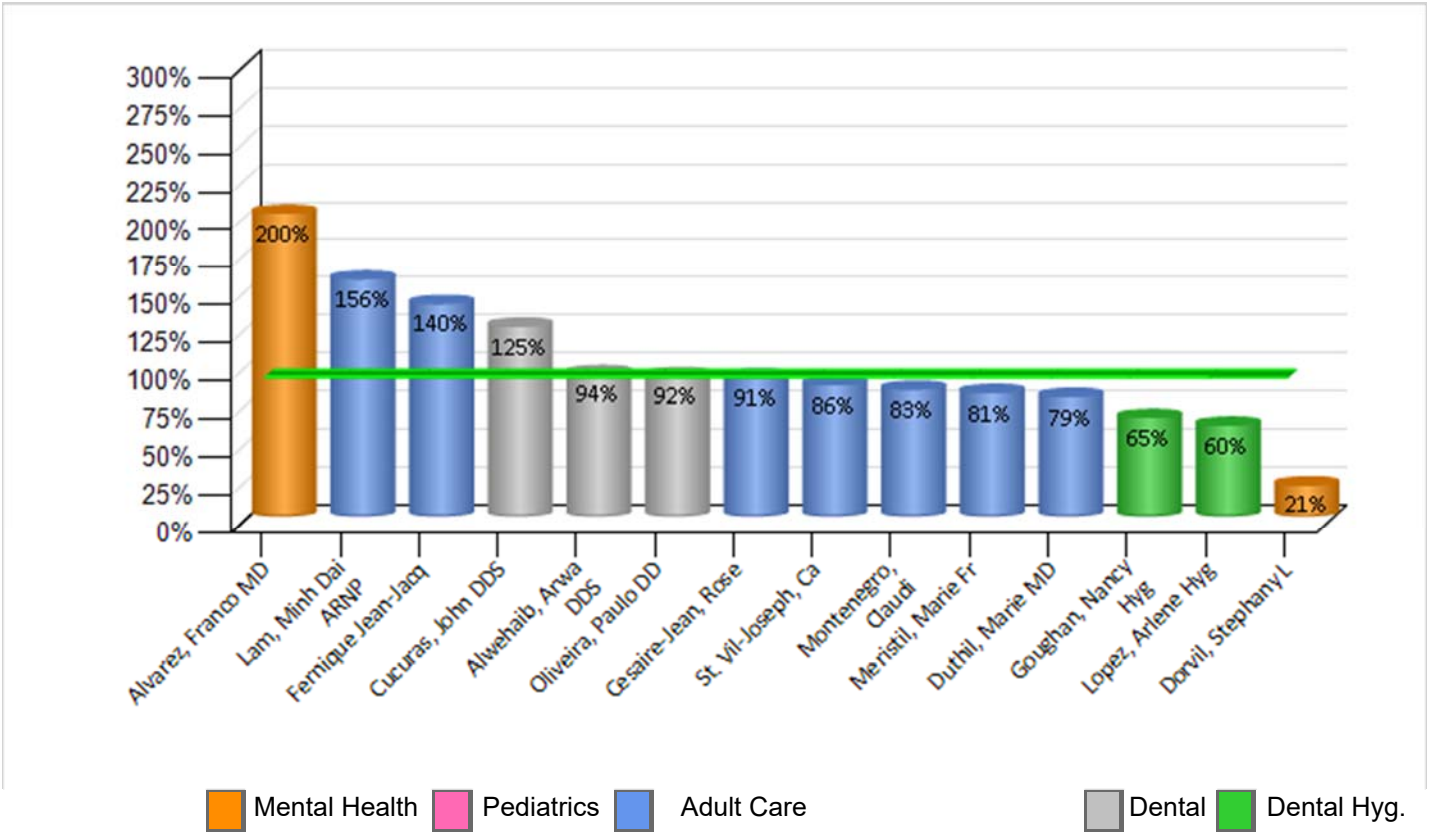


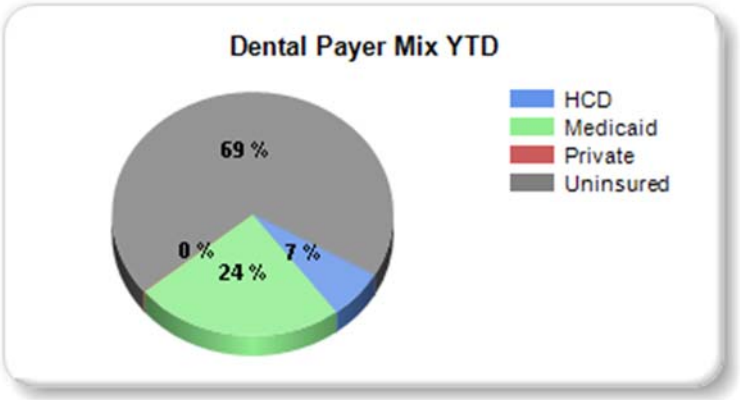


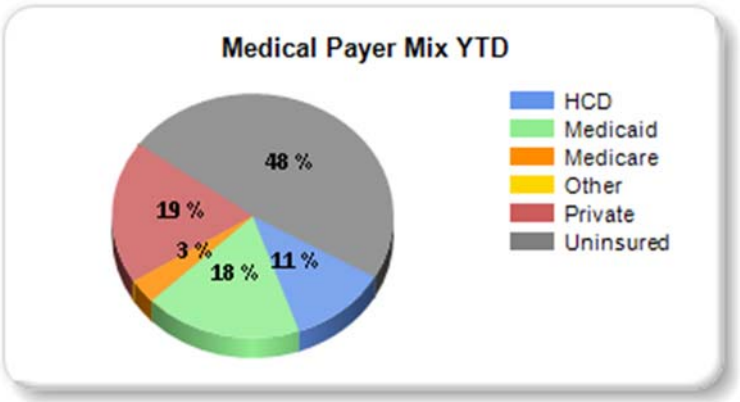
DELRAY BEACH TOTALS FOR DECEMBER 2019

	Daily Target	Days Worked	Target for the month	Total for month seen	% Monthly Target Achieved	Daily Average
ADULT CARE						
Lam, Minh Dai ARNP	16	1.0	16	25	156%	25.0
Fernique Jean-Jacques, ARNP	10	1.0	10	14	140%	14.0
Cesaire-Jean, Rose Carline ARNP	16	19.5	312	285	91%	14.6
St. Vil-Joseph, Carline ARNP	16	16.5	264	228	86%	13.8
Montenegro, Claudia DO	18	18.0	324	270	83%	15.0
Meristil, Marie Frantzcia ARNP	16	1.0	16	13	81%	13.0
Duthil, Marie MD	18	13.0	234	184	79%	14.2
DELRAY BEACH ADULT CARE TOTALS		**70.0**	**1176**	**1019**	**87%**	
MENTAL HEALTH						
Alvarez, Franco MD	1	0.5	1	1	200%	2.0
Dorvil, Stephany LCSW	10	19.5	195	40	21%	2.1
DELRAY BEACH MENTAL HEALTH TOTALS		**20.0**	**196**	**41**	**21%**	
DENTAL						
Cucuras, John DDS	16	1.0	16	20	125%	20.0
Alwehaib, Arwa DDS	16	18.0	288	270	94%	15.0
Oliveira, Paulo DDS	16	15.5	248	229	92%	14.8
DELRAY BEACH DENTAL TOTALS		**34.5**	**552**	**519**	**94%**	
DENTAL HYGIENE						
Goughan, Nancy Hyg	8	12.5	100	65	65%	5.2
Lopez, Arlene Hyg	8	2.5	20	12	60%	4.8
DELRAY BEACH DENTAL HYGIENE TOTALS		**15.0**	**120**	**77**	**64%**	
DELRAY BEACH TOTALS		**139.5**	**2044**	**1656**	**81%**	

DELRAY BEACH PROVIDER PRODUCTIVITY DECEMBER 2019





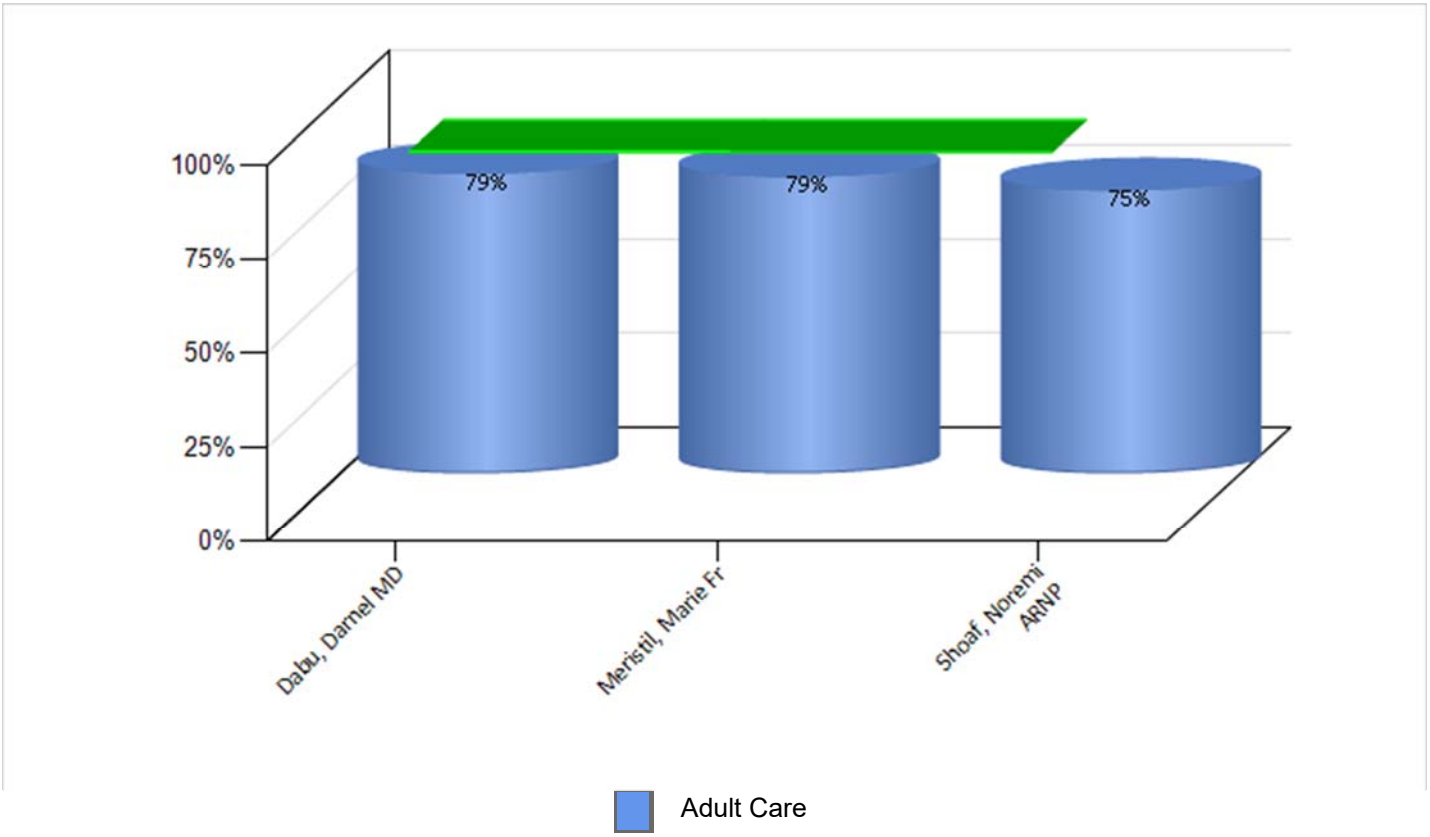


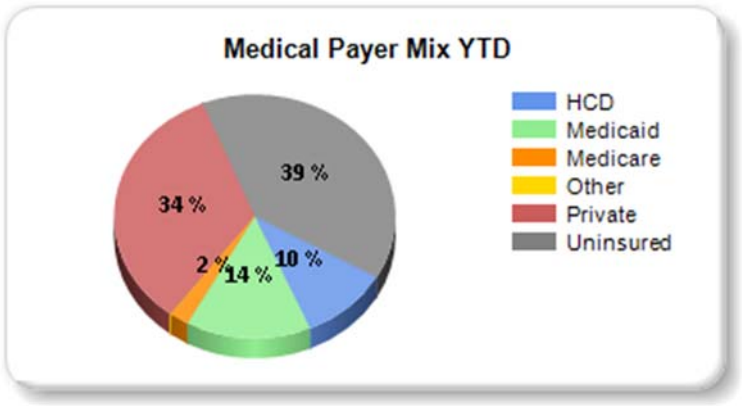
JUPITER TOTALS FOR DECEMBER 2019

	Daily Target	Days Worked	Target for the month	Total for month seen	% Monthly Target Achieved	Daily Average
ADULT CARE						
Dabu, Darnel MD	18	13.5	243	193	79%	14.3
Meristil, Marie Frantzcia ARNP	16	3.5	56	44	79%	12.6
Shoaf, Noremi ARNP	16	15.0	240	180	75%	12.0
JUPITER ADULT CARE TOTALS		**32.0**	**539**	**417**	**77%**	

JUPITER TOTALS		**32.0**	**539**	**417**	**77%**	

JUPITER PROVIDER PRODUCTIVITY DECEMBER 2019

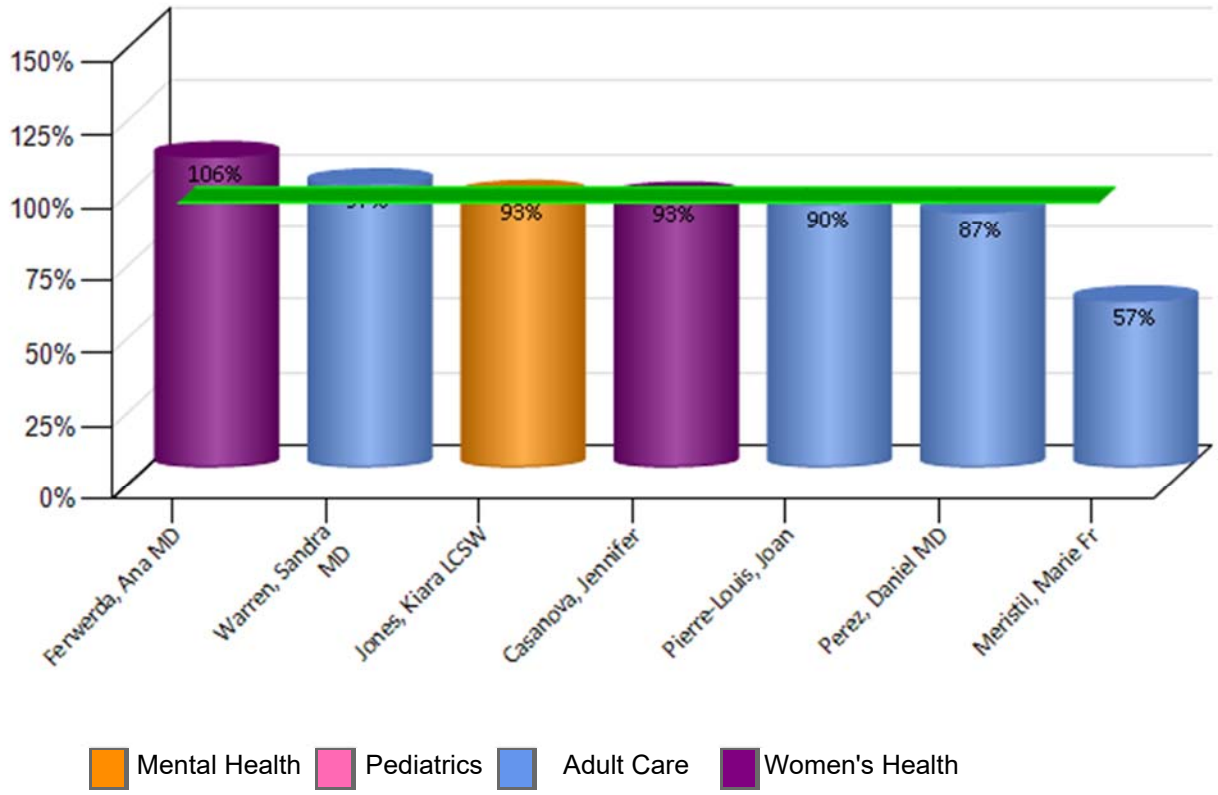


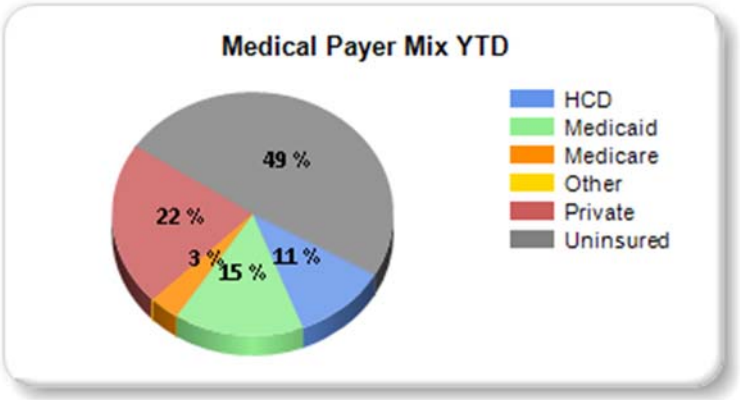


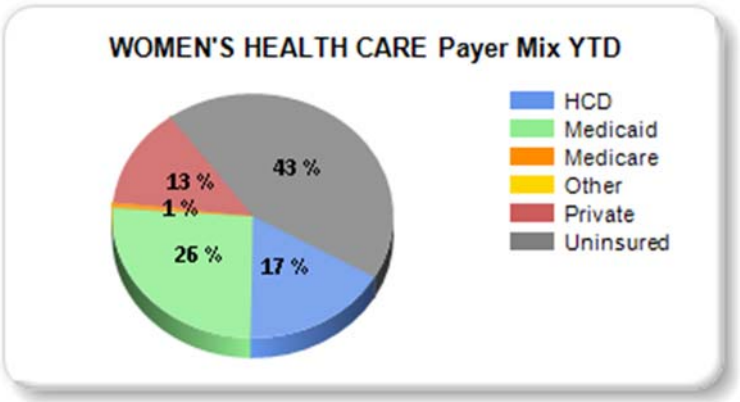
LAKE WORTH TOTALS FOR DECEMBER 2019

	Daily Target	Days Worked	Target for the month	Total for month seen	% Monthly Target Achieved	Daily Average
ADULT CARE						
Warren, Sandra MD	18	15.5	279	271	97%	17.5
Pierre-Louis, Joanne ARNP	16	17.5	280	253	90%	14.5
Perez, Daniel MD	18	18.5	333	291	87%	15.7
Meristil, Marie Frantzcia ARNP	16	15.0	240	136	57%	9.1
LAKE WORTH ADULT CARE TOTALS		**66.5**	**1132**	**951**	**84%**	
WOMEN'S HEALTH CARE						
Ferwerda, Ana MD	18	6.0	108	115	106%	19.2
Casanova, Jennifer, ARNP	16	16.0	256	237	93%	14.8
LAKE WORTH WOMEN'S HEALTH CARE TOTALS		**22.0**	**364**	**352**	**97%**	
MENTAL HEALTH						
Jones, Kiara LCSW	10	17.5	175	163	93%	9.3
LAKE WORTH MENTAL HEALTH TOTALS		**17.5**	**175**	**163**	**93%**	
LAKE WORTH TOTALS		**106.0**	**1671**	**1466**	**88%**	

LAKE WORTH PROVIDER PRODUCTIVITY DECEMBER 2019



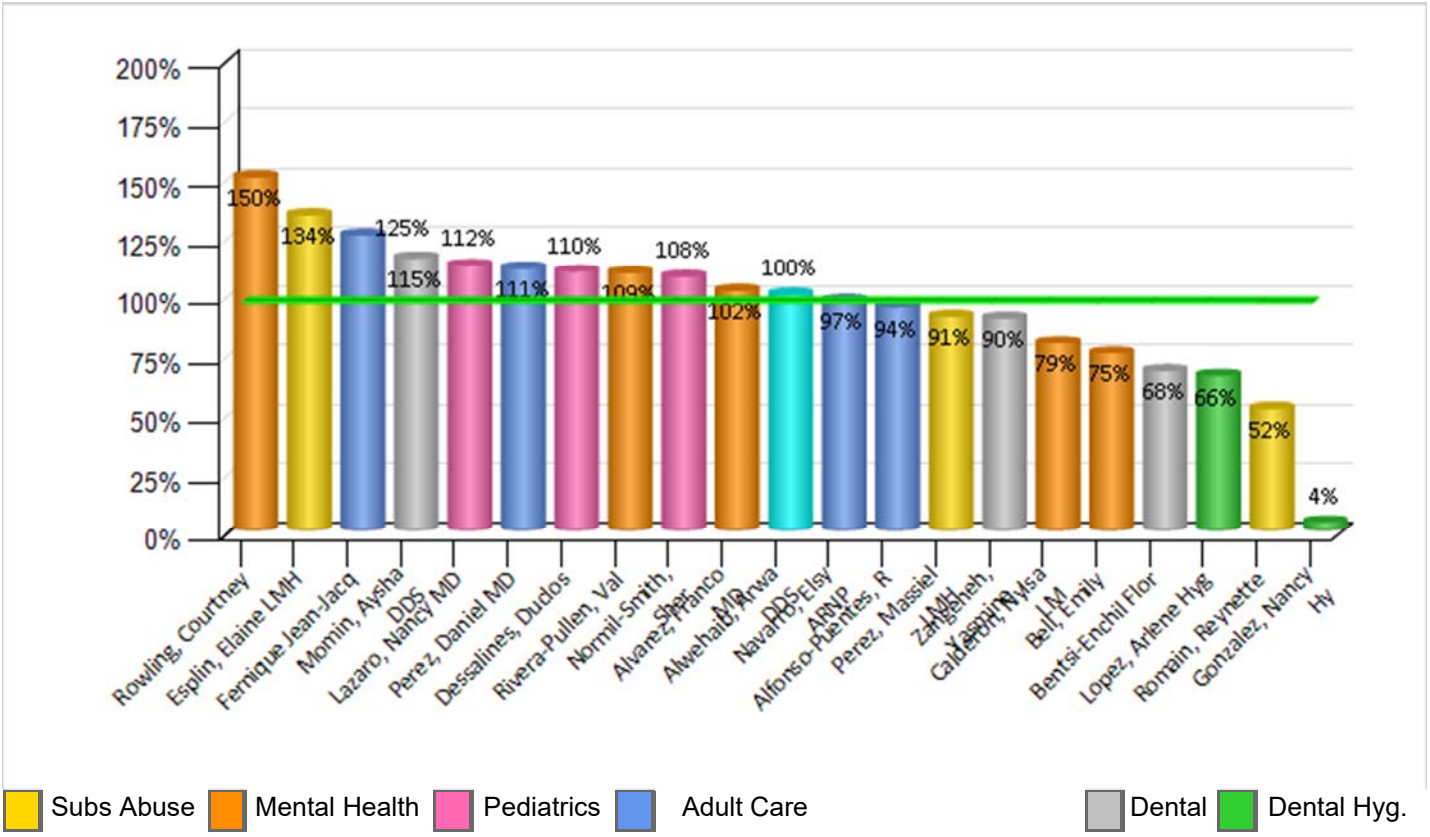


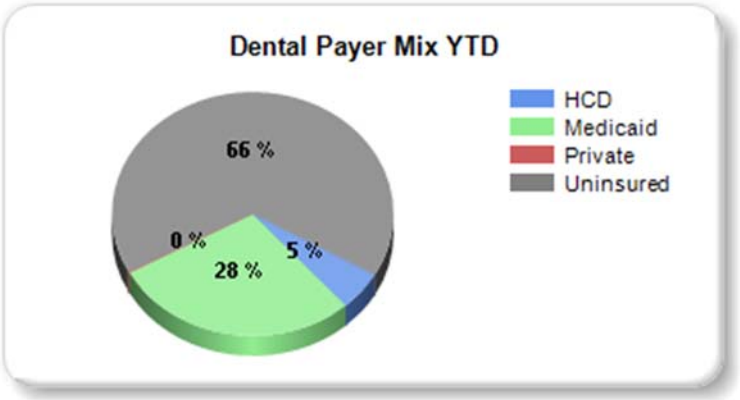


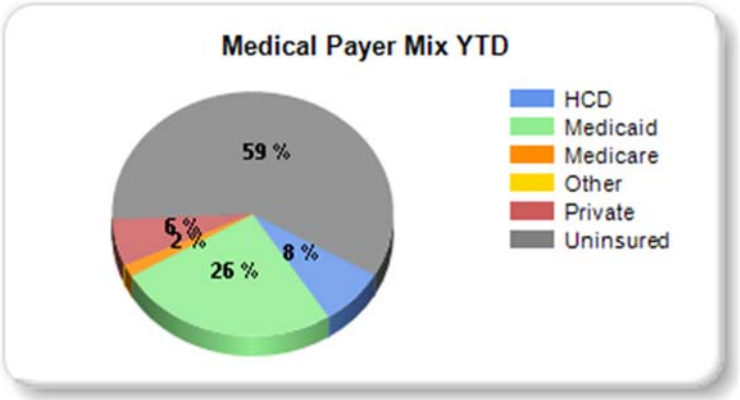
LANTANA TOTALS FOR DECEMBER 2019

	Daily Target	Days Worked	Target for the month	Total for month seen	% Monthly Target Achieved	Daily Average
ADULT CARE						
Fernique Jean-Jacques, ARNP	10	19.0	190	238	125%	12.5
Perez, Daniel MD	18	0.5	9	10	111%	20.0
Navarro, Elsy ARNP	16	20.5	328	319	97%	15.6
Alfonso-Puentes, Ramiro MD	18	14.0	252	238	94%	17.0
LANTANA ADULT CARE TOTALS		**54.0**	**779**	**805**	**103%**	
PEDIATRIC CARE						
Lazaro, Nancy MD	18	14.0	252	283	112%	20.2
Dessalines, Duclos MD	18	12.0	216	237	110%	19.8
Normil-Smith, Sherloune MD	18	17.5	315	339	108%	19.4
LANTANA PEDIATRIC CARE TOTALS		**43.5**	**783**	**859**	**110%**	
MENTAL HEALTH						
Rowling, Courtney MD	16	1.0	16	24	150%	24.0
Rivera-Pullen, Valerie LCSW	10	18.5	185	202	109%	10.9
Alvarez, Franco MD	16	4.0	64	65	102%	16.3
Calderon, Nylsa LMHC	10	13.0	130	103	79%	7.9
Bell, Emily	16	8.5	136	102	75%	12.0
LANTANA MENTAL HEALTH TOTALS		**45.0**	**531**	**496**	**93%**	
SUBSTANCE ABUSE						
Esplin, Elaine LMHC	10	11.5	115	154	134%	13.4
Perez, Massiel LMHC	10	9.5	95	86	91%	9.1
Romain, Reynette	10	8.5	85	44	52%	5.2
LANTANA SUBSTANCE ABUSE TOTALS		**29.5**	**295**	**284**	**96%**	
DENTAL						
Momin, Aysha DDS	16	17.0	272	314	115%	18.5
Alwehaib, Arwa DDS	16	1.0	16	16	100%	16.0
Zangeneh, Yasmine DDS	13	9.0	117	105	90%	11.7
Bentsi-Enchil Flora DDS	16	2.5	40	27	68%	10.8
LANTANA DENTAL TOTALS		**29.5**	**445**	**462**	**104%**	
DENTAL HYGIENE						
Lopez, Arlene Hyg	8	14.5	116	76	66%	5.2
Gonzalez, Nancy Hyg	8	10.5	84	3	4%	0.3
LANTANA DENTAL HYGIENE TOTALS		**25.0**	**200**	**79**	**40%**	
LANTANA TOTALS		**226.5**	**3033**	**2985**	**98%**	

LANTANA PROVIDER PRODUCTIVITY DECEMBER 2019



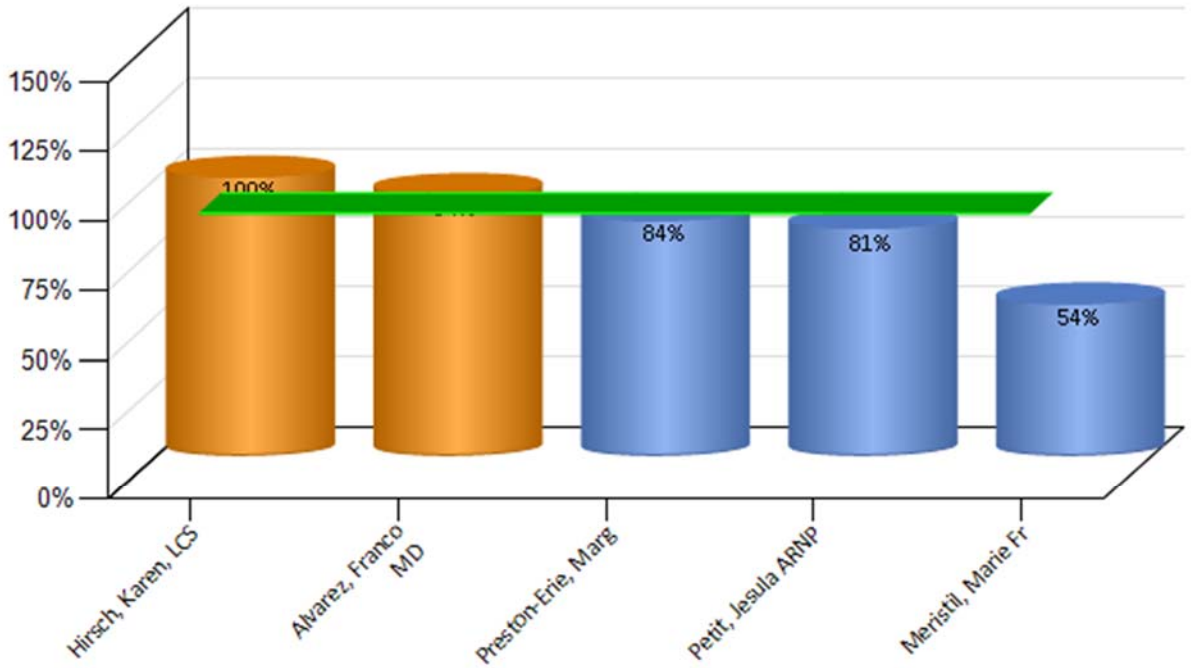




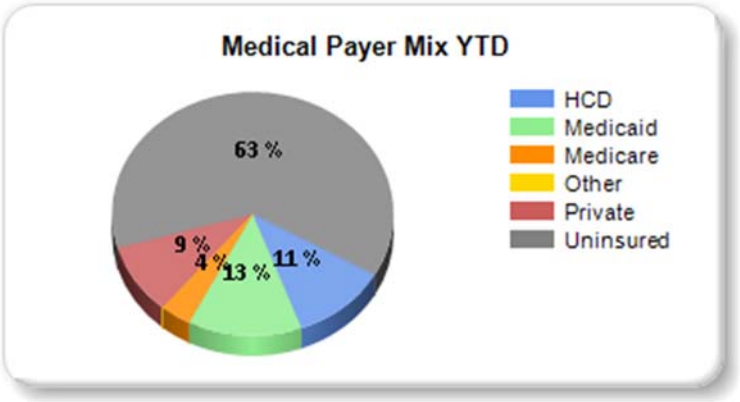
LEWIS CENTER TOTALS FOR DECEMBER 2019

	Daily Target	Days Worked	Target for the month	Total for month seen	% Monthly Target Achieved	Daily Average
ADULT CARE						
Preston-Erie, Margareth ARNP	16	14.0	224	189	84%	13.5
Petit, Jesula ARNP	16	2.0	32	26	81%	13.0
Meristil, Marie Frantzcia ARNP	16	3.0	48	26	54%	8.7
LEWIS CENTER ADULT CARE TOTALS		**19.0**	**304**	**241**	**79%**	
MENTAL HEALTH						
Hirsch, Karen, LCSW	10	0.5	5	5	100%	10.0
Alvarez, Franco MD	16	14.0	224	210	94%	15.0
LEWIS CENTER MENTAL HEALTH TOTALS		**14.5**	**229**	**215**	**94%**	
LEWIS CENTER TOTALS		**33.5**	**533**	**456**	**86%**	

LEWIS CENTER PROVIDER PRODUCTIVITY DECEMBER 2019



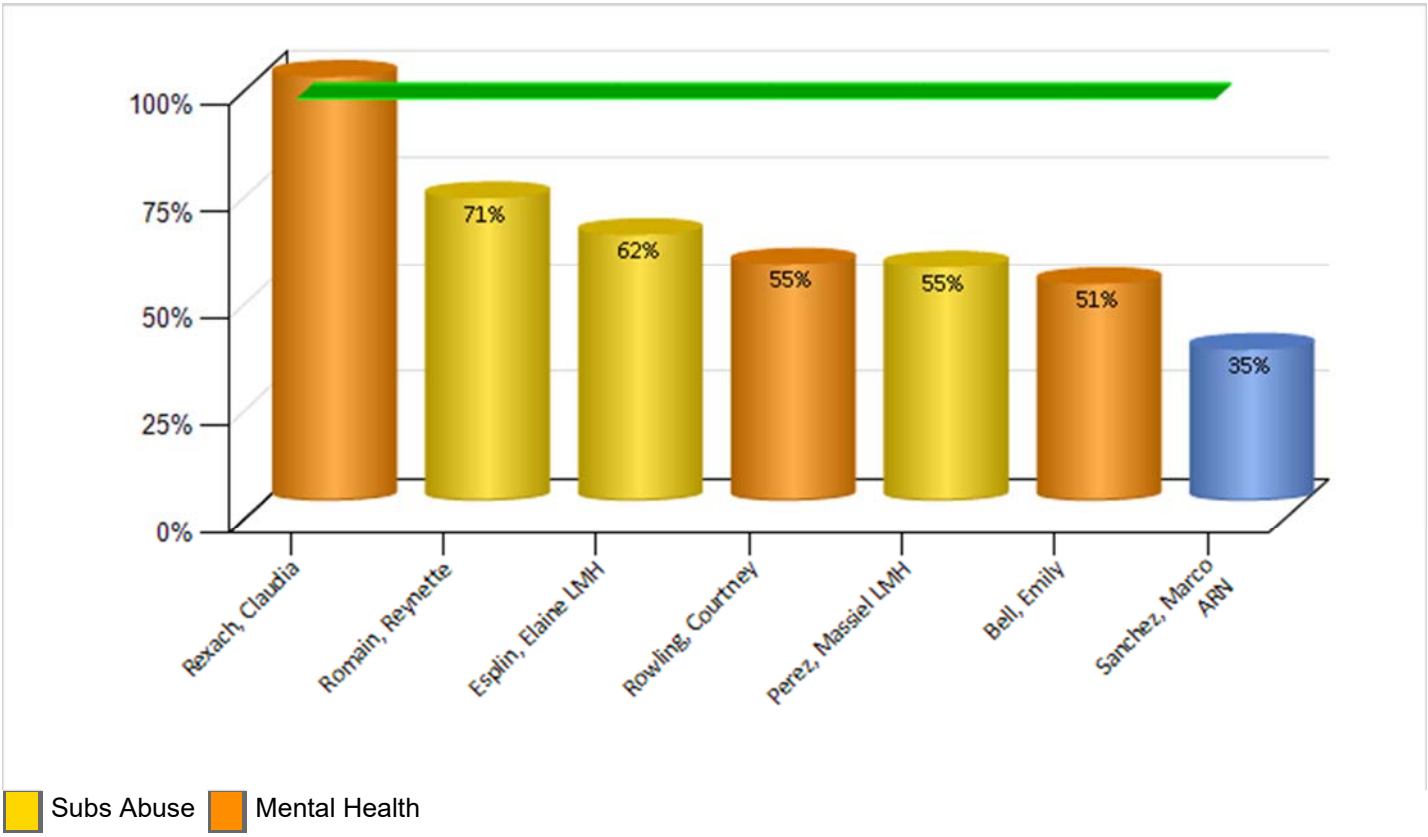
Mental Health Adult Care



MANGONIA PARK TOTALS FOR DECEMBER 2019

	Daily Target	Days Worked	Target for the month	Total for month seen	% Monthly Target Achieved	Daily Average
ADULT CARE						
Sanchez, Marco ARNP	10	16.5	165	58	35%	3.5
MANGONIA PARK ADULT CARE TOTALS		**16.5**	**165**	**58**	**35%**	
MENTAL HEALTH						
Rexach, Claudia	8	14.5	116	115	99%	7.9
Rowling, Courtney MD	16	9.5	152	84	55%	8.8
Bell, Emily	16	12.0	192	97	51%	8.1
MANGONIA PARK MENTAL HEALTH TOTALS		**36.0**	**460**	**296**	**64%**	
SUBSTANCE ABUSE						
Romain, Reynette	10	12.0	120	85	71%	7.1
Esplin, Elaine LMHC	10	9.0	90	56	62%	6.2
Perez, Massiel LMHC	10	5.5	55	30	55%	5.5
MANGONIA PARK SUBSTANCE ABUSE TOTALS		**26.5**	**265**	**171**	**65%**	
MANGONIA PARK TOTALS		**79.0**	**890**	**525**	**59%**	

MANGONIA PARK PROVIDER PRODUCTIVITY DECEMBER 2019



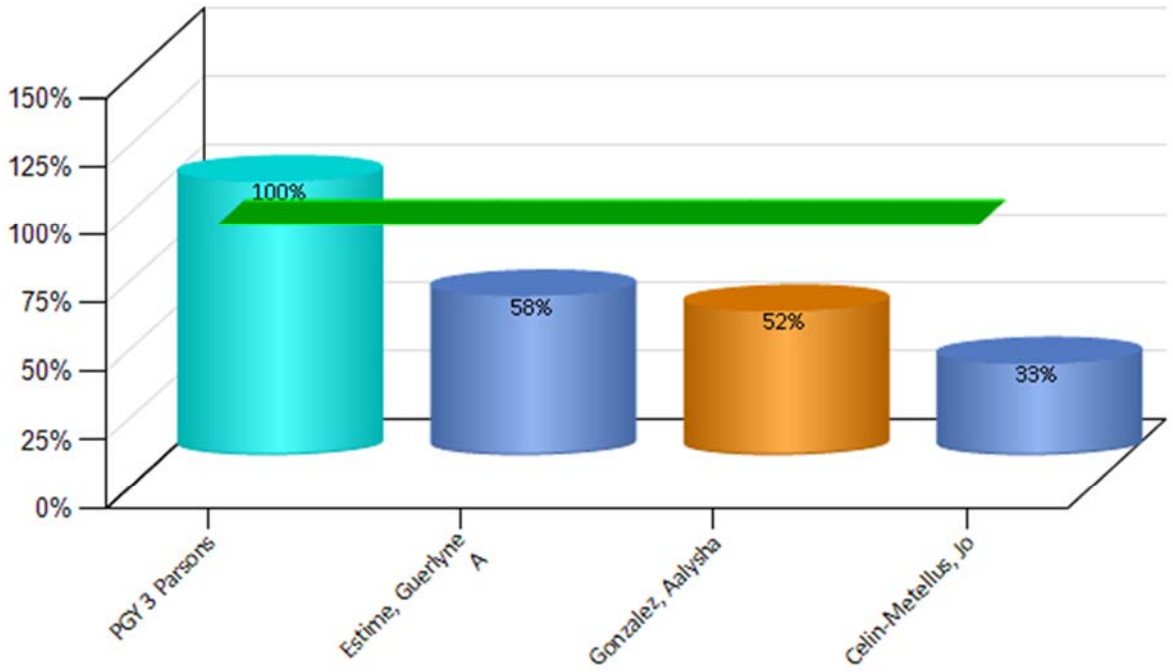
MOBILE CLINIC TOTALS FOR DECEMBER 2019

	Daily Target	Days Worked	Target for the month	Total for month seen	% Monthly Target Achieved	Daily Average
RESIDENT						
PGY 3 Parsons	5	1.0	5	5	100%	5.0
MOBILE CLINIC RESIDENT TOTALS		**1.0**	**5**	**5**	**100%**	
ADULT CARE						
Estime, Guerlyne ARNP	12	18.0	216	125	58%	6.9
Celin-Metellus, Jourdine ARNP	12	0.5	6	2	33%	4.0
MOBILE CLINIC ADULT CARE TOTALS		**18.5**	**222**	**127**	**57%**	
MENTAL HEALTH						
Gonzalez, Aalysha LCSW	10	14.5	145	76	52%	5.2
MOBILE CLINIC MENTAL HEALTH TOTALS		**14.5**	**145**	**76**	**52%**	
MOBILE CLINIC TOTALS		**34.0**	**372**	**208**	**56%**	

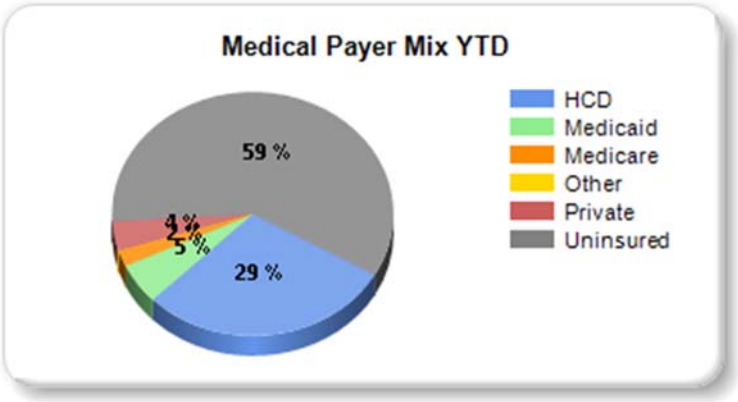
173 total homeless visits for December

Belle Glade Loading Ramp	5
Delray Beach Library	19
Palm Beach State College	2
St. Ann's Place	48
St. George's Center	10
The Lord's Place	89

MOBILE CLINIC PROVIDER PRODUCTIVITY DECEMBER 2019



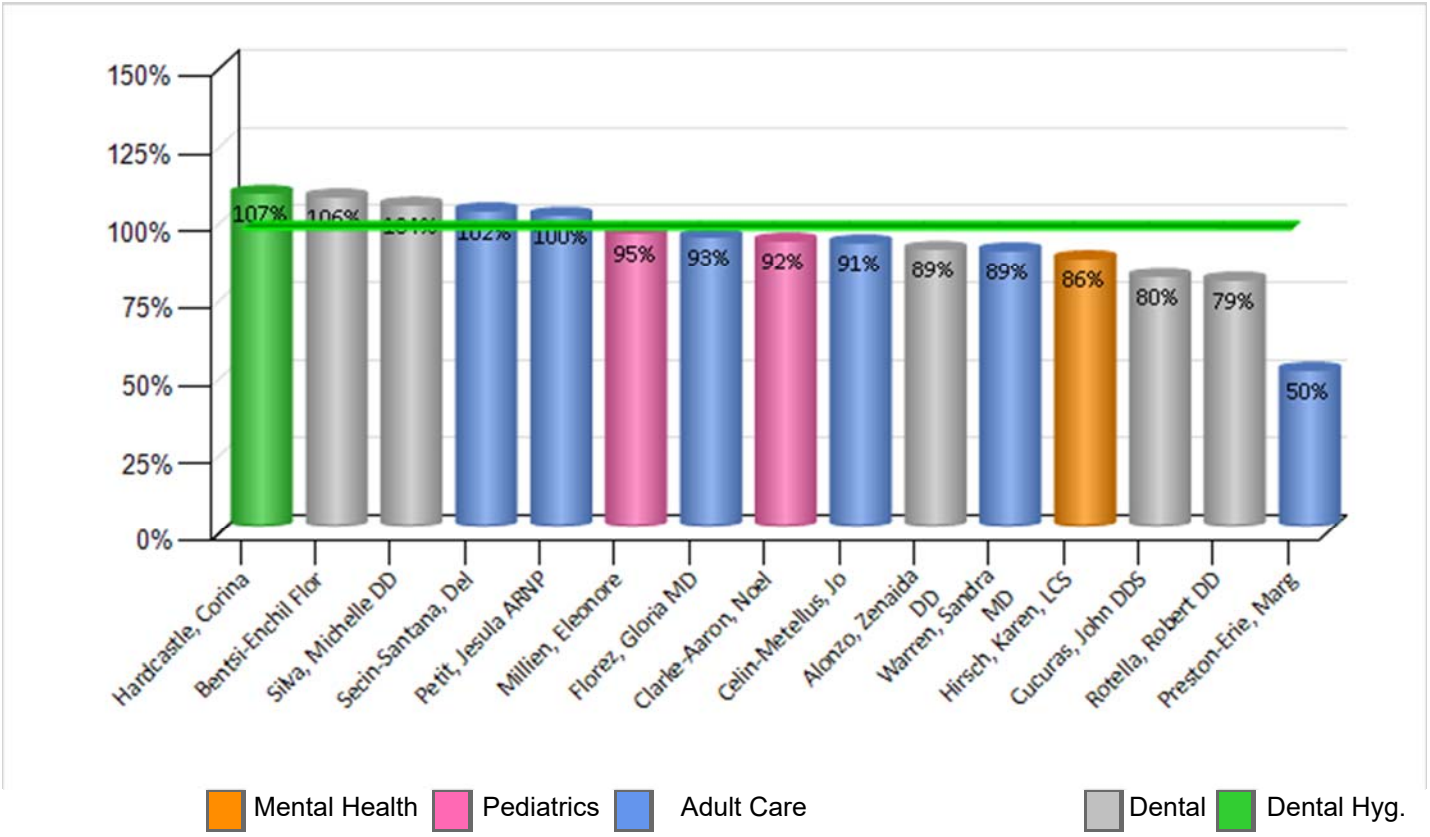
Mental Health Adult Care Women's Health

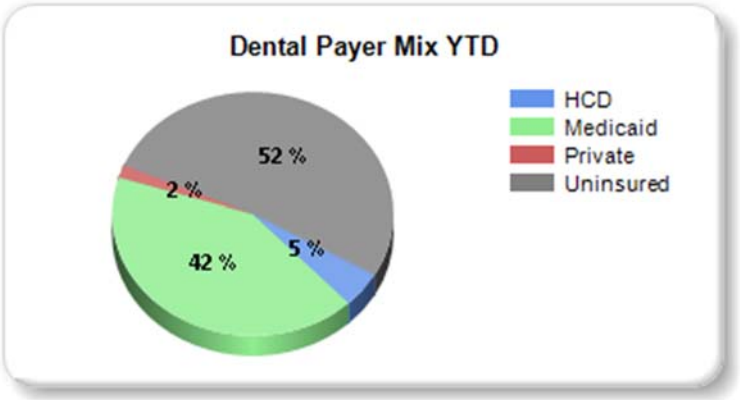


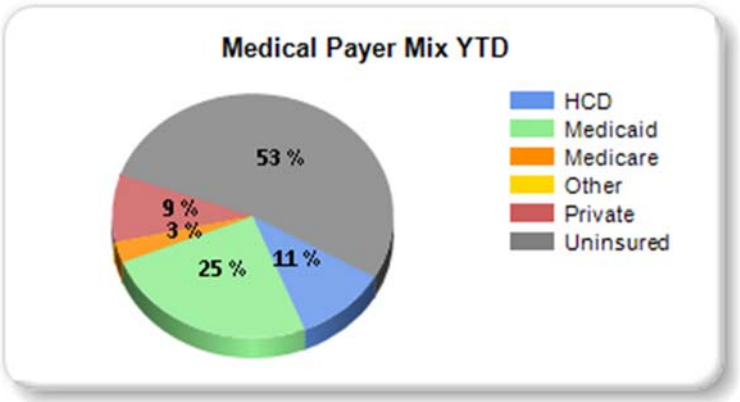
WEST PALM BEACH TOTALS FOR DECEMBER 2019

	Daily Target	Days Worked	Target for the month	Total for month seen	% Monthly Target Achieved	Daily Average
ADULT CARE						
Secin-Santana, Delvis MD	16	20.5	328	334	102%	16.3
Petit, Jesula ARNP	16	17.5	280	281	100%	16.1
Florez, Gloria MD	18	14.0	252	235	93%	16.8
Celin-Metellus, Jourdine ARNP	16	17.5	280	256	91%	14.6
Warren, Sandra MD	18	0.5	9	8	89%	16.0
Preston-Erie, Margareth ARNP	16	0.5	8	4	50%	8.0
WEST PALM BEACH ADULT CARE TOTALS		**70.5**	**1157**	**1118**	**97%**	
PEDIATRIC CARE						
Millien, Eleonore ARNP	16	14.0	224	212	95%	15.1
Clarke-Aaron, Noella MD	18	19.5	351	323	92%	16.6
WEST PALM BEACH PEDIATRIC CARE TOTALS		**33.5**	**575**	**535**	**93%**	
MENTAL HEALTH						
Hirsch, Karen, LCSW	10	19.0	190	164	86%	8.6
WEST PALM BEACH MENTAL HEALTH TOTALS		**19.0**	**190**	**164**	**86%**	
DENTAL						
Bentsi-Enchil Flora DDS	16	1.0	16	17	106%	17.0
Silva, Michelle DDS	10	11.0	110	114	104%	10.4
Alonzo, Zenaida DDS	16	14.0	224	200	89%	14.3
Cucuras, John DDS	16	9.5	152	122	80%	12.8
Rotella, Robert DDS	16	16.5	264	209	79%	12.7
WEST PALM BEACH DENTAL TOTALS		**52.0**	**766**	**662**	**86%**	
DENTAL HYGIENE						
Hardcastle, Corina	8	13.5	108	116	107%	8.6
WEST PALM BEACH DENTAL HYGIENE TOTALS		**13.5**	**108**	**116**	**107%**	
WEST PALM BEACH TOTALS		**188.5**	**2796**	**2595**	**93%**	

WEST PALM BEACH PROVIDER PRODUCTIVITY DECEMBER 2019







DISTRICT CLINIC HOLDINGS, INC.
BOARD OF DIRECTORS
February 26, 2020

1. Description: Licensed Independent Practitioner Credentialing and Privileging

2. Summary:

The agenda item represents the licensed independent practitioner(s) recommended for credentialing and privileging by the FQHC Medical Director.

3. Substantive Analysis:

The LIP(s) listed below satisfactorily completed the credentialing and privileges process and met the standards set forth within the approved Credentialing and Privileging Policy. The credentialing and privileging process ensures that all health center practitioners meet specific criteria and standards of professional qualifications. This criterion includes, but is not limited to:

- Current licensure, registration or certification
- Relevant education, training and experience
- Current clinical competence
- Health fitness, or ability to perform the requested privileges
- Malpractice history (NPDB query)
- Immunization and PPD status; and
- Life support training (BLS)

Last Name	First Name	Degree	Specialty	Credentialing
Bannon	Lori	APRN	Family Medicine Nurse Practitioner	Initial Credentialing

Primary source and secondary source verifications were performed for credentialing and privileging elements in accordance with state, federal and HRSA requirements. A Nationally accredited Credentials Verification Organization (CVO) was utilized to verify the elements requiring primary source verification.

The C.L. Brumback Primary Care Clinics utilized internal Credentialing staff and the FQHC medical Director to support the credentialing and privileging process.

Lori Bannon, APRN is joining the Mangonia Park Clinic as a Nurse Practitioner specializing in Family Medicine. She attended South University and is certified as an Adult Gerontology Primary Care Nurse Practitioner by the American Academy of Nurse Practitioners. Ms. Bannon has been in practice for four years.

4. Fiscal Analysis & Economic Impact Statement:

	Amount	Budget
Capital Requirements		Yes ☐ No ☒
Annual Net Revenue		Yes ☐ No ☒
Annual Expenditures		Yes ☐ No ☒

Reviewed for financial accuracy and compliance with purchasing procedure:

N/A

Joel H. Snook, CPA
Chief Financial Officer

5. Reviewed/Approved by Committee:

N/A

Committee Name

Date Approved

6. Recommendation:

Staff recommends the Board approve the initial credentialing and privileging of Lori Bannon, APRN, Family Nurse Practitioner.

Approved for Legal sufficiency:

Valerie Shahriari
VP & General Counsel

Sarah Gonzalez

Sarah Gonzalez, CPMSM, CPC
Director, Credentialing & Provider Services

Dr. Belma Andric
Chief Medical Officer, VP & Executive Director of Clinic Services

DISTRICT CLINIC HOLDINGS, INC.
BOARD OF DIRECTORS
February 26, 2020

1. Description: Credentialing and Privileging Policy

2. Summary:

The agenda item represents the revised C.L. Brumback Primary Care Clinics Credentialing and Privileging Policy. As the ultimate authority, the Board shall review and approve all changes to the policy.

3. Substantive Analysis:

The purpose of the Credentialing and Privileging Policy is to establish a written process for the credentialing and privileging of health center practitioners, employed or contracted, volunteers and locum tenens at all heath care sites in accordance with state, federal and HRSA requirements.

The C.L. Brumback Primary Care Clinics established a credentialing and privileging policy to ensure health center practitioners meet specific criteria and standards for professional qualifications. Credentialing and privileging is performed for health center practitioners at the time of hire, prior to the practitioner providing patient care services and every two (2) years thereafter.

The revisions to the Credentialing and Privileging Policy include, but are not limited to, the addition of a new Other Clinic Staff (OCS) category for individuals for which licensure or certification is not required and who are not permitted by law to provider patient care services without direction or supervision; and the use of a Credentials Verification Organization (CVO) to perform primary source verification of credentialing elements.

4. Fiscal Analysis & Economic Impact Statement:

	Amount	Budget
Capital Requirements	N/A	Yes ☐ No ☒
Annual Net Revenue	N/A	Yes ☐ No ☒
Annual Expenditures	N/A	Yes ☐ No ☒

Reviewed for financial accuracy and compliance with purchasing procedure:

N/A

Joel H. Snook, CPA
Chief Financial Officer

DISTRICT CLINIC HOLDINGS, INC.
BOARD OF DIRECTORS
February 26, 2020

5. Reviewed/Approved by Committee:

N/A	
Committee Name	Date Approved

6. Recommendation:

Staff recommends the Board approve the Credentialing and Privileging Policy as revised.

Approved for Legal sufficiency:

Valerie Shahriari
VP & General Counsel

Sarah Gonzalez

Sarah Gonzalez, CPMSM, CPC
Director, Credentialing & Provider Services

Dr. Belma Andric
Chief Medical Officer, VP & Executive Director
of Clinic Services

C. L. Brumback
Primary Care Clinics
Health Care District Palm Beach County

Credentialing and Privileging Policy

Policy #:	600-17	Effective Date:	4/23/2013
Business Unit:	Primary Care Clinics	Last Review Date:	1/15/2020
Approval Group:	PCC Credentialing Policy Board Approval	Document Owner(s):	Credentialing
Board Approval Date:	2/26/2020		

PURPOSE

It is the policy of the C.L. Brumback Primary Care Clinics to credential and privilege health center practitioners, employed or contracted, volunteers and locum tenens at all health care sites in accordance with state, federal and HRSA requirements.

SCOPE

This policy applies to all C.L. Brumback Primary Care Clinics practitioners, employed or contracted, volunteers and locum tenens, at all health center sites.

POLICY

Credentialing and privileging will be performed for health center practitioners at the time of hire, prior to the practitioner providing patient care services, and every two (2) years thereafter.

Categories of health center practitioners.

1. Licensed Independent Practitioner (LIP) – an individual permitted by law to provide care and services without direction or supervision, within the scope of the individual practitioner's license and consistent with individually granted privileges. C.L. Brumback Primary Care Clinics defines the following practitioners as LIP's:
    - Physician
    - Dentist
    - Nurse Practitioner
    - Nurse Midwife

2. Other Licensed or Certified Health Care Practitioner (OLCP) – an individual who is licensed, registered, or certified, but is not permitted by law to provide patient care services without direction or supervision. C.L. Brumback Primary Care Clinics defines the following practitioners as OLCP's:
    - Registered Nurse
    - Licensed Practical Nurse
    - Certified and/or Registered Medical Assistant
    - Certified and/or Registered Dental Assistant
    - Licensed Dental Hygienist
    - Certified Mental Health Counselor
    - Licensed Clinical Social Worker
    - Medical Resident

3. Other Clinical Staff (OCS) – an individual for which licensure or certification is not required and who is not permitted by law to provide patient care services without direction or supervision. C.L. Brumback Primary Care Clinics defines the following practitioners as OCS:
    - Medical Assistant
    - Dental Assistant
    - Community Health Worker

The C.L. Brumback Primary Care Clinics Board of Directors has the ultimate authority and responsibility for the provisions of this policy. The Board of Directors shall review and approve any changes to the policy and at a minimum, shall review the policy every three (3) years.

The Medical Director/Dental Director/Women's Health Director/Behavioral Health Director shall oversee the credentialing and privileging activities, provide clinical leadership and direction to credentialing staff, credential other licensed or certified health care practitioners and make credentialing and privileging recommendations of licensed independent practitioners to the Board. The C.L. Brumback Primary Care Clinics may utilize a Credentials Verification Organization (CVO) to perform primary source verification of credentialing elements in accordance with regulatory requirements.

EXCEPTIONS

N/A

RELATED DOCUMENTS

Related Policy Document(s)	Credentialing and Policy Procedure
Related Forms	
Reference(s)	HRSA FTCA Program Assistance Letter (PAL)
Last Revision	1/15/2020
Revision Information/Changes	
Next Review Date	1/15/2023

This policy is only intended to serve as a general guideline to assist staff in the delivery of patient care; it does not create standard(s) of care or standard(s) of practice. The final decision(s) as to patient management shall be based on the professional judgement of the health care providers(s) involved with the patient, taking into account the circumstances at that time. Any references are to sources, some parts of which were reviewed in connection with formulation of the policy/procedure. The references are not adopted in whole or in part by the hospital(s) or clinic(s) / provider(s).

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DISTRICT CLINIC HOLDINGS, INC.
BOARD OF DIRECTORS
February 26, 2020

1. Description: Quality Reports & Updated QI Plan

2. Summary:

This agenda item provides the following:

- Quality Council Minutes January 2020
- UDS Report – YTD December 2019
- QI Plan & Work Plan

3. Substantive Analysis:

PATIENT SAFETY & ADVERSE EVENTS
Patient safety and risk, including adverse events, peer review and chart review are brought to the board "under separate cover" on a quarterly basis.

PATIENT SATISFACTION & GRIEVANCES
C. L. Brumback Primary Care Clinics is in the process of establishing a standardized chart review process for all patient grievances in order to identify possible areas of improvement.

QUALITY ASSURANCE & IMPROVEMENT
Of the 14 UDS Measures; 8 exceeded the HRSA Goal and 6 were short of the HRSA Goal.

Adult weight screening, Tobacco screening, Asthma therapy, Depression Screening and Follow-up, Coronary Artery Disease, Ischemic Vascular Disease, HIV Linkage to Care, Dental Sealants measures were met. We will strive to improve and attempt to achieve even higher goals for 2020.

The childhood immunization measure was not met in 2019, but improved 10% when compared to 2018. Other measures not met were Cervical Cancer Screening, Weight Counseling for children and adolescents, Controlling High Blood Pressure and Uncontrolled Diabetes.

As previously discussed we will be reporting data on special populations including migrant, and homeless as well as focusing on social determinants of health with the goal of identifying and eliminating barriers to improvement.

UTILIZATION OF HEALTH CENTER SERVICES
No updates.

4. Fiscal Analysis & Economic Impact Statement:

	Amount	Budget
Capital Requirements	**N/A**	Yes ☐ No ☒
Annual Net Revenue	**N/A**	Yes ☐ No ☒
Annual Expenditures	**N/A**	Yes ☐ No ☒

Reviewed for financial accuracy and compliance with purchasing procedure:

N/A

Joel Snook
Chief Financial Officer

5. Reviewed/Approved by Committee:

N/A
Committee Name

Date Approved

6. Recommendation:

Staff recommends the Board Approve the Quality Council minutes, YTD UDS Report and updated QI Plan.

Approved for Legal sufficiency:

Valerie Shahriari
General Counsel

Dr. Ana Ferwerda
FQHC Medical Director

Dr. Belma Andric
Chief Medical Officer, VP & Executive Director of Clinic Services

C. L. Brumback
Primary Care Clinics
Health Care District Palm Beach County

Quality Council Meeting Minutes
Date: January 17, 2020
Time: 1:00pm – 3:00pm

Attendees: Dr. John Cucuras - Dental Director; Dr. Ana Ferwerda – Interim Medical Director & Director of Women's Health; David Speciale – Patient Experience Manager; Dr. Duclos Dessalines – Director of Pediatrics; Hyla Fritsch – Executive Director of Clinic Operations & Pharmacy; Jonathan Dominique – Executive Assistant; Julia Bullard - Clinic Board Member; Andrea Steele – Quality Director; Dr. Courtney Rowling - Director of Behavioral Health; Belma Andric – Chief Medical Officer/Executive Director; Shauniel Brown – Risk Manager
Excused: Lisa Hogans – Director of Nursing
Minutes by: Andrea Steele

AGENDA ITEM	DISCUSSION / RECOMMENDATIONS	ACTION ITEMS (AI)	RESPONSIBLE PARTY	DATE
PATIENT RELATIONS				
OUTREACH SUMMARY	**Outreach** HRSA form 5C reviewed with clinic leadership to ensure activities are in alignment with current activities. Form 5C to be reassessed in April 2020. A holistic review of Outreach efforts is being undertaken by Operations. **Patient & Physician Relations Liaison** Patient & Physician Relations Liaison transitioned to a Certified Application Counselor. PX Manager attended one Outreach Event on 1/7/20 at Cason United Methodist Church where lunch was provided to homeless. During this time, PX Manager met with 5 established patients of the Delray Beach clinic who had questions regarding District Cares process, billing questions, and one patient provided a homeless declaration form. Consider having a CAC on the Mobile Van in Delray Beach 1 x per month.			
SURVEY RESULTS	**Patient Satisfaction Survey** In response to the 2019 Patient Satisfaction Survey results, Patient Experience (PX) Manager created and	Ensure clinics are aware of our new initiatives resulting from annual results:	David	2/21/20

	presented a Checklist to train clinic coordinators on daily tasks and objectives to improve Patient Experience. PX Manager will schedule weekly afternoon conference calls with Clinic Coordinators to review checklist and other items to be presented at next day huddles. ***(Patient Satisfaction Survey Completion report with graph presented.)*** **<u>Pediatric Operational Survey</u>** In December 2019, the "C. L. Brumback Primary Care Clinics: Pediatric Hours of Operation - Survey" was completed. There were a total of 90 surveys completed by or on behalf of Pediatric patients. Results did not support a decision to expand pediatric services at this time. Ms. Bullard suggested perhaps we need more questions for this survey or larger sample size. ***(Pediatric Operational Survey Completion report with graph presented.)***	• Improving communication • Clinic phone access • Patient wait time Consider reassessing in Q1 2020.	David	2/21/20
GRIEVANCES, COMPLIMENTS, & COMMENTS	**<u>Patient Relations Report</u>** For December there were 11 complaints (6 Delray Medical, 2 Jupiter, 1 Lantana Medical, 1 Lantana Dental, and 1 Lewis Center) and 5 grievances (1 at the Jupiter clinic, 2 at the WPB clinic, and 2 at the Boca Raton clinic). There were 10 compliments for the month, 2 at the Delray Beach Clinic and 8 at the Boca Raton clinic. Four (4) meetings have been scheduled with Clinic and HCD Leadership to mitigate top trends in patient's complaints/grievances: Communication, District Cares, Phone Service, and Patient Experience. A Patient Experience checklist was developed to help on-site coordinators with routine assessments.			

	(Master Patient Relations Report &Patient Relations Dashboard with Graphs presented.) **Thumbs Up** For December we received a total of 23 "Thumbs Up" (employee to employee) recognitions for employees that have gone above and beyond to serve patient and support team members. The 5 finalists included, Candy Jose-Referral Clerk/Home Office; Dr. Ziemba-Psychologist/Belle Glade; Norma Cash, Registration/Boca; Myriam Fils-Aime, Lead RN/Delray; and Jackcene Destine, MA/Delray. Nominees and winners notified through SnapComms communication in the clinics' shared spaces and break rooms. **SnapComms** David presented the PX Daily checklist and PX Tips, including introducing yourself by name to your patients and improving communication along all stages of the patient experience.			
QUALITY				
48-HOUR METRICS				
DENTAL	**Provider Documents and Labs Reviewed** Total of 14 unlocked charts in December. ***(48-hour metrics report with graphs presented)*** **Provider Encounters Closed Rate** *Provider (YTD)* *December* Bentsi-Enchill 36 2 Momin 25 1 Zangeneh 23 0 Oliveira 22 4 Martins 11 na	Re-educate providers on reviewing their unlocked notes at the end of each day. Dental Director will address the top three providers with unlocked notes to retrain on how to monitor the charts in order to close on time.	Dr. Cucuras Dr. Cucuras	2/21/20 2/21/20

	Gonzalez 16 1 Lopez 14 0 Yanez 10 0 Cucuras 7 1 Seminario 5 0 Alonso 4 4 Hardcastle 3 1 Rotella 3 0 Alwehaib 2 0 Alfaro 1 0 Goughan 1 0			
QUALITY METRICS				
MEDICAL	**Medical Referrals & Orders** Preliminary data for December 2019 reviewed with team. There were 23,697 orders created; 21,150 were lab while 2,231 were imaging related. There were 6,935 referrals created: • 641 are in submit status, • 4,404 were in submitted status, • 1,809 were closed. ***(Referrals & Orders presented from Tableau)***	Follow-up meeting to be scheduled to vet this preliminary data and draw conclusions about our baseline and setting goals for referral clerks.	Andrea/Hyla/ Marguerite	2/21/20
DENTAL	**Dental Referrals** Patient presented on 12-26-19 with abscessed teeth was placed on antibiotics and was advised to proceed to the ER. Patient went to the ER.	Dental Director to train providers/nurses on additional step in the process for re-routing patient cases for review.	Dr. Cucuras	2/21/20
	Dexis Image Report Staff Importing wrong full names into Dexis. • One patient was labeled in all caps.	Discuss at next Dental Team-member meeting.	Dr. Cucuras	2/21/20

	• Another Patient had a name change that wasn't documented.			
QUALITY AUDITS				
MEDICAL	**Peer Review – Adult & Women's Health** 44 charts were peer reviewed. 44 were evaluated as "within standard of care", 0 were evaluated as, "Provider Self-identified Remediation" and 10 as "Provider Education Required", 0 charts were evaluated as "Inappropriate care".	Follow-up with providers that need education. Follow-up with providers that have not completed their Q3 Peer review.	Dr. Ferwerda Dr. Ferwerda	2/21/20 2/21/20
WOMEN'S HEALTH	**Peer Review – Women's Health** 10 charts were peer reviewed. 10 were evaluated as within standard of care, 0 providers require education, and 0 were reported for inappropriate care.			
DENTAL	**New Provider Peer Review** 28 charts were peer reviewed. All 28 were within standard of care. 2 charts were marked for provider self-remediation, and 4 was evaluated as Provider Education Required. **Quality Site Visit (QSV)** In December, Nancy re-organized the logbooks and updated the autoclave training in West Palm Beach.			
BEHAVIORAL HEALTH	**New Provider Peer Review** 10 charts were peer reviewed. All 10 were within standard of care. 0 charts were marked for provider self-remediation, and 0 was evaluated as Provider Education Required.	Follow-up with provider on PHQ2/PHQ9 completion at every visit.	Dr. Rowling	2/21/20
NURSING	***Document Management***			

	It was decided that from now on 2 calls will be made by the clinical team to inform patients of a normal result. If the provider wants to send a letter to the patient with normal results they will need to populate the letter with the appropriate information: Type of test, date and body part (if U/S, MRI, etc.) MAs do not generate normal letters anymore. ***Training Institute*** Karen Gonzalez completed the first draft of the new training manual and orientation agenda. She will be using this on the new MA that is starting on 1/21/2020. Dr. Andric, Dr. Ferwerda and Lisa Hogans will meet with Karen to discuss the revisions needed and how it worked with the first new hire. **2019 Flu Shot Campaign** Vaccination administration is completed unless another team member requests the vaccine. Belle Glade clinic was the winner for the most team members vaccinated with 91%. Total of all clinic team members (working in clinics with direct patient care) vaccinated is 99 (51%). We did not track this information prior to 2019, so there is no comparison data. **Quality Site Visit (QSV)** For Q4, Lantana and Belle Glade were at a 97% compliance during Clinic Walk-thru's. Mangonia Park was a 90%. **Abnormal FIT test report**	Coleen Simon to work with Dr .Ferwerda to revise Normal Diagnostic and Normal Lab letters to include additional information. P&P Diagnostic Tracking will need to be updated to include the new process for normal lab patient notification.	Coleen/ Dr. Ferwerda Maria	2/21/20 2/21/20

	Total remaining from 2018-Feb 2019 is 0. All are followed up. The March 2019 to present log, shows: 120 including all clinics. The clinics with the highest number to be addressed =Jupiter, LKW, WPB. Nurse Manager to address with those Lead Nurses. We let American Cancer Society know that we are interested in the opportunity to have our patients receive the 15 donated colonoscopies. **Higher Level of Care** Out of the months between July and December, October and December had our lowest follow up rates. December had 90 ER referrals. 38% were seen for hospital follow up. 22% have an appt. This equals 60% who were seen or have an appt. 33% have no appt. We will look into which clinics are not following up and discuss. Records were received for 34% of patients. 32% are pending. 66% of records were received or requested. This is the lowest of the previous 6 months. ***After Hours Call Log*** We are at 97% compliance and will continue to report Quarterly. There were 59 total calls, 35 of which were paged to the on-call provider. Of the 24 that were not paged, 4 of them were thought to have been appropriate to page the provider. Sherri is having a call with the Answering Service to discuss these calls and why they weren't paged.	Coordinate with Jennifer from ACS.	Lisa	2/21/20

	Transition into Care 91 % of charts had TIC section completed. We will further audit in the future whether the MR were received after requested during TIC. ***Critical Lab Report*** December total calls were 25. 100% were addressed within 24 hours. We will continue to monitor quarterly. ***Controlled Substance Report*** 51 Reported controlled substances ordered in December (69%), 35 were verified. Dr. Ferwerda will do a re-education at the next provider meeting. Will continue to monitor monthly.	Ensure EFORSCE is a reportable field moving forward through a procedure.	Dr. Ferwerda/ Dr. Rowling	2/21/20
UDS QUALITY Measures				
December 2019 Of the **16** UDS Measures: **9** Exceeded the HRSA Goal and **7** were short of the HRSA Goal *(Clinic Score/ HRSA Goal / Healthy People Goal)*				
Medical UDS Report	**Childhood immunization:** (*52%/ 60%)*	Findings: 1. Lowest rates in Rotavirus and Influenza 2. EMR reports are not capturing patients who have completed all vaccinations as per UDS requirements. Interventions: 1. Create call list for patient access to schedule appointments for those due for vaccines. 2. Work with Athena for solution to capturing completed vaccinations as per UDS requirements.		2/21/20

	Cervical Cancer Screening: *(63% /65%)*	Findings: 1. Difficulty getting records from outside providers that have performed the screening. 2. Patients are showing as non-compliant although they did not have an encounter in the measurement year.3. QMR data is skewed due to attribution and hence duplicating patients. Interventions: 1. Develop care teams to improve efficiencies in following up on requested medical records. 2. Develop a custom report similar to FIT test. 3. Woman's Health Director provided Pap smear guidance and cervical cancer guideline updates to teams.		
	Weight assessment, Children & Adolescent: *(86% /90 %)*	Findings: 1. Providers not dropping the order group at every visit. Interventions: 1. Train providers that health education should be given at every visit regardless of reason for visit.		
	Adult Weight screening and follow up: *(98% / 90%)*			
	Tobacco use screening & cessation: *(98% / 93%)*			
	Asthma Pharmacologic Therapy: *(99%/ 99%)*			
	Coronary Artery Disease CAD: *(82% / 81%)*			
	Ischemic Vascular Disease (IVD): *(88% / 86%)*			

	Colorectal Cancer Screening: *(61% / 82%)*	Findings: 1. Difficulty in getting FIT test returned from patient. 2. Some patients may have colonoscopies in Allscripts that have not been updated in Athena. Interventions: 1. Encourage POD 2. More robust patient follow up through phone call reminders. 3. Custom report developed and dashboard created 4. Work on importing colonoscopy quality data into Athena.		
	HIV linkage: (100*% / 100%)*			
	Depression screening: *(94% / 83%)*			
	Depression screening (Homeless): *(65% / 83%)*	Findings: 1. More challenging to follow-up with homeless patients. Interventions: 1. Consider tracking by location.		
	Dental Sealant: (91% */ 75%)*			
	Hypertension: *(74% / 80%)*	Findings: 1. Providers failing to give short term follow up for uncontrolled BP 2. non-adherence to medication regimen. Interventions: 1. Reeducate on short interval follow up for uncontrolled hypertension and advancement of therapy 2. Encourage use of combination pills. 3. Pharmacy will begin sending patient messages to providers to recommend changing to combination therapy when appropriate.		
	Diabetes: *(60% / 66%)*	Findings: 1. Patients are non-compliant with therapy for various reasons (pill burden, fear of insulin, lack of understanding the disease). 2. Clinical inertia		

		Interventions: 1. Implement POC A1c machines in clinic. 2. Collaborate with pharmacy on educating patients on medications and medication reconciliation. 3. Build care teams to include health educator to address high risk patients. 4. Provide lunch and learns on Diabetes management. 5. Outreach to patients without A1c on chart.		
	Diabetes (Migrant): (69% / 66%)	Migrant/Agricultural data for 2019 was 3,620. 670 have diabetes. 210 are out of control.		
Dental UDS & Quality Metrics	**Caries Risk Assessment** Dr. Cucuras explained that we are doing way better than the National Average with caries risk assessment: YTD 96.5% December 96% N=14618 D=15145 N=1290 D=1344			
UTILIZATION				
OPERATIONS	**<u>Productivity</u>** We are not seeing new patients in mental health, substance abuse or dental hygiene numbers since they must be established patients before using those services. Looking to add Wellness Visits to Jupiter or Lewis Center sites. Mangonia is continuing to trend upwards as they have been open two full months. Mobile Clinic saw most patients at St. Ann and The Lords Place.	Work on productivity data for Mobile Clinic to ensure we are spending right amount of time in the right place each month.	Andrea/Ivonne	2/21/20 2/21/20

	Starting 1/23 Dr. Perez will be at Belle Glade on Thursdays to assist with precepting Residents. Nurse Practitioner Ketely Philistin to Lake Worth clinic 3 days per week in order to support the high % of productivity at that location. She will be in Belle Glade on Wednesdays and in Lantana on Thursdays to cover precepting. **(Clinic productivity report with graphs was presented)** **Cycle Time** Team member documentation of Patient Cycle time is being assessed at all clinic sites. A "Patient Cycle Time Worksheet" has been created to assess employee documentation. Patient Experience Manager completed several assessments at Delray and Lantana. The goals is to streamline Patient Cycle time documentation and accurately capture the amount of time patients spend at each stage of the medical appointment: Check-In, Intake, Exam & Signoff, and Check Out. In the past month there have been multiple reports about the slow performance about the EMR. The IT Department has been made aware and is troubleshooting this issue. **Bring Your Meds with You Campaign** BYMY signage framed and displayed in all clinics and patient work-up areas. BYMY graph and trends presented. Provider completion rates have increased to 84% of encounters. Only 2 clinics (Mangonia Park and Mobile Clinics) decreased BYMY documentation rates from previous month. Patient compliance with BYMY presented for December 2019. ***(BYMY report with graph presented.)***			

	Patient Transportation/Access Between November 21, 2019 and January 10, 2020, CLBPCC has provided a total of 48 Circulation rides for a total of 21 unduplicated patients of which 41 rides were completed and 7 were cancelled. Of the cancelled rides, 5 were by the driver and and 2 by the rider. Of the 48 Rides, 4 were scheduled at the Lantana Clinic and 44 were scheduled at the Mangonia Park Clinic. Total cost for this time period is $578.11. Future plans are to expand this service to other clinic sites. Clinic bus pass utilization for 2019 will be reviewed to determine clinic with the greatest need. ***(Circulation Screenshots presented.)***			
BEHAVIORAL HEALTH	**Cherokee On Site/templates** Dr. Rowling presented on the Cherokee site visit last week and explained the Athena template changes we are making to our integrated behavioral health program before Cherokee Returns in February.			
DENTAL	**Dental Triage** December 2019: n=482 10-Day Return Rate: 53% (257) 86 Returned within 10 days 33% 171 Did not return in 10 days 67% Questions to begin tracking data on: • How Many same-day Call-center Appointments are made for Triage?	Dental Director to create a code to help track teeth not needing an extraction. Code was created to track the rescheduled extractions. Dental Director and Quality Director to meet with Executive Director about waiver of fees qualifications	Dr. Cucuras Andrea, Dr. Cucuras, Dr. Andric	2/21/20 2/21/20

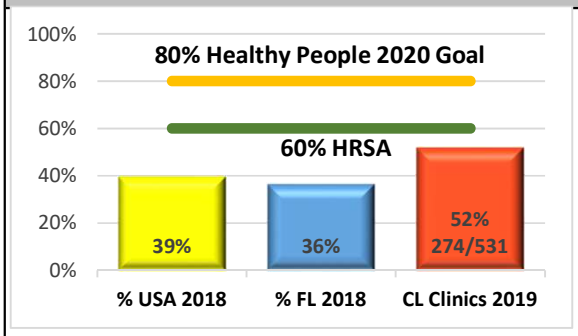
	• What percentage of these Patients are showing up for appointments? ***(Dental Triage graph Presented from Tableau.)*** **MDI** In the month of December 2019, 13% (96) of patients seen in medical (n=731) found a new Dental home in Lantana Clinic. Question regarding WHO patients that cannot be seen the same-day due to capacity challenges. ***(MDI graph Presented from Tableau.)***			
Meeting Adjourned: 2:55PM				

C. L. Brumback Primary Care Clinics
Health Care District Palm Beach County

C. L. BRUMBACK PRIMARY CARE CLINICS

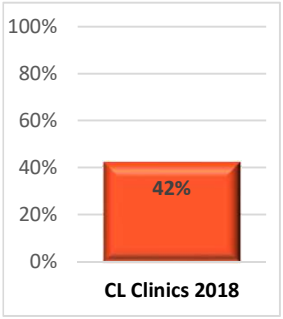
YTD December 2019

CHILDHOOD IMMUNIZATION

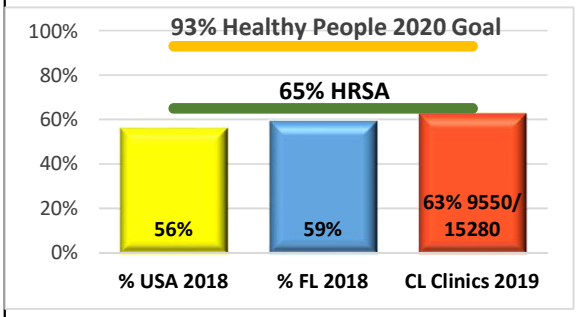


Findings: 1. Lowest rates in Rotavirus and Influenza 2. EMR reports are not capturing patients who have completed all vaccinations as per UDS requirements.

Interventions: 1. Create call list for patient access to schedule appointments for those due for vaccines. 2. Work with Athena for solution to capturing completed vaccinations as per UDS requirements.

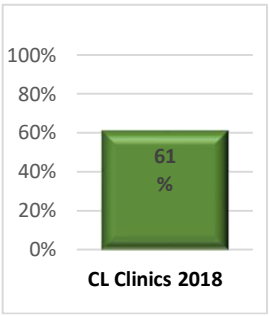


CERVICAL CANCER SCREENING

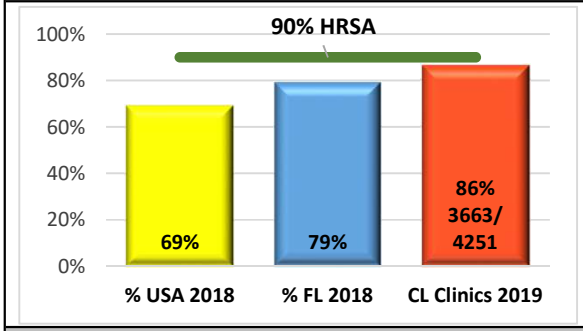


Findings: 1. Difficulty getting records from outside providers that have performed the screening. 2. Patients are showing as non-compliant although they did not have an encounter in the measurement year.3. QMR data is skewed due to attribution and hence duplicating patients.

Interventions: 1. Develop care teams to improve efficiencies in following up on requested medical records. 2. Develop a custom report similar to FIT test. 3. Woman's Health Director provided Pap smear guidance and cervical cancer guideline updates to teams.

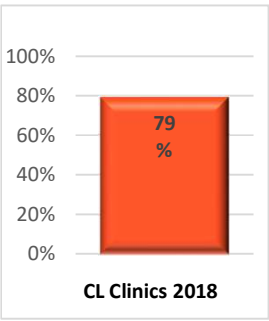


WEIGHT SCREENING AND COUNSELING FOR CHILDREN AND ADOLESCENTS

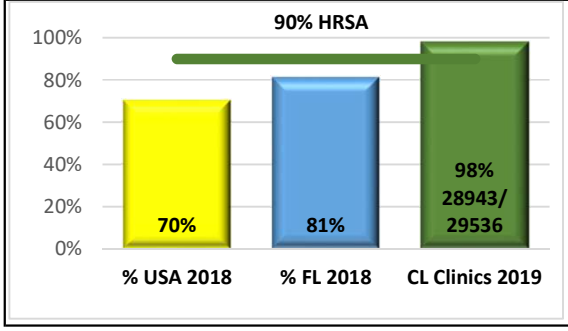


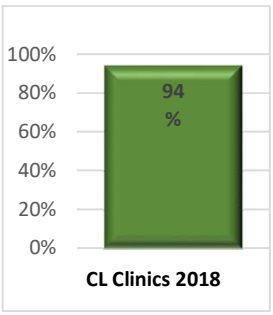
Findings: 1. Providers not dropping the order group at every visit.

Interventions: 1. Train providers that health education should be given at every visit regardless of reason for visit.



ADULT WEIGHT SCREENING AND FOLLOW UP



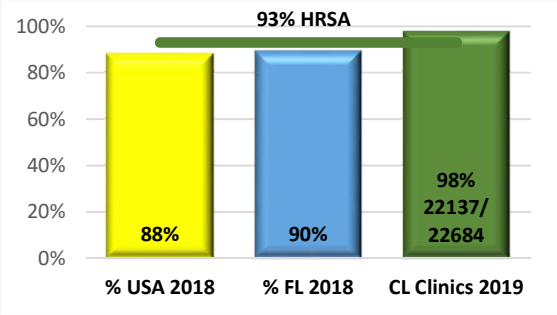


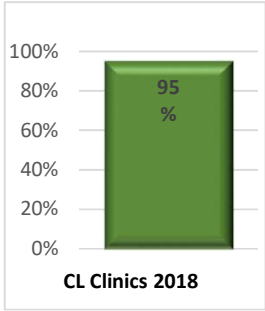
C. L. Brumback Primary Care Clinics
Health Care District Palm Beach County

C. L. BRUMBACK PRIMARY CARE CLINICS

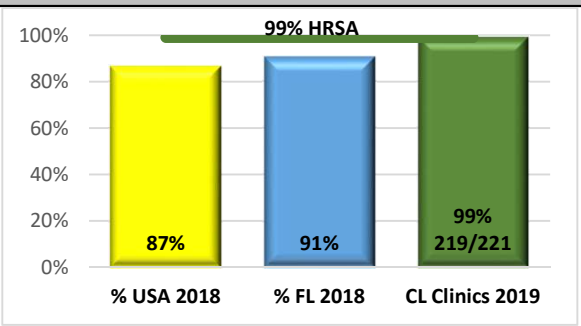
YTD December 2019

TOBACCO USE SCREENING AND CESATION INTERVENTION



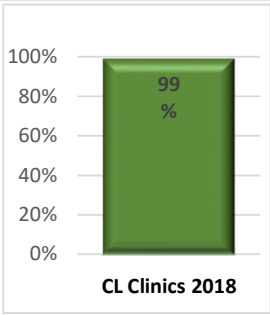


ASTHMA PHARMACOLOGIC THERAPY

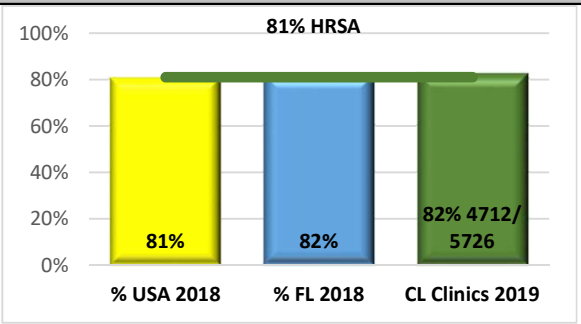


Findings: 1. Asthma medication must dated as active in 2019 to be compliant and some therapies that were first prescribed in 2018 may not have updated dates.

Interventions: 1. Providers have been trained to update the dates. 2. Send cases to individual providers to update medication list if still active.



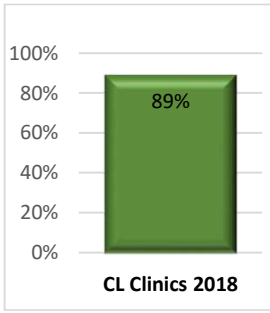
CORONARY ARTERY DISEASE (CAD): LIPID THERAPY



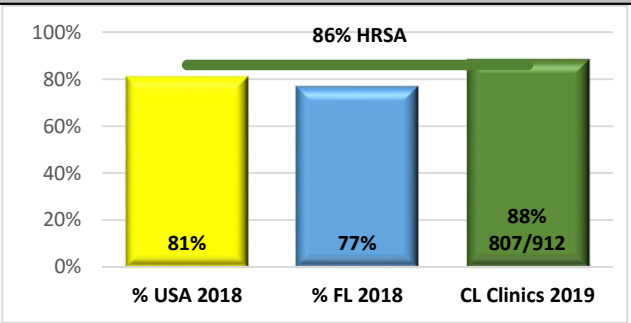
Findings: There are patients who have been recognized as meeting exclusion criteria for measure, however are still presenting as requiring statin on quality tab.

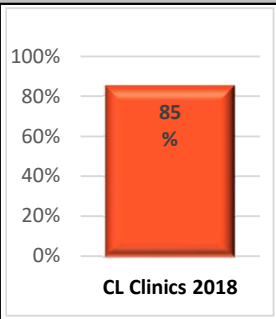
This measure covers 3 populations. It is the theory that the diabetic patients are what is holding us back.

Interventions: (1) Send ticket to Athena for review of exclusion criteria. (2)Measure validation and audit to be completed.



ISCHEMIC VASCULAR DISEASE (IVD): Antiplatelet Therapy



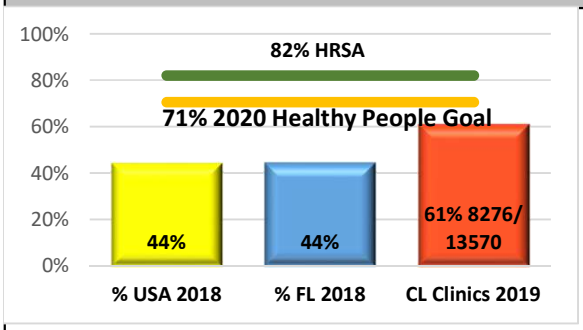


C. L. Brumback Primary Care Clinics
Health Care District Palm Beach County

C. L. BRUMBACK PRIMARY CARE CLINICS

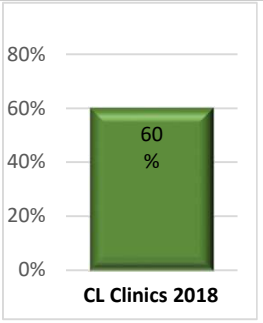
YTD December 2019

COLORECTAL CANCER SCREENING

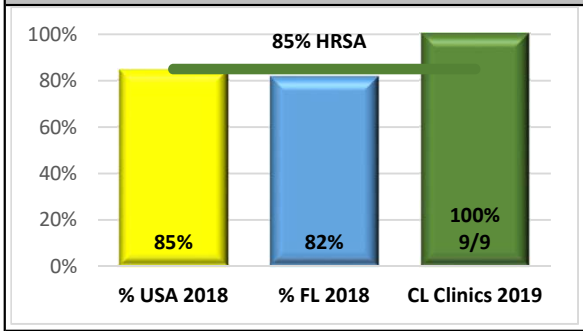


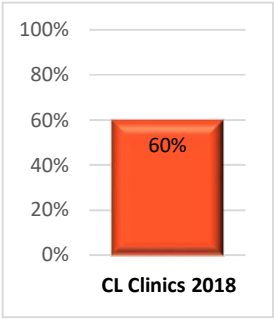
Findings: 1. Difficulty in getting FIT test returned from patient. 2. Some patients may have colonoscopies in Allscripts that have not been updated in Athena.

Interventions: 1. Encourage POD 2. More robust patient follow up through phone call reminders. 3. Custom report developed and dashboard created 4. Work on importing colonoscopy quality data into Athena.

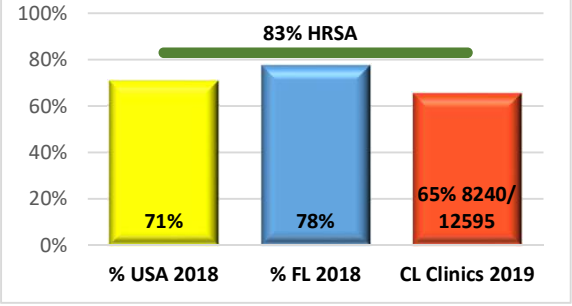


HIV LINKAGE TO CARE



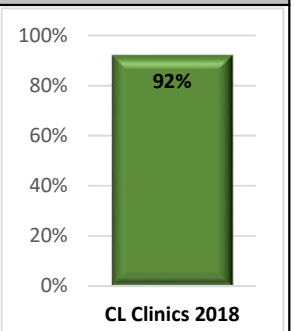


PATIENTS SCREENED FOR DEPRESSION AND FOLLOW-UP SPECIAL POPULATION: HOMELESS

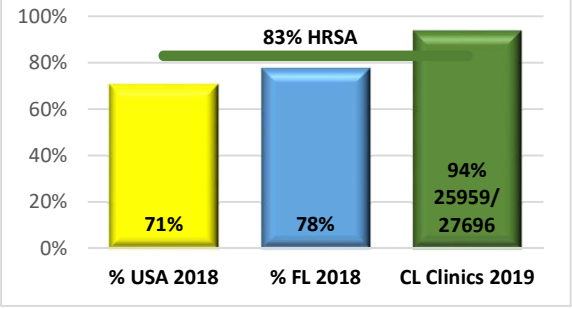


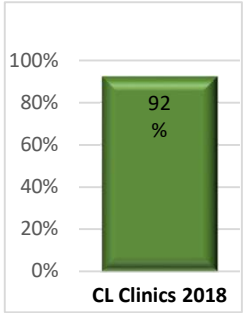
Findings: 1. Rates and screening and follow up for depression were lower for the homeless population.

Interventions: 1. Real-time warm-hand-off of homeless patients to a behavioral health specialist will ensure these patients have a documented follow-up plan right away.



PATIENTS SCREENED FOR DEPRESSION AND FOLLOW-UP



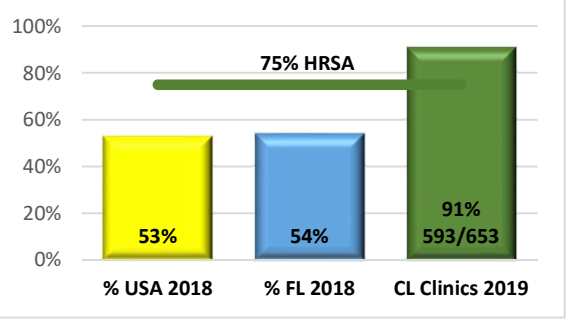


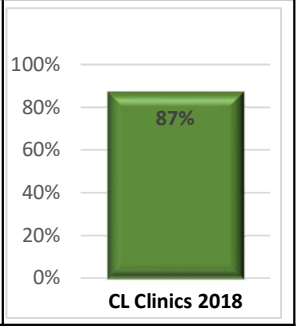
C. L. Brumback Primary Care Clinics
Health Care District Palm Beach County

C. L. BRUMBACK PRIMARY CARE CLINICS

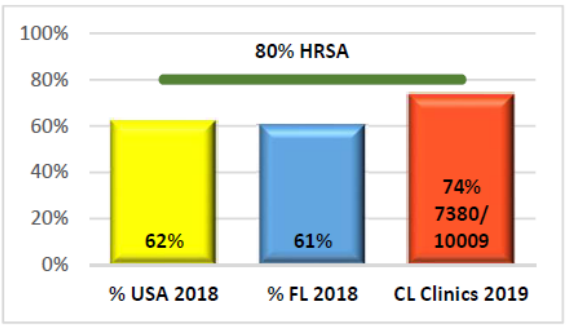
YTD December 2019

DENTAL SEALANTS



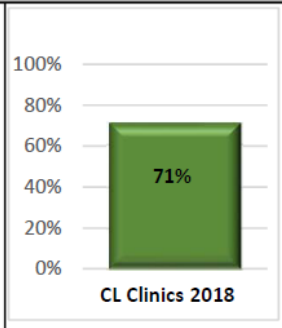


HYPERTENSION

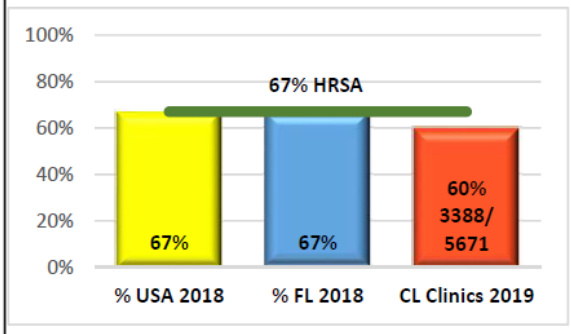


<u>Findings</u>: 1. Providers failing to give short term follow up for uncontrolled BP 2. non-adherence to medication regimen.

<u>Interventions</u>: 1. Reeducate on short interval follow up for uncontrolled hypertension and advancement of therapy 2. Encourage use of combination pills. 3. Pharmacy will begin sending patient messages to providers to recommend changing to combination therapy when appropriate.

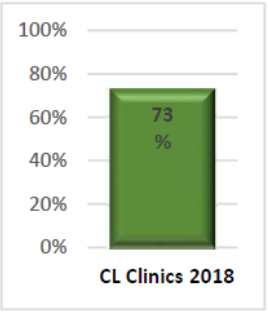


DIABETES



<u>Findings</u>: 1. Patients are non-compliant with therapy for various reasons (pill burden, fear of insulin, lack of understanding the disease). 2. Clinical inertia

<u>Interventions</u>: 1. Implement POC A1C machines in clinic. 2. Collaborate with pharmacy on educating patients on medications and medication reconciliation. 3. Build care teams to include health educator to address high risk patients. 4. Provide lunch and learns on Diabetes management. 5. Outreach to patients without A1c on chart.



C. L. Brumback
Primary Care Clinics
Health Care District Palm Beach County

QUALITY IMPROVEMENT/ ASSURANCE PLAN

Version 8: February 2020

_____ _____
James Elder ***Date***
Chair Board of Directors

_____ _____
Belma Andric, MD, MPH ***Date***
FQHC Executive Director

_____ _____
Ana Ferwerda, MD ***Date***
FQHC Medical Director

INTRODUCTION

C. L. Brumback Primary Care Clinics (CLBPCC) works diligently to improve the health of all families in the service area, including the indigent and medically underserved, by providing an accessible Program of cost effective, high quality and comprehensive primary health services.

CLBPCC strives to ensure that all service delivery is compliant with industry standards, government regulations, and contractual agreements.

CLBPCC works to integrate quality and safe practices into all operations, promoting accountability throughout the organization. CLBPCC also works to promote a just culture that encourages real-time staff reporting of errors and near-misses.

STATEMENT OF PURPOSE

As part of its dedication to providing quality care in alignment with the Mission Statement, CLBPCC has implemented a Quality Improvement (QI) Program under the supervision of the FQHC Medical Director. The purpose of the QI Program is to track clinical, operational and other measures for promoting quality, ensuring patient safety and improving patient care, with an emphasis on the Health Resources and Services Administration' (HRSA) clinical and financial performance measures. CLBPCC's QI Program structure and functions are defined in the CLBPCC QI Plan. Also, the QI Plan is designed to move CLBPCC toward achieving professional accreditations in health care and improving population health at reduced per capita cost.

SCOPE

The scope of CLBPCC QI Plan applies to all clinical and operational activities. The scope of the QI Plan is comprehensive and meant to serve as a guide to all QI activities in CLBPCC. This QI/QA program addresses the following:

1. Quality assurance and improvement;
2. Utilization of health center services;
3. Patient satisfaction and patient grievance processes; and
4. Patient safety, including adverse events.

This plan focuses on:

- Designing, implementing, monitoring and improving a total QI Program
- Ensuring accountability at all levels;
- Establishing clear differentiation of responsibilities;
- Meeting all requirements of the QI Program required by HRSA, the Federal Tort Claims Act (FTCA), Patient Centered Medical Home (PCMH) Accreditation and other grant-related requirements;
- Describing key initiatives; and
- Addressing findings identified through audits and assessments

QI PROGRAM MONITORING

Board of Directors

The CLBPCC is governed by the Federally Qualified Health Center (FQHC) Board of Directors (BOD) which is responsible for providing oversight and direction relative to care and services provided by this organization. The BOD is ultimately accountable for the compliance with the approved Quality Improvement/Assurance Plan for CLBPCC. This accountability begins with the Board's initial approval of the QI Plan, and continues through the re-approval of the plan, which takes place at least every three years (more often if substantial changes are made in the CLBPCC QI Program).

BOD delegates responsibility to the FQHC Executive Director to ensure that resources such as personnel, finances and equipment are available for QI activities. The FQHC Executive Director delegates primary responsibility for implementing, managing and monitoring CLBPCC QI Program efforts to the FQHC Medical Director who reports to the Board on a monthly basis and presents the Quality Council meeting minutes, summary UDS reports and at least quarterly QI/QA assessments.

The BOD is responsible for the following activities:

- Reviewing and approving the QI Plan;
- Reviewing summary reports of the QI Program;
- Credentialing and privileging of provider staff;
- Reviewing and approving policies;
- Reviewing summary reports and patient complaints;
- Reviewing the results of quality audits, patient satisfaction and trend report results; and
- Reviewing legal claims related to patient care

Quality Council

The Quality Council is a cross-functional committee that meets monthly (per our bylaws), includes clinical and administrative staff, and serves as the umbrella committee for quality across the CLBPCC service lines. The Quality Council is chaired by the FQHC Medical Director.

The Quality Council shall review and make recommendations for clinical services, monitor progress of Health Care Plan objectives, review Clinical Outcome measures audits, monitor and review Quality Assurance and Continuous Quality Improvement, Principles of Practice, credentialing, community needs survey data, patient satisfaction survey, and recommend new clinical programs. The Quality Council will meet on a monthly basis. The Executive Director, or his/her designee, will serve as a non-voting, ex-officio member of this committee.

The Quality Council provides leadership by defining organizational priorities as agreed upon, and continually assessing the CLBPCC needs for QI improvement activities. The Quality Council selects and prioritizes quality metrics to be monitored and assesses the data source and integrity for each metric. The Quality Council sets a performance goal for each metric, assigns responsibility for each improvement, institutionalizes improvements, and recommends development of policies and procedures as needed. The Quality Council reviews incidents, complaints, grievances, high-risk condition reports, and any sentinel events. The Quality Council develops the QI Plan which shall be approved by the BOD. Recommendations which are discussed and approved at the Quality Council meetings are presented to the BOD at the next full BOD meeting by the FQHC Medical Director for review and approval.

This Quality Council consists of:

- FQHC Senior Management (Executive Director, Medical Director, Dental Director, Director of Operations, Director of Behavioral Health, Director of Nursing)
- HCD Corporate Quality (Quality Director)
- FQHC Quality Manager
- Invited Guests as required

Quality Workgroups

The QWs consist of service-line leadership and team-members who are tasked with identifying problems, providing corrective actions, as well as presenting and reviewing metrics, outcomes, trends and processes. The Quality Workgroups are a combination of program specific teams that meet one to two times per month and are responsible for actively monitoring service-specific activities. Quality Workgroups are chaired by respective service-line directors/managers.

The QWs recommend process improvement strategies and ensures implementation down the service-line; review chart audits and peer review summaries; analyze Clinic Quality Site Visit summaries and recommend improvements. The QWs ensure that the chosen metrics

are being monitored, data is being collected, and those metrics not meeting the required threshold are moved into the QI action phase. The QWs will work to determine whether findings are employee specific, clinic specific, or systemic issues. Quality Workgroups validate data, evaluate effectiveness of QI activities, document improvements and ensure that identified quality issues are fully resolved. The QWs will also identify areas of improvement, initiate Quality Improvement opportunities, and provide any corrective actions to improve the delivery of quality care. Ad-hoc committees may be formed as needed to address unique challenges that can be addressed and resolved in smaller workgroups on shorter timelines.

Quality Workgroups (QWs) include, but are not limited to:

- Medical Quality Workgroup
- Dental Quality Workgroup
- Behavioral Health Quality Workgroup
- Operations Departmental Quality Workgroup

Pertinent issues, metrics, summaries as well as recommended action plans are presented monthly to Quality Council for further review and discussion.

QI/QA Assessments

Clinic Quality Site Visits (QSV) are performed at each clinic location and for each clinic service line at least quarterly. The QSVs are conducted by Clinic and Administrative Leadership. The QSV is a combination of facility assessments, staff interviews / meetings, and clinic leadership meetings. Facility assessments include review of compliance / regulatory requirements, HIPAA and Privacy Practices and assurance, Equipment and Supply checks, Quality Binders and QI Logs, patient care areas, Lab-related activities, Vaccine Management, Safety and Security measures, clinic flow, OSHA, Infection Control, and special focus items for each service line: Medical, Dental, Behavioral Health and Clinic Operations. During the QSV, the Quality team meets with staff, assesses competencies, shares provider metrics, reports clinic trends, identify problems and provider corrective

actions, provides staff training, requests staff input and feedback. At the conclusion of a QSV, the Quality Team meets with Providers, Practice Management, Clinical Leads, and other clinic staff to review results, launch new protocols, sets goals for corrective actions, and gathers additional information to review at the appropriate QW.

Team-member Meetings

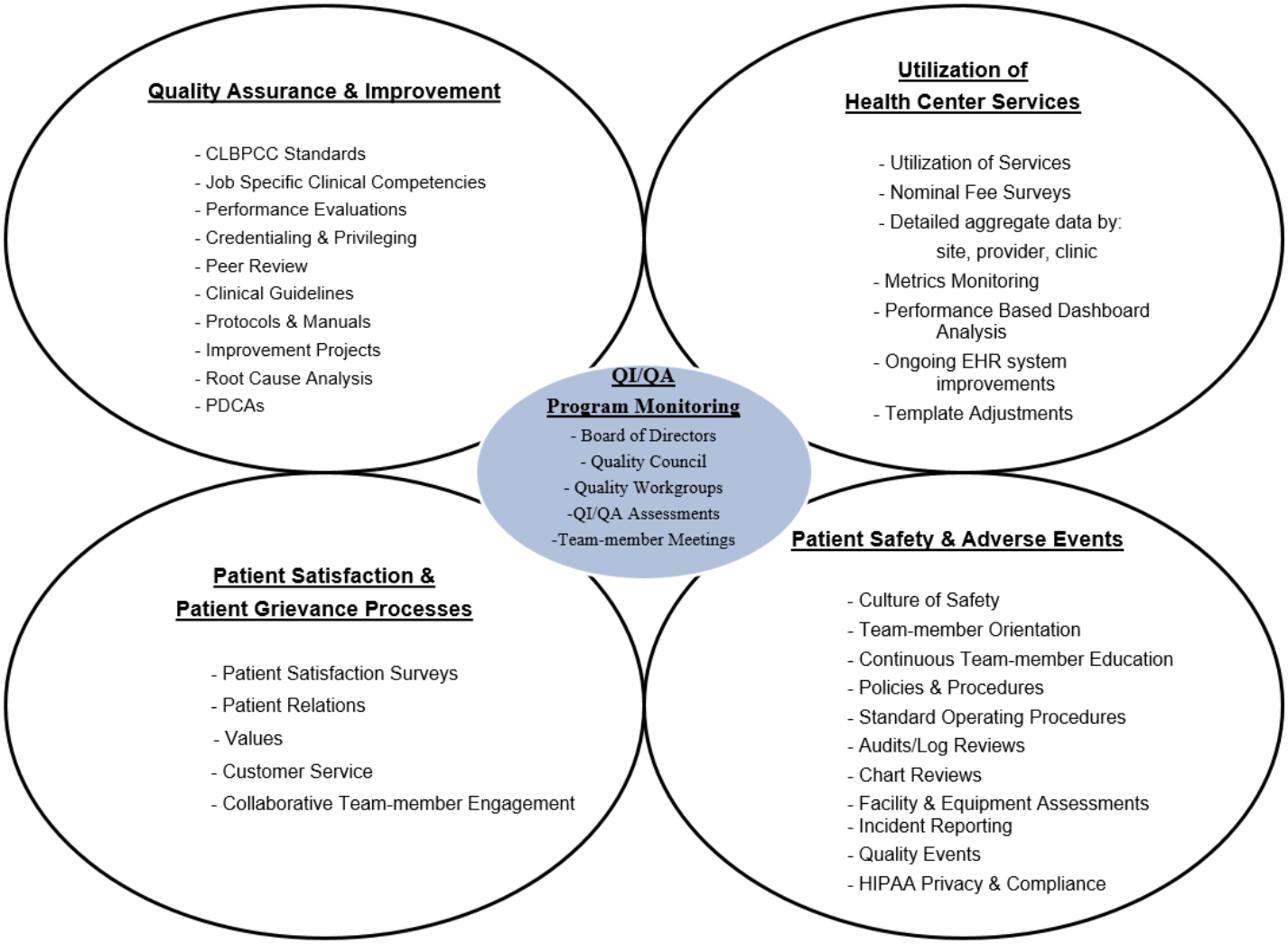
Team-member meetings are held to provide an opportunity for Clinic Administration and Practice Management to share clinic updates and provide education and/or training to clinic team-members. During this time team-members also have the opportunity to ask questions, learn best practices from other clinics and share opportunities for improvement. Feedback and comments are gathered from team-members and brought back to relevant workgroups for further discussion and follow-up.

Title	Quality Responsibility
FQHC Executive Director	Provides direction to QI Program activities and supports Quality Improvement activities assuring that quality improvement initiatives are consistent with our mission. Leads strategic planning for the clinics.
FQHC Medical Director	Responsible for assessing the CLBPCC QI Program. Responsible for periodic assessment of the appropriateness of the utilization of services and the quality of services provided or proposed to be provided to individuals served by the center. Responsible for oversight and direction for medical providers. Responsible for providers credentialing and privileging. Responsible for after-hours coverage and on-call schedule and procedure. Assures that all activities of the medical staff are in alignment with QI plan. Responsible for adoption of

	clinical guidance for providers. Responsible for pharmaceutical quality review of prescribing practices by providers and reporting on their compliance with best practices. Presentation of Peer Review results for quality documentation in patient records. Responsible for development of the electronic health record templates and standardized order sets. Responsible for grant compliance with clinical performance expectations. Responsible for development of appropriate policies and procedures.
Quality Director	Responsible for implementing, managing and updating CLBPCC QI Program in accordance with the HRSA Compliance Manual. Implements initiatives resulting from strategic planning. Responsible for oversight and direction for clinics quality metrics. Responsible for grant compliance. Responsible for ensuring the development of appropriate policies and procedures.
FQHC Operations Director	Responsible for periodic assessment of the appropriateness of the utilization of services and the quality of services provided or proposed to be provided to individuals served by the center. Producing and sharing reports on QI/QA to support decision-making and oversight by key management staff and by the governing board regarding the provision of health center services. Responsible for business processes including flow of the clinics, patient access and cycle time, and efficient operations in a fiscally sound manner.

	Responsible for accuracy of the financial and business-related EHR documentation and business-related reports and quality metrics. Responsible for coordinated information flow such as referrals, record transfers, and coordination of care with other providers. Ensures patient experience data are collected and provides directions on improvement efforts based on this data. Ensures that patient complaints are answered in timely manner. Responsible for timeliness of patient encounter closure. Responsible for oversight of Works closely with the Call Center, established under the Health Care District of Palm Beach County, co-applicant to the FQHC's, to coordinate activities including all related reports. Suggests customization and optimization of EHR. Responsible for development of appropriate policies and procedures. Responsible for communicating action items to FQHC Practice Management.
Appointed Board of Director Member	Participates in monthly Quality Council meetings and monitors all activities and effects of the committee. The incumbent acts as a liaison between the Quality Council and the Board of Directors.

The following diagram summarizes the scope of the QI Program at CLBPCC:



QUALITY ASSURANCE & IMPROVEMENT

CLBPCC Standards

CLBPCC standards are defined in our Policies and Procedures, and Standard Operating Procedures (SOPs) that provide the framework for all programs.

All BOD approved Policies and Clinic Procedures are posted on the organization's Intranet, so that all staff can access them at any time. New hires are instructed on how to access the policies and procedures at their initial orientation and existing employees are advised by their supervisors when new policies are added. Additionally, all new Policies, Procedures, and Standard Operating Procedures are discussed during the staff meetings and clinic huddles and are a standing agenda item. Once a new policy is reviewed with staff, sign-off sheets are utilized to track that training is completed. A copy of the sign-off sheets are kept for each clinic.

Policies and Procedures are grouped into fourteen categories: Administration, Compliance, Human Resources, Information Technology, Finance, Credentialing, Risk, Clinical, Dental, Pharmacy, Behavioral Health, Women's Health, Substance Abuse and Telemedicine.

Job Specific Clinical Competencies & Performance Evaluation

Each staff is presented with a job description upon their first day of employment, as well as a defined list of detailed job-specific competencies. An assessment of the competencies for the staff is completed during each employee's performance evaluation (the initial evaluation is done during on-boarding, again after three months of employment, followed by a six month evaluation, and then a one year evaluation. Evaluations are done annually thereafter.). Assessment of the competencies is completed by immediate supervisors with input provided by key stakeholders.

Credentialing & Privileging

CLBPCC has policies in place that ensure verification of the credentials of health care practitioners and define their privileges to increase safety of the patients and provide the highest quality care to our patients. The Health Care District of Palm Beach County has established a "Credentialing and Provider Service Department" that works with the CLBPCC in all credentialing activities. Credentialing with primary and secondary source verification is performed on all licensed or certified health care staff members before assuming patient care activities. Completed and verified packets are reviewed by the corresponding Director

(Medical, Dental, Women's Health, and/or Behavioral Health) and the Director of Credentialing and Provider Services established under the Health Care District of Palm Beach County, the co-applicant to the FQHC's. For all Licensed Individual Practitioners, the corresponding Director (Medical, Dental, Women's Health, and/or Behavioral Health) makes recommendations to approve (or not approve) applicant for credentialing and privileging to the BOD. These recommendations are based on thorough review of the practitioner's credentials and evaluation of clinical qualifications. Renewal of all previously credentialed and privileged staff will be performed every two years.

Peer Review

CLBPCC has an ongoing Provider Peer Review process as a mechanism of having medical, dental, women's health, and behavioral health providers work routinely reviewed by their peers. The purpose of Peer Review is to ensure the delivery of high quality care, assess clinical performance, and is used to reappoint providers in the credentialing and privileging process. Charts are audited by using an electronic *Peer Review Form* in the Electronic Risk/ Quality reporting platform. Please refer the Peer Review Policy and Procedure regarding the minimum number of charts requiring review per quarter. Clinicians are required to respond to all identified deficiencies. Any identified deficiencies affecting direct patient care will be corrected at the future visit with the patient. Peer review data is aggregated and reviewed monthly with providers during provider meeting as well as Quality Council meetings. Any trends on an individual level will be discussed privately with the clinician and the corresponding FQHC Director and will result in a corrective plan of action for the clinician. Provider specific Peer Review summaries are reviewed during provider's re-credentialing process.

Clinical Guidelines

CLBPCC adheres to current evidence-based clinical guidelines, standards of care, and standards of practice, as applicable. Program-specific evidence based guidelines from National sources (including, but not limited to: the American Diabetes Association, American Heart Association, the United States Preventative Services Task Force guidelines, etc.) are

adopted and followed by CLBPCC providers and updated when necessary. Similarly, the dental program also follow guidelines (including, but not limited to: the Organization for Safety, Asepsis, Prevention (OSAP), and Lexi-comp). These guidelines are discussed during monthly provider meetings. Adherence to these guidelines are monitored via periodic chart reviews, peer reviews, audits, and the *Tableau* platform.

In addition, CLBPCC maintains an organization-wide subscription to "UpToDate", an online clinical information resource that is evidence based and constantly updated. "UpToDate" encompasses all current clinical practice guidelines and is recommended and endorsed by the Society of General Internal Medicine, the American Academy of Pediatrics, and the American Academy of Family Practice. It is CLBPCC expectation that our medical clinicians refer to "UpToDate" for all current guideline reference.

Protocols & Manuals

CLBPCC works diligently to develop Standard Operating Procedures (SOPs) for all clinical and nonclinical operations in order to ensure standardized training so that patient care is consistent. All departments develop and maintain their own protocols consisting of SOPs (including, but not limited to: Frontline Manual, Referrals Processing Manual - *Referral Institute*, Clinical Manual, Dental Clinical Manual, Call Center Manual, etc.). Clinical and Dental Protocols are grouped into two categories: Adults and Pediatrics. These protocols consist of all standard nursing procedures, standing lab orders, immunization standards and protocols, process maps, screen prints, etc. Every reasonable attempt will be made to streamline our protocols so they follow clinical competencies.

Improvement Projects

Process Improvement is an ongoing system. Through monthly Quality meetings, established reporting systems & protocols, and consistent review of services, CLBPCC staff are able to identify areas in need of improvement in a timely and consistent manner. It is expected that all improvements should enhance our processes and ultimately the health care outcomes of our patients.

The following criteria are followed when establishing priorities for Performance Improvement Projects:

- Any process/procedure that presents a significant risk to patients and staff members
- Any process/procedure that is high in volume (regardless if low risk)
- Any process/procedure that is high risk (regardless if low volume)
- Any process/procedure of high expense or conversely one that could save money

CLBPCC strives to maintain the highest quality standards. Leadership provides thorough, detailed analysis of all sentinel events, performance that significantly reflects sub-standard care, and trends or patterns that significantly deviate from recognized standards of care.

All performance improvement processes will begin with expectation of what is determined to be minimum acceptable standard of compliance for CLBPCC. All criteria used in the evaluation process will be measurable and responsibility for implementation of the project defined.

Effective actions that might be taken once issues are thoroughly evaluated include, but are not limited to:

- Improvement in operations or facilities
- Actions to improve staff knowledge, such as changes in orientation, in-service training and continuing education Programs
- Redistribution or addition of staff, supplies or equipment
- Change in clinical or administrative policies and procedures
- Changes in modifications in clinical privileges
- Individual counseling or disciplinary action

All final findings, conclusions and recommendations are presented to the Quality Council for review, discussion and implementation of change as appropriate.

Root Cause Analysis

Root Cause Analyses are used as our process for identifying, analyzing, and addressing patient adverse events primarily for in-depth analysis of an adverse incident (or "sentinel event"). However, it is also used as the first step in our improvement process by asking the "Five Whys". By repeatedly asking the question "Why", you can peel away the layers of symptoms which can lead to the root cause of a problem. With each successive step, the team asks "Why?" again, until it has been asked five times. This approach enables the team to dig deeply into the source of the issue, generally resulting in a better understanding and, thus, a more functional solution.

Plan Do Check Act (PDCA)

CLBPCC uses QI tools such as PDCA cycles, process mapping, brainstorming and other techniques for problem identification and/or process improvement.

Plan - Determine what data will be collected and what change/intervention/test to be performed.
Do - Carry out the determined change/intervention/test then collect data again to begin analysis.
Check - Complete analysis of data, summarize what was learned and compare to prediction.
Act – Implement the change tested and study again.

Frequency of data collection and the timeline for sampling of events or activities monitored will be determined based on the frequency of the identified problem. Measurement criteria will be modified as needed based on assessment activities and current literature.

In addition to standard data collection methods (EHR reports, incident reports, management reports, etc.), performance is monitored by patient/staff satisfaction surveys, suggestion boxes, staff reporting errors, and staff suggestions.

UTILIZATION OF HEALTH CENTER SERVICES

Utilization of Services

CLBPCC conducts periodic assessments of the appropriateness of the utilization of services and the quality of services provided or proposed to be provided to individuals served by our clinics. These assessments are:

- Conducted by physicians or by other licensed health professionals under the supervision of physicians;
- Based on the systematic collection and evaluation of patient records;
- Assess patient satisfaction, achievement of project objectives, and include a process for hearing and resolving patient grievances; and
- Identify and document the necessity for change in the provision of services by the center and result in the institution of such change, where indicated.

Additionally, a detailed annual review is undertaken to examine the relevance of service area boundaries, to identify opportunities to better serve the needs of the target population and to ensure adherence with compliance requirements.

Sliding Fee Scale Program and Nominal Fee Surveys

Sliding Fee Scale Program and Nominal Fee Surveys are conducted at least every three years to ensure the Sliding Fee Scale Program is being helping the patients we serve and the flat nominal charge(s) are set at a level that is considered to be nominal from the perspective of the patient based on input from patient surveys.

Detailed Aggregated Data by Site, Provider, Clinic

CLBPCC conducts a monthly overall, as well as clinic-specific and provider-specific, analysis of productivity including number of patients seen by each provider in each service line as compared to targets set for that provider, daily average, percent monthly target achieved and payor mix.

Metrics Monitoring

CLBPCC monitors clinical outcomes (such as UDS requirements, PCMH, and HEDIS indicators), clinical patient care (such as access and cycle time), and business process metrics (such as operational efficiencies and maximized revenue). For selected metrics, the Quality Council leadership establishes a goal and related plan for performance measurement.

Clinical Outcome Measure Audits

UDS Measure Audits and Meaningful Use Audits are performed monthly and presented to the monthly Quality Council meetings as overall "up to date" reports and/or clinic-specific or provider-specific reports. Reports are measured against national goals and closely monitored from month to month. The PDCA process is mapped for the selected measures not meeting the goals.

Clinical Patient Care

CLBPCC continuously monitors both fundamental primary care metrics and program-specific quality metrics for initiatives such as access, cycle time, health information technology, referral tracking, chronic disease management, and team care. These may be measured with reports such as *Third Next Available Appointment, Percentage of Closed Referrals*, *Number of Referrals vs. PCP Encounters*, *Percentage of Chronic Disease Management Patients tracked by Health Coaches,* and *Percentage of Patients who are Compliant with Team Care Plans and Goals* as well as other improvement measures.

Business Processes

CLBPCC continuously monitors finances, coding and billing accuracy and consistency, patient access, staff turnover, and efficiencies seen as a result of PCMH. These may be measured with reports such as *Cash Collection* and *Coding/Billing Audits.*

Performance Based Dashboard Analysis

Selected performance measures are presented on a monthly basis to the Quality Council and BOD relative to pre-established goals. Metrics identified as deterring from our goals are followed and expected improvement is specified by leadership. Quality Councils track and report progress until improvement is reached. When improvement activity is complete, the Quality Councils re-analyze dashboard outcome data to ensure improvements are sustained. Dashboards are shared with the clinics and personalized goals presented to providers at least quarterly to increase staff awareness of goals achieved and identify where improvements can be made.

Additionally, CLBPCC utilizes a *Tableau* platform which provides a wide variety of user-friendly performance-specific dashboards to drive improvement in population health. This unique high-tech software is based on extrapolated data from the EHR/EDR which is provided to the software vendor for aggregation. This tool provides performance feedback and comparative benchmarking for the selected measure set. Providers have access to the *Quality Report Module* that they may use for actionable patient lists with the goal to improve these metrics. *Clinic Quality Boards* are also updated on a monthly basis in each clinic break-room.

Ongoing EHR system Improvements

EHR improvements can come from new interfaces that improve efficiencies, EHR/EDR enhancements and updates from the vendor, as well as suggested improvement from internal customers or consultants. We aim to review our health IT tools, add-on products, and software solutions on an ongoing basis.

Template Adjustments

CLBPCC internal customers strive to offer and suggest improvements such as provider, program or service-line specific order sets which streamline documentation and increase overall standardization.

PATIENT SATISFACTION & PATIENT GRIEVANCE PROCESSES

Patient Satisfaction Surveys

Patient Satisfaction Surveys enable CLBPCC to ensure a process is followed for assessing patient satisfaction and to better meet patient expectations and create loyalty. These are conducted monthly when possible and at least annually. The summary of the results are shared with the staff, Quality Workgroups, Quality Council, and the BOD.

Patient Relations

CLBPCC monitors all patient relations activities including Patient Complaints, Grievances, and Compliments. CLBPCC has a BOD approved Patient Grievance Policy and Procedure that describes our process for hearing and resolving patient grievances. The Patient Experience Manager processes, investigates, tracks, provides follow-up, and strives to resolve patient grievances. The Patient Experience Manager processes, investigates, tracks, provides follow-up on Patient Complaints and Compliments. All patient complaints and grievances are reported to the Executive Director, Medical Director, and appropriate Program Director by the Patient Experience Manager. The Quality Manager provides monthly reports to the Quality Council and at all Clinic Quality Workgroups. CLBPCC presents Patient Relations data quarterly at the Corporate Quality, Patient Safety and Compliance Committee Meeting.

Values

CLBPCC values the following**:**

Patient Focus – Providing high quality services for patients, which exceed their expectations. Physical space, patient care processes and clinical and business procedures at the clinics respect the comfort and dignity of the patient at all times. Patient satisfaction is assessed regularly through patient satisfaction surveys. Patient complaints are answered in timely manner. Patient should have timely access to appointments as measured by appointments availability. Access relates to ease and timeliness in obtaining care and

includes hours of operation, after-hours on-call systems and telephone systems. These must meet the needs of patient.

Vitality and Efficiency – In order to deliver the highest quality of care, our staff needs to be well trained, satisfied, and empowered to serve the patients. Our organization must be fiscally sound in order to continue our Mission. CLBPCC are devoted to using available resources to produce the highest quality health services.

Equity – All patients will be served with dignity and respect. Sliding fee scale fees will be available to those uninsured patients who qualify according to federal regulations. Pharmacy Programs utilizing the 340B Program are available to our patients. Multilingual staff and appropriate translations are available to patients. No disparities regarding race, ethnicity, or payer class will exist within CLBPCC.

Accessibility – Access to care for underserved communities and patients is achieved by forming outreach teams, careful planning, marketing, and removal of barriers of care. This includes the establishment of extended hours at specified clinics and the availability of a After Hours Answering Service.

Leadership Involvement – The BOD and Executive Director provide strong leadership, direction, and support of QI activities. This involvement of organizational leadership assures that QI initiatives are consistent with our mission and strategic plan.

Data Informed Practice – CLBPCC uses feedback loops and data to better inform the practice and make fact-based decisions.

Analytic Tools – For continuous improvement of care, tools, and methods are needed that foster knowledge and understanding. CLBPCC uses a defined set of analytic tools, reports, and metrics for both clinical patient care and quality of business processes to

turn data into information. This information is reported at the Quality Council meetings each month and escalated to the Quality Council as appropriate.

Customer Service

CLBPCC strives to partner with patients and families to understand each patient's unique needs, culture, values and preference. We are working to change our culture from reactive to proactive in addressing patient experience. We aim to develop and support an empathetic culturally diverse, competent, motivated and service oriented-workforce; to recruit and retain highly competent team-members. We smile.

Collaborative Team-member Engagement

CLBCC approach to quality improvement is that all staff, regardless of their position, are considered to be customer service improvement agents. They receive training during their orientation and training on the QI Program, including patient satisfaction and are expected to participate in these activities. Customer service and QI activities are considered to be embedded in all operations, not separate from the full operations.

PATIENT SAFETY & ADVERSE EVENTS

Culture of Safety

CLBPCC strives to maintain a patient-centered and "Just Accountable" culture that encourages all employees to provide safe quality care and conduct themselves in a professional, team-driven manner.

Team-member Orientation

New staff at CLBPCC complete new employee orientation. During the on-boarding period, new employees receive job-specific training that includes, but is not limited to: training on clinical manuals, electronic health/dental records training, clinical competencies, policies and procedures, quality metrics, HIPAA compliance, and Risk & OSHA. During this period,

skills are assessed for clinical and dental privileging. All new clinic employees are paired with a clinic peer for a minimum of two weeks. Their work is assessed during the first month by an assigned evaluator, via chart audits, and during 1:1 meetings with their supervisor, or a designated Manager.

Continuous Team-member Education

Education of staff at CLBPCC occurs on a continuous basis. As the need arises, updated policies and procedures are reviewed with staff. Select Policies and Procedures are reviewed with staff annually. Employee trainings are tracked through the use of sign-in sheets. In the event an employee missed a required training, the employee is provided a make-up training. Selected training is provided on an annual basis (such as OSHA & Risk, Medical Malpractice, clinical skills, guideline review, EHR/EDR, and standing orders). All licensed medical clinical staff have access to continuing education through an organizational subscription.

Policies & Procedures and Standard Operating Procedures (SOPs)

CLBPCC seeks to implement best practices and streamline processes across all clinics and departments. Policy and Procedure are established by Clinic Administration with input from Corporate Departments (Legal, Compliance, Information technology, Finance, Human Resources, Provider Services, Quality, and Risk) as needed. All clinic policies are reviewed and signed by the FQHC Board. The Policies and Procedures of the Healthcare District Palm Beach County are reviewed and adopted by the CLBPCC and FQHC Board of Directors. All policies and procedures are reviewed at a minimum once every three years or as needed to reflect current processes. The CLBPCC also creates Standard Operating Procedures to introduce new workflows or to provide specific instructions on a new process.

Audits/Log Reviews

CLBPCC conducts scheduled clinic quality audits by conducting clinic quality site visits on rotating basis with the goal that each clinic is visited at least quarterly. During the quality site visits, all clinics are reviewed and audited through the use of an established audit tools

that encompasses a variety of topics (such as compliance signage, equipment, safety, OSHA, inventories, and employee performance). Visit findings are recorded by using a standardized checklist. Visit findings are then tracked by documenting newly created action items and by updating ongoing action items. Findings and action items are presented at Clinical Quality Workgroups and Quality Council Meetings. A copy of findings is placed in each clinic for staff review at meetings and clinic huddles.

CLBPCC maintains the Quality Improvement Action items log that identifies all action items from Quality Workgroups, Clinical Site Visits, Quality Council Meetings, Internal/External Audit findings, Accreditation Bodies, Grant-Funded Programs, and Administrative and Corporate Departments.

Chart Reviews

Chart Audits of the Electronic Health and Dental Records are done on a routine basis by Clinical Directors, Quality Manager, Corporate Risk Manager, Clinical Coordinators, and Chart Auditor and through the Peer Review process. Performance Measures including UDS indicators, specific grant program requirements, and insurance company's requirements are monitored, analyzed, and reported through electronic reports generated in the "Tableau" database and the Electronic Medical Record systems. The results of clinical audits are presented in the Clinic Quality Workgroups and Quality Council meetings in the form of dash boards, graphs, and pivot tables. These results are escalated to the Board of Directors as necessary.

Facility & Equipment Assessments

CLBPCC seeks to provide an environment of care where safe operations of medical equipment implements and supports the care of patients. CLBPCC has implemented the "Management of Clinical Equipment" SOP that establishes, supports, and maintains a Program that is based on assessed clinical and physical risks of the equipment, monitoring and evaluation of organizational practices, applicable law and regulation, and accepted practices within the healthcare industry. Users of medical equipment receive training on the

safe operation of all equipment as part of their orientation to specific job responsibilities. Training is ongoing and as necessary. All medical equipment is inspected, tested, and maintained through agreements with vendors.

Incident Reporting

The office of Corporate Risk, established under the Health Care District of Palm Beach County, has been tasked to lead CLBPCC Risk Management activities, but efforts are made in every service line. The Medical Director, Dental Director, Women's Health Director, Behavioral Health Director, Practice Operations Director, Nurse Manager, Quality Manager, Dental Quality Coordinator, and Practice Management or delegate work with all staff to discuss actual, potential, and alleged risk management cases and potential system improvements to improve care of all CLBPCC sites. CLBPCC stresses timely, constructive and educational dialogues between involved parties in continuous efforts to improve the quality of the patient care. CLBPCC has a BOD approved "Risk Management Plan" that defines the goals and objectives of the Risk Program including a process for identifying, analyzing, and addressing patient safety and adverse events and for implementing follow-up actions, as necessary. This plan emphasizes implementing evidence-based best practices, learning from incident analysis, and providing constructive feedback, rather than blame and punishment. In a just culture, unsafe conditions and hazards are readily and proactively identified, medical or patient care incidents are reported and analyzed, issues are openly discussed, and suggestions for systemic improvements are welcomed.

Risk Management:

The Corporate Risk and FQHC Leadership incorporates best practices throughout its operations to provide a safe environment for staff and patients. CLBPCC maintains a culture of patient safety and performs routine activities to ensure staff are educated and reminded of patient safety practices. The Director of Corporate Risk Management, established under the Health Care District of Palm Beach County, co-applicant to the FQHC's, works alongside the Clinic Risk Manager to provide direction, oversight and support to CLBPCC Risk Management education and activities. The Clinics Risk Manager provides monthly reports

to the Quality Council on all incidents from the previous month. Risk Management Education/Activities are conducted and tracked in accordance with the Risk Management Plan.

Quality Events

CLBPCC has established a process in which clinical and/or operational challenges that have been noted as a trend can be documented, analyzed, and improved through a "Quality Event" portion of the Risk & Quality Electronic Management System. Those events are opportunities to provide corrective actions or quality improvement activities in a more structured way to improve the overall quality of service and minimize risk. Quality events are reviewed and tracked by the CLBPCC Quality Manager. Quality Events are reported at the Quality Councils. The Risk Manager provides oversight and support for reviewing and handling Quality Events.

HIPAA Privacy and Compliance

CLBPCC maintains the confidentiality of patient records, including all information as to personal facts and circumstances obtained by the health center staff about recipients of services. Specifically, CLBPCC does not divulge such information without the individual's consent except as may be required by law or as may be necessary to provide service to the individual or to provide for medical audits by the Secretary of Health and Human Services or his/her designee with appropriate safeguards for confidentiality of patient records.

KEY INITIATIVES

Quality and Patient Safety

To provide quality, patient centered health care that can be defined and measured. To enforce and invest in a pervasive culture of safety with zero preventable errors.

People

To be the employer of choice. To develop and support a culturally diverse, competent, motivated and service oriented workforce. To recruit and retain highly competent providers to meet patient needs.

Cost

To maximize taxpayer investment while advancing the mission and vision. To offer unquestionable value to payers and consumers.

Community Leader

To lead Palm Beach County in improving health status and access to care through community coordination and collaboration. To protect and advance the county's health care safety net.

Data-Driven Culture

To encourage the use of data to improve decision making and inform strategy by promoting a data-driven culture using "democratized" data.

Key Performance Indicator (KPI) Work Plan

KEY PERFORMANCE INDICATOR WORK PLAN						
Performance Indicator	**Performance Goal and Source/YR**	**Method of Collection**	**Data Source**	**Monitor Freq**	**Report Freq**	**Responsible Person/Depart**
CLINICAL MEASURES						
Early Entry into Prenatal Care HRSA Required Measure	Baseline: 65% Source/YR: UDS 2019 HRSA Goal: 70%	**Refer to Attachment A*	Athena QMR Report with manual data validation	Monthly	Quarterly	Women's Health Director Quality Reporting Analyst
Childhood Immunization Status HRSA Required Measure	Baseline: 52% Source/YR: UDS 2019 HRSA Goal: 60% TARGET: 80% Source/YR: Healthy People 2020	**Refer to Attachment A*	Athena QMR Report with manual data validation	Monthly	Quarterly	Medical Director Quality Reporting Analyst
Cervical Cancer Screening HRSA Required Measure	Baseline: 63% Source/YR: UDS 2019 HRSA Goal: 65% TARGET: 93% Source/YR: Healthy People 2020	**Refer to Attachment A*	Athena QMR Report with manual data validation	Monthly	Quarterly	Medical Director Quality Reporting Analyst
BMI Screening and Follow-Up HRSA Required Measure	Baseline: 86% Source/YR: UDS 2019 HRSA Goal: 90%	**Refer to Attachment A*	Athena QMR Report with manual data validation	Monthly	Quarterly	Medical Director Quality Reporting Analyst
Tobacco Use HRSA Required Measure	Baseline: 98% Source/YR: UDS 2019 HRSA Goal: 93%	**Refer to Attachment A*	Athena QMR Report with manual data validation	Monthly	Quarterly	Medical Director Quality Reporting Analyst

Key Performance Indicator (KPI) Work Plan

KEY PERFORMANCE INDICATOR WORK PLAN						
Performance Indicator	**Performance Goal and Source/YR**	**Method of Collection**	**Data Source**	**Monitor Freq**	**Report Freq**	**Responsible Person/Depart**
Use of Asthma Medications HRSA Required Measure	Baseline: 99% Source/YR: UDS 2019 HRSA Goal: 99%	**Refer to Attachment A*	Athena QMR Report with manual data validation	Monthly	Quarterly	Medical Director Quality Reporting Analyst
Coronary Artery Disease HRSA Required Measure	Baseline: 82% Source/YR: UDS 2019 HRSA Goal: 81%	**Refer to Attachment A*	Athena QMR Report with manual data validation	Monthly	Quarterly	Medical Director Quality Reporting Analyst
Ischemic Vascular Disease HRSA Required Measure	Baseline: 86% Source/YR: UDS 2019 HRSA Goal: 92%	**Refer to Attachment A*	Athena QMR Report with manual data validation	Monthly	Quarterly	Medical Director Quality Reporting Analyst
Colorectal Cancer Screening HRSA Required Measure	Baseline: 61% Source/YR: UDS 2019 HRSA Goal: 82% TARGET: 71% Source/YR: Healthy People 2020	**Refer to Attachment A*	Athena QMR Report with manual data validation	Monthly	Quarterly	Medical Director Quality Reporting Analyst
Clinical Depression Screening HRSA Required Measure	Baseline: 94% Source/YR: UDS 2019 Stratified by special population: Homeless Baseline: 65% HRSA Goal: 83%	**Refer to Attachment A*	Athena QMR Report with manual data validation	Monthly	Quarterly	Behavioral Health Director Medical Director Quality Reporting Analyst
HIV Linkage to Care HRSA Required Measure	Baseline: 100% Source/YR: UDS 2019	**Refer to Attachment A*	Manual report kept	Monthly	Quarterly	Medical Director Quality Reporting

Key Performance Indicator (KPI) Work Plan

KEY PERFORMANCE INDICATOR WORK PLAN						
Performance Indicator	**Performance Goal and Source/YR**	**Method of Collection**	**Data Source**	**Monitor Freq**	**Report Freq**	**Responsible Person/Depart**
	HRSA Goal: 85%		by Nursing team			Analyst
Dental Sealants HRSA Required Measure	Baseline: 91% Source/YR: UDS 2019 HRSA Goal: 75%	**Refer to Attachment A*	Athena QMR Report with manual data validation	Monthly	Quarterly	Dental Director Quality Reporting Analyst
Diabetes Hemoglobin A1C – Poor Control HRSA Required Measure	Baseline: 60% (40% uncontrolled) Source/YR: UDS 2019 Stratified by special population: Agricultural Baseline: 69% (31% uncontrolled) HRSA Goal: 67% (33% uncontrolled)	**Refer to Attachment A*	Athena QMR Report with manual data validation	Monthly	Quarterly	Medical Director Quality Reporting Analyst
Controlling High Blood Pressure HRSA Required Measure	Baseline: 74% Source/YR: UDS 2019 HRSA Goal: 80%	**Refer to Attachment A*	Athena QMR Report with manual data validation	Monthly	Quarterly	Medical Director Quality Reporting Analyst
Low Birth Weight HRSA Required Measure	Baseline: 2% Source/YR: UDS 2019 HRSA Goal: <8%	**Refer to Attachment A*	Athena QMR Report with manual data validation	Monthly	Quarterly	Women's Health Director Quality Reporting Analyst
SATISFACTION						
Patient Satisfaction	Baseline: Not yet established. New metric for 2020 TARGET: 85%	Numerator: Total number of patients surveyed who would recommend C. L. Brumback to a friend or family member	Patient Satisfaction Survey Tool	Ongoing	Annually	Patient Relations Manager

Key Performance Indicator (KPI) Work Plan

KEY PERFORMANCE INDICATOR WORK PLAN						
Performance Indicator	**Performance Goal and Source/YR**	**Method of Collection**	**Data Source**	**Monitor Freq**	**Report Freq**	**Responsible Person/Depart**
	Source/YR: Internal Goal/2020	Denominator: Total number of patients surveyed				
Employee Satisfaction	Baseline: New Metric for 2020 TARGET: 85% participation rate Source/YR: Internal Goal/2020	Administration of Employee Satisfaction Survey Tool via 3rd Party Vendor with report	Employee Satisfaction Survey Tool	Annually	Annually	Human Resources
COORDINATON OF CARE						
Tracking Emergency Room Visits / Inpatient Hospitalizations	Baseline: New Metric for 2020	Internal ER Visit/Inpatient Hospitalization Tracking Process Numerator: a. Total number of patients discharged from the hospital with a follow up appointment scheduled within 5-7 days b. Total number of patients discharged from the emergency room with a follow up appointment scheduled within 5-7 days Denominator: a. Total number of patients discharged from the hospital b. Total number of patients discharged from the emergency room	ER/Hospital Tracking Log	Monthly	Quarterly	Director of Nursing

Key Performance Indicator (KPI) Work Plan

KEY PERFORMANCE INDICATOR WORK PLAN						
Performance Indicator	**Performance Goal and Source/YR**	**Method of Collection**	**Data Source**	**Monitor Freq**	**Report Freq**	**Responsible Person/Depart**
ACCESS / SERVICE UTILIZATION						
No Show Appointments	Baseline: New Metric for 2020	Practice Management System Numerator: Total number of patients scheduled appointments who did not show for their appointment and did not cancel. Denominator: Total number of patients scheduled for face to face encounters	Athena Custom Report	Monthly	Quarterly	Exec. Director of Operations
SAFETY/RISK MGMT						
Compliance with 72-hour chart closure standards	Baseline: New Metric for 2020	Athena CSM Report Numerator: Total number of patients with open medical records 72 hours after the face to face encounter Denominator: Total number of patients with face to face encounters	Athena 48-Hour Metrics Report	Monthly	Quarterly	Quality Reporting Analyst
Tracking Hospital Readmissions	Baseline: New Metric for 2020	Internal Hospital Tracking Process Numerator: Total number of patients readmitted to the hospital within 30 days of discharge Denominator: Total number of patients with inpatient hospitalizations	Athena Report with manual data validation	Weekly	Quarterly	Nursing Director

Key Performance Indicator (KPI) Work Plan

KEY PERFORMANCE INDICATOR WORK PLAN						
Performance Indicator	**Performance Goal and Source/YR**	**Method of Collection**	**Data Source**	**Monitor Freq**	**Report Freq**	**Responsible Person/Depart**
Patient Complaints	Baseline: Not yet established due to new numerator and denominator Source/YR: See Baseline TARGET: 100% Source/YR: Internal Goal 2020	Internal Patient Complaint Tracking Process Numerator: Total number of patient complaints forwarded to the QM Coordinator within 48 hours of report with documented patient follow - up Denominator: Total number of patient complaints	RiskQual	Ongoing	Quarterly	Patient Experience Manager
Employee Incidents	There is no goal. Reporting of incidents is always encouraged.	Internal Employee Incident Tracking Process Numerator: Total number of employee incidents forwarded to the QM Coordinator and CEO within 24 hours of incident with documented follow up. Denominator: Total number of employee incidents	RiskQual	Ongoing	Quarterly	Risk Manager

Table	Line	UDS Measure Name	Brief Description	Denominator (Universe)	Numerator	Exclusions or Exceptions	eCQM # (for 2019 Report)	2018 National Average	Major Differences from 2018 to 2019	Major Differences from UDS to eCQM	Reminders
6B	7-9	Early Entry into Prenatal Care	Percentage of prenatal care patients who entered prenatal care during their first trimester	Women seen for prenatal care during the year	Women beginning prenatal care at the health center or with a referral provider, or with the another prenatal care provider during their first trimester	None	no eCQM	73.8%	None	None	• Trimester of entry is based on last menstrual period (vs. conception) • 1st trimester is through end of 13th week • 2nd trimester is start of 14th week to end of 27th week • 3rd trimester starts at 28th week • If you referred women to other providers for all their prenatal care, report the trimester of their first prenatal visit with the other provider in Column A • Patient self-report of trimester of entry is permitted • Include women who began prenatal care in 2018 and delivered in 2019 • To determine the appropriate age group, use the woman's age on June 30th of the reporting year
6B	10	Childhood Immunization Status	Percentage of children 2 years of age who were fully immunized by their second birthday	Children who turn 2 years of age during the measurement period and who had a medical visit during the measurement period	Children who were fully immunized by their second birthday. A child is fully immunized if s/he has been vaccinated or there is documented evidence of history of illness, a seropositive test result, or an allergic reaction for ALL of the following: 4 diphtheria, tetanus, and acellular pertussis (DTaP); 3 polio (IPV), 1 measles, mumps, and rubella (MMR); 3 H influenza type B (HiB); 3 Hepatitis B (Hep B); 1 chicken pox (VZV); 4 pneumococcal conjugate (PCV); 1 Hepatitis A (Hep A); 2 or 3 rotavirus (RV); and 2 influenza (flu) vaccines	Patients who were in hospice care during the measurement period	CMS117v7	39.4%	None	None	• Record must list the dates of all immunizations and names of immunization agents • Good faith efforts do not meet the measurement standard, including: • Failure to bring patient in • Refusal for personal or religious reasons • Be sure to assess patients: • Who turned two during the year (do not include other ages), even if they were not seen before they turned two • Whose only medical visit is for acute or urgent care

Table	Line	UDS Measure Name	Brief Description	Denominator (Universe)	Numerator	Exclusions or Exceptions	eCQM # (for 2019 Report)	2018 National Average	Major Differences from 2018 to 2019	Major Differences from UDS to eCQM	Reminders
6B	11	Cervical Cancer Screening	Percentage of women 21*–64 years of age who were screened for cervical cancer(*Use age 23 as the initial age to include in the assessment)	Women 23 through 64 years of age with a medical visit during the measurement period	Women with one or more screenings for cervical cancer using either of the following criteria: * Women age 23-64 who had cervical cytology during the measurement period or the 2 years prior to the measurement period for women who are at least 21 years old at the time of the test * Women age 30-64 who had cervical cytology/human papillomavirus (HPV) co-testing performed during the measurement period or the 4 prior years to the measurement period	• Women who had a hysterectomy with no residual cervix or a congenital absence of cervix • Women who were in hospice care during the measurement period	CMS124v7	56%		None	• Documentation in the medical record must include date of test, who performed it, and test result • Do not count in the numerator: • Referrals to third parties without documentation of results • Statements from patient that it was done—without documentation • Refusal of patient to have the test • Include women in the evaluation of this measure if they had any medical visit during the year, regardless of the nature of the visit • Include patients who were provided obstetrics / gynecological services elsewhere

Table	Line	UDS Measure Name	Brief Description	Denominator (Universe)	Numerator	Exclusions or Exceptions	eCQM # (for 2019 Report)	2018 National Average	Major Differences from 2018 to 2019	Major Differences from UDS to eCQM	Reminders
6B	12	Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents	Percentage of patients 3 -17 years of age who had an outpatient medical visit and who had: • evidence of height, weight, and body mass index (BMI) percentile documentation • and who had documentation of counseling for nutrition • and who had documentation of counseling for physical activity during the measurement period	Patients 3 through 17 years of age with at least one medical visit during the measurement period	Patients who had: • Their BMI percentile (not just BMI or height and weight) recorded during the measurement period AND • Who had documentation of counseling for nutrition during the measurement period AND • Who had documentation of counseling for physical activity during during the measurement period	• Patients who have a diagnosis of pregnancy during the measurement period • Patients who were in hospice care during the measurement period	CMS155v7	69.2%	None	• eCQM denominator is limited to outpatient visits with a primary care physician or obstetrician / gynecologist. UDS includes children seen by nurse practitioners and physician assistants • Numerator BMI, nutrition, and activity are reported separately in the eCQM, but combined in the UDS	• Include children and adolescents in the evaluation of this measure if they had any medical visit with the health center during the year • Do not count well-child visits as automatically meeting the measurement standard

Table	Line	UDS Measure Name	Brief Description	Denominator (Universe)	Numerator	Exclusions or Exceptions	eCQM # (for 2019 Report)	2018 National Average	Major Differences from 2018 to 2019	Major Differences from UDS to eCQM	Reminders
6B	13	Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up Plan	Percentage of patients aged 18 years and older with BMI documented during the most recent visit or within the 12 months prior to that visit and when the BMI is outside of normal parameters, a follow-up plan is documented during the visit or during the previous 12 months of that visit	Patients 18 years of age or older on the date of the visit with at least one medical visit during the measurement period	Patients with a documented BMI (not just height and weight) during the most recent visit in the measurement period or during the previous 12 months of that visit, AND when the BMI is outside of normal parameters, a follow-up plan is documented during the visit or during the previous 12 months of the current visit. Normal parameters: Age 18 years and older BMI was greater than or equal to 18.5 and less than 25 kg/m^2	• Patients who are pregnant during the measurement period • Patients receiving palliative care during or prior to the visit • Patients who refuse measurement of height and/or weight, or refuse follow-up during the visit • Patients with a documented medical reason during the visit or within 12 months of the visit, including: • Elderly patients for whom weight reduction/ weight gain would complicate other underlying health conditions • Patients in an urgent or emergent medical situation where time is of the essence and to delay treatment would jeopardize the patient's health status	CMS69v7	70.1%	None	None	• Include adults in the evaluation of this measure if they had any medical visit during the year, regardless of the nature of the visit • If more than one BMI is reported during the measurement period, use the most recent BMI to determine if the performance has been met.

Table	Line	UDS Measure Name	Brief Description	Denominator (Universe)	Numerator	Exclusions or Exceptions	eCQM # (for 2019 Report)	2018 National Average	Major Differences from 2018 to 2019	Major Differences from UDS to eCQM	Reminders
6B	14a	Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention	Percentage of patients aged 18 and older who were screened for tobacco use one or more times within 24 months and who received cessation counseling intervention if defined as a tobacco user	Patients aged 18 years and older seen for at least two medical visits in the measurement period or at least one preventive medical visit during the measurement period	Patients who were screened for tobacco use at least once within 24 months before the end of the measurement period, AND who received tobacco cessation intervention if identified as a tobacco user	Documentation of medical reason(s) for not screening for tobacco use or for not providing tobacco cessation intervention (e.g., limited life expectancy, other medical reason)	CMS138v7	88.1%	None	• Denominator patient population and numerator are reported separately in the eCQM, but combined in the UDS	• Cessation counseling intervention for a tobacco user must occur at or following the most recent screening and before the end of the measurement year. • Count in the numerator both patients with a negative screening result AND those with a positive screening who had cessation services provided • Include all forms of tobacco, but exclude e-cigarettes, in the screening • Include patients who receive tobacco cessation intervention by any provider, including: • Received tobacco use cessation counseling services, or • Received an order (a prescription or a recommendation to purchase an over the counter [OTC] product) for a tobacco use cessation medication, or • Are on (using) a tobacco use cessation agent
6B	16	Use of Appropriate Medications for Asthma	Percentage of patients 5-64 years of age who were identified as having persistent asthma and who were appropriately ordered medication during the measurement period	Patients age 5 through 64 years with persistent asthma with a medical visit during the measurement period	Patients who were ordered at least one prescription for a preferred therapy during the measurement period	• Patients with a diagnosis of emphysema, chronic obstructive pulmonary disease, obstructive chronic bronchitis, cystic fibrosis, or acute respiratory failure that overlaps the measurement period	CMS126v5	86.6%	None	Note: eCQM specifications for this measure have not been updated.	• Preferred therapy includes patients who: Received a prescription for or were using an inhaled corticosteroid, or received a prescription for or were using an acceptable pharmacological agent, specifically inhaled steroid combinations, anti-asthmatic combinations, antibody inhibitor, leukotriene modifiers, mast cell stabilizers, or methylxanthines • Query system to identify only those patients with persistent asthma (not mild or intermittent asthma)

Table	Line	UDS Measure Name	Brief Description	Denominator (Universe)	Numerator	Exclusions or Exceptions	eCQM # (for 2019 Report)	2018 National Average	Major Differences from 2018 to 2019	Major Differences from UDS to eCQM	Reminders
6B	17a	Statin Therapy for the Prevention and Treatment of Cardiovascular Disease	Percentage of the following patients at high risk of cardiovascular events aged 21 years and older who were prescribed or were on statin therapy during the measurement period • Patients 21 years of age or older previously diagnosed with or currently have an active diagnosis of clinical atherosclerotic cardiovascular disease (ASCVD); or • Patients 21 years of age or older who have ever had a fasting or direct low-density lipoprotein cholesterol (LDL-C) level greater than or equal to 190 mg/dL or were previously diagnosed with or currently have an active diagnosis of familial or pure hypercholesterolemia; or • Patients 40 through 75 years of age with a diagnosis of diabetes with a fasting or direct LDL-C level of 70-189 mg/dL.	Patients 21 years of age and older with who have an active diagnosis of ASCVD or ever had a fasting or direct laboratory result of LDL-C greater than or equal to 190 mg/dL or were previously diagnosed with or currently have an active diagnosis of familial or pure hypercholesterolemia; or patients 40 through 75 years of age with Type 1 or Type 2 diabetes and with an LDL-C result 70-189 mg/dL recorded as the highest fasting or direct laboratory test result in the measurement year or the 2 years prior; with a medical visit during the measurement period	Patients who are actively using or who received an order (presciption) for statin therapy at any point during the measurement period	• Patients who have a diagnosis of pregnancy • Patients who are breastfeeding. • Patients who have a diagnosis of rhabdomyolysis. • Patients with adverse effect, allergy, or intolerance to statin medication. • Patients who are receiving palliative care. • Patients with active liver disease or hepatic disease or insufficiency. • Patients with end-stage renal disease (ESRD). • For patients 40 through 75 years of age with diabetes who have the most recent fasting or direct LDL-C laboratory test result less than 70 mg/dL and are not taking statin therapy.	CMS347v2	n/a	• New measure for CY2019. Replaces previous CAD measure.		• Current statin therapy use (including statin medication samples provided to patients) must be documented in the patient's current medication list or ordered during the measurement period. • Do not count other cholesterol lowering medications as meeting the measurement standard—only statin therapy meets the measurement standard. • Ensure patients are not counted in the denominator more than once. Once a patient meets one set of denominator criteria (check from first listed in Measure Description to last), he/she is included and further risk checks are not needed. • Intensity of statin therapy or lifestyle modification coaching is not being assessed for this measure—only prescription of any statin therapy.

Table	Line	UDS Measure Name	Brief Description	Denominator (Universe)	Numerator	Exclusions or Exceptions	eCQM # (for 2019 Report)	2018 National Average	Major Differences from 2018 to 2019	Major Differences from UDS to eCQM	Reminders
6B	18	Ischemic Vascular Disease (IVD): Use of Aspirin or Another Antiplatelet	Percentage of patients aged 18 years of age and older who were diagnosed with acute myocardial infarction (AMI), or who had a coronary artery bypass graft (CABG) or percutaneous coronary interventions (PCIs) in the 12 months prior to the measurement period, or who had an active diagnosis of IVD during the measurement period, and who had documentation of use of aspirin or another antiplatelet during the measurement period	Patients 18 years of age and older with a medical visit during the measurement period and who had an AMI, CABG, or PCI in the 12 months prior to the measurement period or who had a diagnosis of IVD overlapping the measurement period	Patients who had an active medication of aspirin or another antiplatelet during the measurement period	• Patients who had documentation of use of anticoagulant medications overlapping the measurement period • Patients who were in hospice care during the measurement period	CMS164v7	80.9%	None	None	• Include in the numerator patients who received a prescription for, were given, or were using aspirin or another antiplatelet drug

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6B	19	Colorectal Cancer Screening	Percentage of adults 50–75 years of age who had appropriate screening for colorectal cancer	Patients 50 through 75 years of age with a medical visit during the measurement period	Patients with one or more screenings for colorectal cancer. Appropriate screenings are defined by any one of the following: • Fecal occult blood test (FOBT) during the measurement period • Fecal immunochemical test (FIT)-deoxyribonucleic acid (DNA) during the measurement period or the 2 years prior to the measurement period • Flexible sigmoidoscopy during the measurement period or the 4 years prior to the measurement period • Computerized tomography (CT) colonography during the measurement period or the 4 years prior to the measurement period • Colonoscopy during the measurement period or the 9 years prior to the measurement period	• Patients with a diagnosis of colorectal cancer or history of total colectomy • Patients who were in hospice care during the measurement period	CMS130v7	44.1%	• Do not count digital rectal exam (DRE), FOBT tests performed in an office setting or performed on a sample collected via DRE.	None	• There are two FOBT test options: Guaiac fecal occult blood test (gFOBT) and the immunochemical-based fecal occult blood test (iFOBT - commonly known as a FIT test)
6B	20	HIV Linkage to Care	Percentage of patients newly diagnosed with HIV who were seen for follow-up treatment within 90 days of diagnosis	Patients first diagnosed with HIV by the health center between October 1 of prior year through September 30 of the current measurement year and who had at least one medical visit during the measurement period or prior year	Newly diagnosed HIV patients that received treatment within 90 days of diagnosis. Include patients who: • Were newly diagnosed by your health center providers, and • Had a medical visit with your health center provider who initiates treatment for HIV, or • Had a visit with a referral resource who initiates treatment for HIV	None	no eCQM	85.5%	None	None	• Only include patients in the denominator who have never before been diagnosed with HIV anywhere • Note that the identification of patients for this measure crosses years and may include prior year patients • To confirm HIV diagnosis, patient must receive a reactive initial HIV test confirmed by a positive supplemental HIV (blood) test • Medical treatment must be initiated within 90 days of HIV diagnosis (not just a referral made, education provided, or retesting conducted)

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6B	21	Preventive Care and Screening: Screening for Depression and Follow-Up Plan	Percentage of patients aged 12 years and older screened for depression on the date of the visit using an age-appropriate standardized depression screening too, and if positive, a follow-up plan is documented on the date of the positive screen	Patients aged 12 years and older with at least one medical visit during the measurement period	Patients screened for depression on the date of the visit using an age-appropriate standardized tool and, if screened positive for depression, a follow-up plan is documented on the date of the positive screen	• Patients with an active diagnosis for depression or a diagnosis of bipolar disorder • Patients who refuse to participate • Patients who are in urgent or emergent situations where time is of the essence and to delay treatment would jeopardize the patient's health status • Patients whose functional capacity or motivation to improve may impact the accuracy of results of standardized assessment tools	CMS2v8	70.6%	Do not count a PHQ-9 screening that follows a positive PHQ-2 screening during the measurement period as meeting the measurement standard for a follow-up plan to a positive depression screening.	None	• Use the most recent screening results • Patients who are in ongoing treatment for depression are not included in the denominator • Remember to count in the numerator both patients with a negative screening result AND those with a positive screening who had a follow-up plan • Do not count patients who are re-screened as meeting the measurement standard as a follow-up plan to a positive screen
6B	22	Dental Sealants for Children between 6-9 Years	Percentage of children, age 6–9 years, at moderate to high risk for caries who received a sealant on a first permanent molar during the measurement period	Children 6 through 9 years of age with an oral assessment or comprehensive or periodic oral evaluation dental visit and are at moderate to high risk for caries in the measurement period	Children who received a sealant on a permanent first molar tooth during the measurement period	• Children for whom all first permanent molars are non-sealable (i.e., molars are either decayed, filled, currently sealed, or un-erupted/missing)	CMS277v0	52.8%	None	Note: Although measure title is age 6 through 9 years, draft e-CQM reflects age 5 through 9 years —Health centers should continue to use age 6 through 9 years, as measure steward intended	• Include patients who had a dental visit with the health center or with another dental provider through a paid referral • You must determine risk level, not count all dental patients of this age range in universe • Risk level is a finding at the patient-level, not a population-based factor such as low socio-economic status • If risk level or tooth placement is unknown for patients, pull a sample to help identify this information

Table	Line	UDS Measure Name	Brief Description	Denominator (Universe)	Numerator	Exclusions or Exceptions	eCQM # (for 2019 Report)	2018 National Average	Major Differences from 2018 to 2019	Major Differences from UDS to eCQM	Reminders
7	1a-1d	Low Birth Weight	Percentage of babies of health center prenatal care patients born whose birth weight was below normal (less than 2,500 grams)	Babies born during measurement period to prenatal care patients	Babies born with a birth weight below normal (under 2,500 grams)	• Still-births or miscarriages	no eCQM	8%	None	None	• Report babies according to their birth weight in grams: • Very low (Column 1b) = Less than 1,500 grams • Low (Column 1c) = 1,500 grams through 2,499 grams • Normal (Column 1d) = 2,500 grams or greater • The higher the percentage of babies born below normal birth weight, the poorer the outcome • Report race and ethnicity of mother and baby separately • Report all live births separately by birth weight • Report mothers in prenatal program and their babies, even if prenatal care or delivery was done by a non-health center provider • Prenatal Women ≠ Deliveries ≠ Birth Outcomes • Review outcomes against overall patient population mix
7	2a-2c	Controlling High Blood Pressure	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	Patients 18 through 85 years of age who had a diagnosis of essential hypertension within the first six months of the measurement period or any time prior to the measurement period with a medical visit during the period	Patients whose blood pressure at the most recent visit is adequately controlled (systolic blood pressure < 140 mmHg and diastolic blood pressure < 90 mmHg) during the measurement period	• Patients with evidence of end-stage renal disease (ESRD), dialysis, or renal transplant before or during the measurement period• Patients with a diagnosis of pregnancy during the measurement period• Patients who were in hospice care during the measurement period	CMS165v7	63.3%	None	None	• Do not include patients in the denominator if initial diagnosis of hypertension was made after June 30th of measurement period • Include patients with no test during the year in the denominator, but do not include in the numerator • Report them in Columns 2a and 2b, but not in Column 2c • Include blood pressure readings taken at any visit type at the health center as long as the result is from the most recent visit • Review crude prevalence rates by taking number with hypertension by race and ethnicity (Table 7) divided by total patients of same race and ethnicity (Table 3B)

Table	Line	UDS Measure Name	Brief Description	Denominator (Universe)	Numerator	Exclusions or Exceptions	eCQM # (for 2019 Report)	2018 National Average	Major Differences from 2018 to 2019	Major Differences from UDS to eCQM	Reminders
7	3a-3f	Diabetes: Hemoglobin A1c (HbA1c) Poor Control (>9%)	Percentage of patients 18–75 years of age with diabetes who had hemoglobin A1c > 9.0% during the measurement period	Patients 18 through 75 years of age with diabetes with a medical visit during the measurement period	Patients whose most recent HbA1c level during the measurement year is greater than 9.0 percent or who had no test conducted during the measurement period	• Patients who were in hospice care during the measurement period	CMS122v7	32.9%	None	None	• Include patients with an active diagnosis of Type 1 or Type 2 diabetes • Include patients with active diabetes regardless of when first diagnosed •Do not include patients with a diagnosis of secondary diabetes due to another condition (such as gestational diabetes) in the denominator • Note: The higher the percentage of patients with Hba1c of 9.0 percent or over, the poorer the clinical performance • Review crude prevalence rates by taking number with diabetes by race and ethnicity (Table 7) divided by total patients of same race and ethnicity (Table 3B)

Web link reference: https://ecqi.healthit.gov/eligible-professional/eligible-clinician-ecqms/2019-performance-period-ep/ec-ecqms

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