County of Solano
Community Healthcare Board
Regular Meeting

April 17, 2019
12:00 pm-2:00 pm
2101 Courage Drive, Fairfield, CA 94533
Multi-Purpose Room

Agenda

1) CALL TO ORDER – 12:00 PM
a) Welcome
b) Roll Call

2) APPROVAL OF THE AGENDA

3) APPROVAL OF THE MARCH 20, 2019 MEETING MINUTES

4) ITEMS FROM THE PUBLIC
This is your opportunity to address the Board on a matter not listed on the Agenda, but it must be within the subject matter jurisdiction of the Board. Please submit a Speaker Card before the first speaker is called and limit your comments to three minutes.

5) EXECUTIVE DIRECTOR'S REPORT
a) Credentialing
b) Board elections
c) Contracts i.e. Greg Facktor & Associates

6) OPERATIONS COMMITTEES' REPORTS
a) Provider Advisory, Finance, Quality Performance, HRSA OSV

7) UNFINISHED BUSINESS
a) Review and consider for approval key management staff and organization charts of Family Health Services Health Centers
b) Provide an update to Family Health Services' Mission, Vision, and Values

8) NEW BUSINESS
a) Receive a presentation on the Mobile Clinics' redeployment and consider for approval proposed redeployment plan
b) Review and consider for approval Family Health Services Policies:
   i) #100.04 – Claims Processing
   ii) #100.08 – Fee Waiver & Payment Plan
   iii) #100.10 – Patient Registration
   iv) #100.12 – Fee Schedule
   v) #200.01 – Supervision of Minor Children
   vi) #200.02 – Patient Grievance/Complaint Process
   vii) #300.01 – After Hours Coverage
   viii) #900.01 – Use of funding from the Health Resources and Services Administration
c) Receive and consider recommended nominees for board membership

d) Discuss and consider for approval a rotation of the Regular Meeting locations to accommodate patient attendance

9) BOARD MEMBER COMMENTS

10) CONSIDERATIONS FOR FUTURE AGENDA ITEMS

11) ADJOURN:

To the Community Healthcare Board Regular Meeting of
May 15, 2019 at 12:00PM
2101 Courage Drive, Fairfield, CA 94533, Multipurpose Room

The County of Solano Community Healthcare Board does not discriminate against persons with disabilities and is an accessible facility. If you wish to attend this meeting and you will require assistance in order to participate, please call Solano County Family Health Services at 707-784-4444 at least 24 hours in advance of the event to make reasonable arrangements to ensure accessibility to this meeting.

If you wish to address any item listed on the Agenda, or Closed Session, please submit a Speaker Card to the Board Clerk before the Board considers the specific item. Cards are available at the entrance to the Board chambers. Please limit your comments to three minutes.

County of Solano
Community Healthcare Board

REGULAR GOVERNING BOARD MEETING MINUTES
March 19, 2019
2101 Courage Drive, Fairfield, CA 94533, Multipurpose Room

Members present:
Mike Brown, Ruth Forney, Tracee Stacy, Sandra Whaley, Brandon Wirth

Members absent:
Anthony Lofton, Charlotte Webb, Eva Yra-Bernardes

Staff Present:
Bela Matyas, Michael Stacey, Ciara Gonsalves, Sneha Innes, Janine Harris, Noelle Soto, Amanda Meadows, Daniel Yolangco, Alicia Jones, Jaron West, Shandi Fuller

1) CALL TO ORDER – 12:00 PM

a) Welcome
b) Roll Call

2) APPROVAL OF THE AGENDA

Move to approve the agenda with no changes.

Motion by Brandon Wirth, second by Ruth Forney
Aye: Mike Brown, Ruth Forney, Tracee Stacy, Sandra Whaley, Brandon Wirth
Motion carries

3) APPROVAL OF THE FEBRUARY 20, 2019 MEETING MINUTES

Move to approve the February 20, 2019 meeting minutes with no changes.

Motion by Brandon Wirth, second by Mike Brown
Aye: Mike Brown, Ruth Forney, Tracee Stacy, Sandra Whaley, Brandon Wirth
Motion carries

4) ITEMS FROM THE PUBLIC

No Public Comment

5) EXECUTIVE DIRECTOR'S REPORT

Dr. Michael Stacey, Medical Services Officer, highlighted the following:

- Town Hall Meeting held on March 19, 2019 – All FHS Staff members meeting
- Three top initiatives
    1. Working on getting ready for HRSA site visits Sep 10-12 2019
        - Committees have been developed to focus of the specific needs of the HRSA site visit
    2. Patient Access
        - Senior Leadership Committee- laying out work flows
            - Dr. Leary overseeing Adult Medicine
            - Dr. Shinder overseeing Pediatrics
            - Dr. Innes overseeing Dental

- Making improvements to maximize patient access

3. Revenue Cycle Management
   - Janine Harris supervising front office account clerks and standardizing our processes for billing and collections.

Board member Tracee Stacy requested a future report on the progress and results of the work flow process for patient access.

Board member Ruth Forney commented that staff is working on and approving actions to be taken before the Board provides approval to move forward.

Health Officer Dr. Bela Matyas requested guidance from the Board on when the Board would like to approve actions prior to being taken.

6) OPERATIONS COMMITTEES' REPORTS

Dr. Stacey presented:

1) Physician Advisory Committee – once a month meeting
   - Name change – Provider Advisory Committee
   - Committee has met one time
   - Purpose – address any provider's concerns
   - Committee members – made up of physician supervisors/medical directors & Touro University participant, Executive Director, Chief Operations Officer, Medical Services Officer, Health Officer
   - Located TBD monthly
2) Finance Committee – once a month meeting
   - First meeting set for March 28, 2019
   - Located at 275 Beck, Fairfield, CA
3) Quality Performance Committee – twice a month meeting
   - Committee has met once so far – March 15, 2019
   - Focus will be measurements to comply with HRSA with quality of care
   - Chair – Dr. Leary & Dr. Shinder
   - Located 2101 Courage Dr. Fairfield, CA HSS-FHS Multi-Purpose RM
4) HRSA OSV – twice a month meeting
   - Specific committee for HRSA OSV in September
   - Responsibilities assigned to members in compliance with HRSA standards

7) UNFINISHED BUSINESS

a) Board member conflict of interest

Dr. Stacey provided the response for technical assistance on Compliance Manual Chapter 13 Conflict of Interest from their HRSA Project Officer. The HRSA Project Officer referenced language from the Compliance Manual and provided that the health center has discretion in establishing methods for disclosure or real or apparent conflicts.

b) Review and consider for approval of key management staff and organization charts of Family Health Services Centers

Dr. Stacey informed the Board that this item is contingent upon the Health and Social Services proposal to the Board of Supervisor (BOS) reorganization – no vote was taken at the BOS meeting.

Ms. Stacy requested the item be tabled for discussion until the April or May meeting, once the BOS action items have taken place.

8) NEW BUSINESS

a) Receive a presentation on the Kindergarten Round-Up (KRU) initiative and consider for approval staff to carry out the event and solicit the community for donations

Dr. Shandi Fuller, Deputy Health Officer provided a presentation on the Kindergarten Round-Up event.

Move to approve staff to carry out the event (KRU) and solicit the community for donations.

Motion by Tracee Stacy, second by Brandon Wirth
Aye: Mike Brown, Ruth Forney, Tracee Stacy, Sandra Whaley, Brandon Wirth
Motion carries

b) Discuss and consider for approval the Mobile Clinics' redeployment date

Move to consider approval for the Mobile Clinics' redeployment date to be presented at the April 17, 2019 Board meeting.

Motion by Sandra Whaley, second by Ruth Forney
Aye: Mike Brown, Ruth Forney, Tracee Stacy, Sandra Whaley, Brandon Wirth
Motion carries

c) Review and consider for approval the Solano County Family Health Services Patient Satisfaction Survey

Alicia Jones, Vallejo Practice Manager, discussed the Patient Satisfaction Survey with the purpose to consider patients' feedback at all clinics.

Move to approve the Solano County Family Health Services Patient Satisfaction Survey, with staff's discretion on how to administer the survey

Motion by Ruth Forney, second by Mike Brown
Aye: Mike Brown, Ruth Forney, Tracee Stacy, Sandra Whaley, Brandon Wirth
Motion carries

d) Discuss board member travel and attendance to conference, establish a process for board member participation, and consider for approval upcoming conference attendance.

The Board discussed attending two upcoming health center conferences in the future, the National Healthcare for the Homeless Conference in May 2019, and the National Association of Community Health Centers Community Health Institute & Expo in August 2019.

Move to approve Board Member Ruth Forney to attend the National Healthcare for the Homeless Conference in May 2019

Motion by Tracee Stacy, second by Ruth Forney
Aye: Mike Brown, Ruth Forney, Tracee Stacy, Sandra Whaley
Abstain: Brandon Wirth
Motion Carries

e) Provide an update to Family Health Services' Mission, Vision, and Values
The Board agreed to table this item for the next meeting.

9) BOARD MEMBER COMMENTS

Ms. Stacy inquired of the likelihood of dental expansion before the next fiscal year.

Dr. Matyas responded that there is zero percent chance of dental expansion before the next fiscal year, due to Solano County General Services being understaffed and unable to take on the project.

Ms. Forney informed the board members and staff of Charlotte Webb and Eva Yra-Bernardes verbally resigning their positions as board members. Anthony Lofton is pending due to lack of transportation.

Staff will identify a method for transportation for Mr. Lofton for him to attend board meetings as a board member.

Board Member Brandon Wirth recommended the Board accept the resignations of Board Members Charlotte Webb and Eva Yra-Bernardes. The Board concurred.

10) CONSIDERATIONS FOR FUTURE AGENDA ITEMS

Ms. Tracy requested the outcomes from the Board of Supervisors' Health and Social Services reorganization workshop.

Chair Sandra Whaley requested to stick to the annual calendar items to be added to the agenda accordingly.

11) ADJOURNMENT

Handouts:

- Solano County Family Health Services Patient Satisfaction Survey
- February 20, 2019 meeting minutes

Claims Processing

Policy Number: 100.04

Effective Date	May 1, 2019
Frequency of Review	Annual
Last Reviewed	April 8, 2019
Last Updated	April 8, 2019
Author	Janine Harris
Responsible Department	Revenue Cycle Management

PURPOSE:
The purpose of this policy is to describe requirements for claims processing for Family Health Services (FHS) front office operations. FHS staff are expected to comply with this policy and procedure.

DEFINITIONS:
None

BACKGROUND
It is the policy of Solano County Health and Social Services to uphold compliance with government regulations. FHS is a Federally Qualified Health Center (FQHC) and receives federal funding under the Health Center Program authorized by section 330 of the Public Health Service (PHS) Act (42 U.S.C. 254b) ("section 330"), as amended (including sections 330(e) and (h)). The program is administered by the federal Health Resources and Services Administration (HRSA).

POLICY:
FHS front office Accounting Clerks will submit claims for billing daily using mass billing within the electronic health records. For encounters that do not pass the claim edits in mass billing, or cannot be billed using mass billing, the encounters will be processed individually daily. Each day, the prior day's encounters will be billed. If charges have not been entered by the provider, the Accounting Clerks will attempt to bill it the following day. After three days, the Accounting Clerk will send the provider a reminder email requesting for the charges to be entered.

Front office Accounting Clerks are not coders. Any coding errors that prevent the billing from passing the claim edits will be sent to the FHS Policy & Financial Analyst (PFA)/Revenue Cycle Manager (RCM) for review and correction, as stated in the Coding policy, #100.05.

PROCEDURE:
1. Charge Development
    a. Providers select appropriate Current Procedural Terminology (CPT), Healthcare Common Procedure Coding System (HCPCS), and International Classification of Diseases, Tenth Revision (ICD-10) codes for each outpatient face-to-face encounter.

Once providers complete the documentation for each encounter, the charges are ready for processing by the front office Accounting Clerks.

2. Encounter to Claim Process
    a. Front office Accounting Clerks will review the prior day's unbilled encounters for self-pay/sliding fee scale encounters. The encounters are processed individually to ensure the charges slide appropriately if the patient is on the sliding fee scale. After review, self-pay encounters are billed.
    b. Front office Accounting Clerks will individually process the emergency/pregnancy Medi-Cal encounters for Dental.
        i. Pregnancy encounters require an additional narrative to be added prior to billing electronically.
        ii. Emergency encounters require additional documentation to be attached to a paper claim and mailed. They cannot be billed electronically.
    c. Non-provider encounters, such as Registered Nurse/Medical Assistant (RN/MA) encounters, are individually processed to determine if the encounter is eligible to be claimed under the Supervising Physician, or if it is a non-billable encounter.
        i. For example, certain injections and administration may be billed under the Supervising Physician if administered without being seen by a provider.
    d. Front office Accounting Clerks will work the exceptions to mass billing, as described in a-c, and any other exceptions that arise. After exceptions are worked, the remaining encounters are claimed using mass billing in the electronic health records. Any encounters that do not pass the mass billing claim edits are worked individually.
    e. Any encounters that are missing charges are reviewed each day to determine if the charges are entered. After three days of missing charges, the Accounting Clerk will send a reminder email to the provider to document the encounter and submit charges.
    f. All coding corrections are sent to the PFA/RCM. Medical billing corrections can be made by the Accounting Clerk.
    g. Claims are submitted to the back-office Billing and Collections team to submit the electronic primary claims, process the secondary and tertiary claims, and to work denials.
3. PM160 Information Only forms are required for FQHC's to complete for CHDP State and Gateway patients. The PM160 template is finalized by the provider in the electronic health records. The front office Accounting Clerk will print and mail the forms for all CHDP State and Gateway patients.
    a. If the template is not finalized by the provider, the Accounting Clerk is authorized to finalize it, if the required documentation is completed. The Accounting Clerk will notify the PFA/RCM and Supervising Physicians over the Pediatricians.
    b. Front office Accounting Clerks, back-office Billing and Collections, and the PFA/RCM are the authorized designee to sign the PM160 forms on behalf of the providers. The signature on the PM160 form represents that the information on the form is a true and accurate representation of the information the provider documented in the patient's chart.

Knowledge of a violation or potential violation of this policy must be reported directly to the FHS Revenue Cycle Manager, FHS Executive Director, or to the employee compliance hotline.

REFERENCED POLICIES	100.05 Coding Policy
REFERENCED FORMS	
REFERENCES	

_____ _____

Chair - Community Healthcare Board **Date**

_____ _____

Vice-Chair - Community Healthcare Board **Date**

Fee Waiver & Payment Plans

Policy Number: 100.08

Effective Date	May 1, 2019
Frequency of Review	Annual
Last Reviewed	April 3, 2019
Last Updated	April 3, 2019
Author	Janine Harris
Responsible Department	Revenue Cycle Management

PURPOSE:
The purpose of this policy is to reduce and/or eliminate financial barriers to patients who qualify for the program to ensure access to services regardless of the patient's ability to pay. At no time will a patient be denied services because of an inability to pay.

The Sliding Fee Scale Discount Program is available for all patients to apply for, as described in policy number 100.03 – Sliding Fee Scale Discount Program. The fee waiver and payment plan options are available in addition to the sliding fee scale discount program for patients who qualify for a fee waiver or payment plan, as described in this policy.

DEFINITIONS:
None

BACKGROUND
It is the policy of Solano County Health and Social Services to uphold compliance with government regulations. FHS is a Federally Qualified Health Center (FQHC) and receives federal funding under the Health Center Program authorized by section 330 of the Public Health Service (PHS) Act (42 U.S.C. 254b) ("section 330"), as amended (including sections 330(e) and (h)). The program is administered by the federal Health Resources and Services Administration (HRSA).

POLICY:
Family Health Services shall provide medical and dental services regardless of a patient's ability to pay. The Sliding Fee Scale Discount Program is available for all patients to apply for, as described in policy number 100.03 – Sliding Fee Scale Discount Program. Patients who are unable to pay for services due to special circumstances may request for fees to be waived. All fee waiver applications must be reviewed and approved by a Practice Manager or the Revenue Cycle Manager.

Payment plan agreements may be approved by the front office Accounting Clerks, Office Supervisor or Practice Manager. Patients who apply for a payment plan agreement will not be sent to collections as long as the patient adheres to the terms of the payment plan.

Fee Waiver & Payment Plans

Policy Number: 100.08

PROCEDURE:

1. Fee Waivers
    a. Patients may request a fee waiver, or if the Accounting Clerk, Office Supervisor or Practice Manager sees a need to offer a fee waiver based on special circumstances, it may be offered to the patient.
    b. Patients who apply for a fee waiver must complete the fee waiver request form. The Practice Manager or Revenue Cycle Manager must review and approve the fee waiver request.
    c. The Practice Manager may complete the fee waiver form on behalf of the patient, if necessary.
    d. Fee waiver forms will be scanned into NextGen into the patient's chart.
2. Payment Plan Agreements
    a. Payment plans are available upon request. Patients who would like to apply for a payment plan will complete the payment plan agreement form. Front office Accounting Clerks, Office Supervisors or Practice Managers may approve the agreement.
    b. Payment plan agreement forms will be scanned into NextGen into the patient's chart.
    c. As long as the patient adheres to the terms of the agreed upon payment plan, the back-office Billing and Collections team will not send the patient to collections, as described in the Sliding Fee Scale Discount Policy - #100.03 and the Health and Social Services collection policy.
    d. If a patient is not meeting the terms of the payment plan, the back-office Billing and Collections team will notify the front office Accounting Clerk. The front office Accounting Clerk will attempt to reach out to the patient. If the patient does not meet the terms of the payment plan, the plan will be null and void.

Knowledge of a violation or potential violation of this policy must be reported directly to the FHS Revenue Cycle Manager and the FHS Executive Director or to the employee compliance hotline.

REFERENCED POLICIES	100.03 – Sliding Fee Scale Discount Program
REFERENCED FORMS	Payment Plan Agreement Fee Waiver
REFERENCES	

_____ _____

Chair - Community Healthcare Board **Date**

_____ _____

Vice-Chair - Community Healthcare Board **Date**

Solano County Family Health Services

FEE WAIVER REQUEST

FAIRFIELD	**FAIRFIELD**	**VACAVILLE**	**VALLEJO**
2201 Courage Dr.	2101 Courage Dr.	1119 E. Monte Vista	365 Tuolumne St.

PATIENT'S NAME: _____ PATIENT'S DOB: _____

DATE: _____ ENCOUNTER#_____

If you are currently experiencing a financial hardship and would like Family Health Services to consider you for a one-time fee waiver for the requested encounter, please provide the reason for your request below:

_____

_____

_____

_____

_____

_____

_____

_____

By signing below, I certify that the information given by me on this form is true in all respects. My signature below certifies that I have read and understand to the best of my knowledge the information on this form and have been given an opportunity to ask questions regarding the fee waiver request. I acknowledge that my fee waiver request must be approved and signed by either the Practice Manager or Revenue Cycle Manager before it can be assigned to me and my signature below is not a guarantee of approval.

_____

Patient's Signature Date

Processed by:_____ **Date:**_____
Health Center Representative Title

Approved by: _____ **Date:** _____
Health Center Manager Title

Solano County Family Health Services

PAYMENT PLAN AGREEMENT

FAIRFIELD	**FAIRFIELD**	**VACAVILLE**	**VALLEJO**
2201 Courage Dr.	2101 Courage Dr.	1119 E. Monte Vista	365 Tuolumne St.
707-784-2010	707-784-2010	707-784-2010	707-784-2010

PATIENT'S NAME: _____ PATIENT'S DOB: _____

DATE: _____ CURRENT BALANCE ON ACCOUNT: _____

I understand that I am responsible for the outstanding balance and agree to the following:

☐ I agree to notify this health center if any changes occur in family size, income, medical insurance status or address.

☐ I agree to pay $_____ each month until paid in full.

☐ I agree to pay $_____ every two (2) weeks until paid in full.

NOTES: _____

_____

I certify that the information given by me on this form is true in all respects. My signature below certifies that I have read and understand to the best of my knowledge the information on this form and have been given an opportunity to ask questions regarding any issues that I might have regarding the sliding fee-scale.

PLEASE NOTE: **If payment is not made as agreed upon above, your account may be transferred to the Collection Agency.**

You may call us at the above number if you have any questions regarding your statement.

_____

Date Print Name Signature Relationship (if not self)

Approved by: _____ **Date:** _____
Health Center Representative Title

Patient Registration

Policy Number: 100.10

Effective Date	May 1, 2019
Frequency of Review	Annual
Last Reviewed	April 5, 2019
Last Updated	April 5, 2019
Author	Janine Harris
Responsible Department	Revenue Cycle Management

PURPOSE:
The purpose of this policy is to describe requirements for patient registration for Family Health Services (FHS) patients. FHS staff are expected to comply with this policy and procedure.

FHS will ensure access to health care services by families and individuals regardless of the patient's ability to pay. At no time will a patient be denied services because of an inability to pay, as described in the Sliding Fee Scale Discount Program policy #100.03.

DEFINITIONS:
None

BACKGROUND
It is the policy of Solano County Health and Social Services to uphold compliance with government regulations. FHS is a Federally Qualified Health Center (FQHC) and receives federal funding under the Health Center Program authorized by section 330 of the Public Health Service (PHS) Act (42 U.S.C. 254b) ("section 330"), as amended (including sections 330(e) and (h)). The program is administered by the federal Health Resources and Services Administration (HRSA).

POLICY:
FHS shall verify patient demographics, insurance eligibility, balance due, and sliding fee scale eligibility for each patient upon check-in, as described in the Insurance Eligibility policy #100.01 and the Sliding Fee Scale Discount Program policy #100.03. If the patient has a balance due, registration staff will request applicable payments from the patient while ensuring the patient is not denied service based on inability to pay. Registration staff may refer the patient to the front office Accounting Clerk to discuss payment plans, Sliding Fee Scale program, or fee waivers.

Registration staff will educate patients on insurance or programs available to them upon registration, including but not limited to: Every Woman Counts (EWC), Family Planning, Access, Care and Treatment (FPACT) and Sliding Fee Scale (SFS).

PROCEDURE:
1. For health centers with the automated Q-Matic numbering system, the patient will take a number upon entering the health center. Numbers are called in order of priority set forth by each health center.

2. For health centers without the automated Q-Matic numbering system, the patient will stand in line until called to the counter by the front office registration staff. Patients are called in order of arrival time.
3. Registration staff will check each patient into their appointment after verifying name, address, telephone number, balance due, and eligibility, as described in the Insurance Eligibility policy #100.01. If any other patient demographics are missing from the patient's chart, such as social security number, the information is requested upon check-in.
4. Registration staff will read alerts set up in NextGen and gather the requested information from the patient. Upon receipt of the information, registration staff will request the Office Supervisor to expire the alert.
5. Registration staff will educate patients on insurance or programs available to them. If the patient has a balance due, registration staff will request applicable payments from the patient while ensuring the patient is not denied service based on inability to pay.
    a. Registration staff may refer the patient to the front office Accounting Clerk to discuss payment plans, Sliding Fee Scale program, or fee waivers.

Knowledge of a violation or potential violation of this policy must be reported directly to the Office Supervisor, Practice Manager, FHS Revenue Cycle Manager, FHS Executive Director, or to the employee compliance hotline.

REFERENCED POLICIES	100.01 – Insurance Eligibility 100.03 – Sliding Fee Scale Discount Program
REFERENCED FORMS	
REFERENCES	

_____ _____

Chair - Community Healthcare Board **Date**

_____ _____

Vice-Chair - Community Healthcare Board **Date**

Fee Schedule

Policy Number: 100.12

Effective Date	May 1, 2019
Frequency of Review	Annual
Last Reviewed	April 5, 2019
Last Updated	April 5, 2019
Author	Janine Harris
Responsible Department	Revenue Cycle Management

PURPOSE:
The purpose of this policy is to prepare a schedule of fees consistent with locally prevailing rates or charges and designed to cover the reasonable cost of operating.

DEFINITIONS:
***Relative Value Units (RVU)* –** Units assigned to a Current Procedural Terminology (CPT) code that measures for a relative value scale. The RVU is multiplied by the cost per RVU to determine the charge amount.

***Cost per RVU* –** Total adjusted Family Health Services (FHS) expenditures for the period divided by the total RVU's for the same period to determine the cost per RVU.

***Geographic Adjustment Factor (GAF)* –** The adjustment that is made to the usual and customary fees and/or Medicare fees to determine the *local* usual and customary fees, based on the geographic location of the practice.

Medicare Multiplier – The adjustment that is made to the Medicare rate to determine the Medicare Multiplier cost per unit.

BACKGROUND
It is the policy of Solano County Health and Social Services to uphold compliance with government regulations. FHS is a Federally Qualified Health Center (FQHC) and receives federal funding under the Health Center Program authorized by section 330 of the Public Health Services (PHS) Act (42 U.S.C. 254b) ("section 330"), as amended (including sections 330(e) and (h)). The program is administered by the federal Health Resources and Services Administration (HRSA).

POLICY:
Family Health Services (FHS) shall provide medical and dental services regardless of a patient's ability to pay, according to the Sliding Fee Scale Discount Program, policy number 100.03.

FHS shall develop the fee schedule using data on locally prevailing rates and actual health center costs.

PROCEDURE:

1. FHS Policy & Financial Management (PFM) team will:
    a. Prepare the cost per unit based on Relative Value Units
        i. PFM team will determine the total expenditures for medical services and for dental services for the prior fiscal year using reports from the County's accounting system.
        ii. Retrieve the Relative Value Unit (RVU) file from CMS.GOV. This file identifies the relative value units for each CPT code.
        iii. Retrieve the Geographic Practice Cost Index (GPCI) file from CMS.GOV. This file identifies the adjustment factor to be applied to the RVU's to determine the local RVU per CPT code.
        iv. Retrieve the CPT usage report from the electronic health records for the prior fiscal year to determine the total CPT codes used.
        v. For CPT codes without an RVU, back into an RVU by using the CPT codes that do have RVU's. Divide the published Medi-Cal fee by the Medicare RVU to determine the conversion factor, then average the conversion factors to determine the average conversion factor. For the CPT codes without an RVU, divide the published Medi-Cal fee by the average conversion factor to determine the RVU for each CPT.
        vi. Using the CPT usage report, assign the local RVU or backed into RVU to each CPT code. Multiply the RVU by the total number of times the CPT code was used to determine the weighted RVU for each CPT code.
        vii. Divide the total medical expenditures by the total medical RVU's, and the total dental expenditures by the total dental RVU's to determine the medical cost per RVU and dental cost per RVU.
        viii. Multiply the RVU per CPT by the cost per RVU to determine the cost per unit for each CPT code. This cost per unit is based on actual costs and RVU's.
    b. Prepare the cost per unit based on the Medicare Multiplier
        i. Using the cost per unit based on actual costs and RVU's and the CPT usage report from the previous steps, determine the weighted cost per unit by multiplying the CPT usage by the cost per unit.
        ii. Using the published Medicare and Medi-Cal rates, determine the weighted cost per unit by multiplying the CPT usage by the higher of the Medicare or Medi-Cal cost per unit.
        iii. Divide the total cost per unit using FHS expenditures by the total cost per unit using Medicare or Medi-Cal cost per unit to determine the percentage FHS rates are greater than the Medicare or Medi-Cal rates.
        iv. Multiply the greater of the Medicare or Medi-Cal cost per unit by the percentage to determine the cost per unit for each CPT code. This cost per unit is based on the Medicare multiplier methodology.
    c. Preparing the cost per unit based on the Medicare cost report (for Medicare G-codes only)
        i. Using the Medicare cost report for the prior fiscal year, determine what the cost per visit is for each Medicare G-code.

ii. Multiply the current Medicare G-code rate by the current year Medicare Economic Index (MEI) to determine the cost of living change to the current rate.
iii. This methodology will determine the actual cost per unit for the Medicare G-codes and will determine the adjustment that should be made to the current G-code based on cost of living changes. The cost per unit that will be used in the fee schedule will be based on current year analysis and decision-making.

d. Preparing the cost per unit for vaccine administration and sexually transmitted disease (STD) visits.
i. Determine the estimated administration time for vaccines and STD encounters. Divide the current year salary and benefit cost by the time it takes to determine the average administration time.

2. FHS Policy & Financial Analyst (PFA)/Revenue Cycle Manager (RCM) will:
a. Determine the cost per unit for certain laboratory procedures, vaccines, and supplies based on contracted pricing and/or actual costs paid for the service or supply.
i. Actual costs paid will be reviewed twice per year, once during the preparation of the fee schedule and once in mid-year. Rates will be adjusted based on the actual cost paid by FHS for the services and/or supplies.
b. Determine the usual and customary rates for the local area for each CPT used in the prior year, based on the CPT usage report.
i. Context 4 Healthcare publishes a book annually on medical fees, usual and customary charges, Medicare fees, and RVU's for each medical CPT code. Using this book, adjust the usual and customary rates by the geographic adjustment to determine the local usual and customary rates.
ii. Optum360 customizes a dental fee analyzer book for the local usual and customary rates for dental CPT codes.
c. Prepare the Fee Schedule
i. Analyze the cost per units calculated using the RVU methodology, Medicare multiplier methodology, and Usual and Customary Rates methodology to determine the appropriate cost per unit for the fee schedule.
ii. Analyze the Medicare G-code cost per units to determine if the Medicare cost report methodology or the current cost per unit adjusted by the MEI will be used.
iii. Analyze the admin fees to determine the change from prior year to current year.
iv. Analyze the contract and/or invoices for vaccines, lab services and supplies to determine the cost per unit FHS pays.
v. Compile the proposed fees into one final document. Submit proposed fees to the Director of Administrative Services and the FHS PFM for review.

3. The proposed fee schedule is submitted to the Solano County Board of Supervisors each year, along with the rest of the County's proposed fees for the following fiscal year.
4. The PFA/RCM will send the revised fees to the Department of Information Technology upon approval from the Board of Supervisors to update the fees in FHS's electronic health records.

Knowledge of a violation or potential violation of this policy must be reported directly to the FHS Revenue Cycle Manager, FHS Policy & Financial Manager, Director of Administrative Services, or to the employee compliance hotline.

REFERENCED POLICIES	100.03 Sliding Fee Scale Discount Program
REFERENCED FORMS	
REFERENCES	

_____ _____

Chair - Community Healthcare Board **Date**

_____ _____

Vice-Chair - Community Healthcare Board **Date**

Supervision of Minor Children

Policy Number: 200.01

Effective Date	May 1, 2019
Frequency of Review	Annually
Last Reviewed	April 9, 2019
Last Updated	Initial Policy
Author	Alicia Jones, MPA Practice Manager
Responsible Department	Medical Services- Operations

PURPOSE:
Ensure the safety and wellbeing of children, patients and county staff within The Family Health Services (FHS) Federally Qualified Health Centers.

DEFINITIONS:

Minor Child- Any individual under 18 years of age.

Disruptive Behavior- Any behavior which may distract, impede or delay the deliverance of safe and effective care by health center staff.

Procedural Appointment- Appointments requiring dental, medical, or gynecological treatment and involve the use of sharp instruments, insertion of medical or dental equipment and/or devices into the body or skin of a patient (i.e. Pap Smear, IUD).

Medically Sensitive Appointment- Appointments which are sensitive in nature and focus on matters deemed potentially inappropriate for children (i.e. STD, contraception discussions).

Responsible friend/family member- Designated individual 18 years of age or older with the ability to modify/control the disruptive behaviors of minor children or remove child from the health center if necessary.

BACKGROUND
It is the intent of FHS to comply with requirements outlined by the Health Resources and Services Administration (HRSA). FHS is a Federally Qualified Health Center (FQHC) and receives federal funding under the Health Center Program authorized by section 330 of the Pubic Health Services (PHS) Act (42 U.S.C. 254b) ("section 330"), as amended (including sections 330(e) and (h)). While we understand many of our patients have family responsibilities and daycare challenges, due to safety concerns, privacy issues, and space constraints, our health centers strongly recommend children without an appointment not be allowed in the examination rooms while services are being provided.

POLICY:
Medical Services shall recommend patients with minor children arrange for appropriate childcare prior to arriving to their scheduled procedural or medically sensitive appointments.

Alternatively, responsible friends/family members are encouraged to accompany patients to their appointments to supervise their child/children in the reception area. In the event a minor child is present during an appointment, the display of any disruptive behaviors shall result in the immediate termination and rescheduling of the appointment.

PROCEDURE:

1. When scheduling procedural or medically sensitive appointments through the call center, front office, or with a medical/registered dental assistant, patients shall be advised that the presence of minor children during an examination is strongly discouraged. Appointments may be rescheduled based on the sensitivity of the appointment and age of the minor child.

2. If the presence of minor children is anticipated or unavoidable, patients will be asked to have a responsible friend/family member accompany them to their appointment to supervise the child/children in the reception area.

3. Under no circumstance shall health center staff take responsibility for the supervision of a minor child/children during a patients' appointment.

4. Minor children shall not be left unattended or unsupervised within the health center while a patient is inside of an exam room in receipt of medical or dental services.

5. Patients who are unable to schedule a procedural or medically sensitive appointment without the presence of a minor child/children shall not automatically be turned away or refused services for this reason. If the patient is agreeable to the child being inside of the exam room **AND** the child/children can remain seated and non-disruptive during the exam appointment, the visit may continue.

6. If at any time during the procedural or medically sensitive appointment, disruptive behavior is exhibited, the appointment shall immediately be terminated and rescheduled.

REFERENCED POLICIES	None
REFERENCED FORMS	None
REFERENCES	None

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Chair-Community Healthcare Board **Date**

_____ _____

Vice-Chair- Community Healthcare Board **Date**

Patient Grievance/Complaint Process

Policy Number: 200.02

Effective Date	May 1, 2019
Frequency of Review	Annually
Last Reviewed	April 9, 2019
Last Updated	July 5, 2018
Author	Alicia Jones, MPA/Practice Manager
Responsible Department	Medical Services-Operations

PURPOSE:
This policy establishes a uniform process allowing a patient or patient's authorized representative to submit a written or verbal grievance/complaint pertaining to any of the Family Health Services (FHS) Health Centers. All grievances/complaints shall be evaluated and resolved in a manner that assures quality care and services.

DEFINITIONS:
Grievance – An official statement of complaint over something believed to be wrong or unfair.

Complaint- A statement which identifies a situation is unsatisfactory or unacceptable.

BACKGROUND
It is the intent of FHS to comply with requirements outlined by the Health Resources and Services Administration (HRSA). FHS is a Federally Qualified Health Center (FQHC) and receives federal funding under the Health Center Program authorized by section 330 of the Pubic Health Services (PHS) Act (42 U.S.C. 254b) ("section 330"), as amended (including sections 330(e) and (h)). Requirements indicate health centers must maintain operating procedures or processes that address hearing and resolving patient grievances/complaints.

POLICY:
It is the policy of Family Health Services to provide and adhere to a procedure for receiving, resolving, and responding to the grievances/complaints of a patient and/or patient's authorized representative. This procedure shall include informing patient and/or patient's representative of the right to file a grievance/complaint and the mechanisms available for doing so. Investigation of the grievance/complaint, ensuring a resolution occurs, and responding to the grievance/complaint is required under applicable state and federal law.

PROCEDURE:
1. Procedure for informing patient and/or patient's authorized representative of the right to file grievance/complaint.
    A. Staff is required to inform each patient and/or authorized representative of the patient's rights in advance of furnishing or discontinuing patient care. Patients are informed of their right to file a grievance/complaint in the following ways:
        a. FHS feedback forms located at each registration window. (FHS staff can assist with completing the form if necessary).

b. Patients Policy Agreement Form, located at registration and provided to all new patients.
c. Notice of Privacy Practices for complaints regarding the violation of privacy rights.

2. Patient and/or patients authorized representative may register a grievance/complaint with the health center in the following ways:
   A. By telephone- Patient and/or authorized representative can register a grievance/complaint through the FHS call center, which will be forwarded to the appropriate Practice Manager.
   B. In writing- Patient and/or authorized representative can register a grievance/complaint in writing while present in the health center or by mailing a written letter to the attention of the Practice Manager at one of the following addresses:
      a. Fairfield FHS (Adult Medical and Dental)-2201 Courage Dr. Fairfield, CA 94533
      b. Fairfield FHS (Pediatric Medical and Dental)-2101 Courage Dr. Fairfield, CA 94533
      c. Vacaville FHS (Medical and Dental)-1119 E. Monte Vista Ave. Vacaville, CA 95688
      d. Vallejo FHS (Medical and Dental)- 365 Tuolumne St., Vallejo, CA 94590
   C. Patient's capped to Partnership HealthPlan of California (PHC) may file a grievance/complaint through use of the their "Member Grievance Toolkit" located in the front office of each health center. Grievances to PHC may also be filed in the following ways:
      a. Telephone- Member Services (800) 863-4155
      b. In writing-Either by mail or by fax- PHC c/o Member Services Department 4665 Business Center Dr. Fairfield, CA 94534 or (707) 863-4415
      c. In person- 4665 Business Center Dr. Fairfield, CA 94534
      d. PHC Website- www.partnershiphp.org

3. Response to Patient and/or patient's authorized representative
   A. Responses to a telephone or written grievance/complaint may be referred to either the Front Office or Back Office Supervisor as appropriate. If resolution is not obtained, the grievance/complaint shall be referred to the appropriate Practice or Dental Manager. If the Practice or Dental Manager is unable to resolve the grievance/complaint, it shall be forwarded to the Chief Operations Officer. If unresolved at this level the Chief Operations Officer will refer the matter to the Executive Director or Medical Director, as appropriate.
   B. Responses may be made using one of the following methods:
      a. Phone call when appropriate and when the issue can be resolved without a formal investigation.
      b. Letter of explanation to include a description of actions taken to address any concerns that cannot be resolved quickly and require a formal investigation.
   C. Final Response to Formal Investigations should be provided in writing within 30 days of the initial reporting date. If the investigation is expected to take longer, patient will be advised of an anticipated date of completion. Copies of the response are sent to those named on the grievant/complainant's letter and to other appropriate

individuals/agencies subject to HIPAA authorization requirements. The written response should include the following:

a. Health centers decision regarding the grievance/complaint
b. An explanation of steps taken to investigate the grievance/complaint
c. Date review completed
d. Name of the individual completing the review
e. A copy of the grievance/complaint as well as the written response shall be scanned into the patient's chart under Grievances/Complaints.

D. Grievances/Complaints received by PHC shall be referred to the appropriate Practice Manager for investigation and will be resolved as outlined in the Appeals and Grievances policies set forth in the Partnership Operations Manual.

REFERENCED POLICIES	-Patient Grievance Procedure last revised 7/5/2018 -Health Resources and Services Administration (HRSA) Health Center Program Compliance Manual -Partnership HealthPlan of California Member Grievance Toolkit. -Partnership HealthPlan of California Medi-Cal Member Grievance System Policy and Procedure last reviewed 2/14/2018.
REFERENCED FORMS	Contract # 08164/1001.1077C Medical Services Agreement between PHC and Solano County
REFERENCES	Section 8- Grievances and Appeals

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Chair - Community Healthcare Board **Date**

_____ _____

Vice-Chair - Community Healthcare Board **Date**

After Hours Coverage

Policy Number: 300.01

Effective Date	June 1, 2019
Frequency of Review	Annually
Last Reviewed	April 9, 2019
Last Updated	June 15, 2016
Author(s)	Medical Director, Michelle Leary, DO Medical Director, Teresa Shinder, DO Dental Director, Sneha Innes, DDS
Responsible Department	Medical Services- Clinical

PURPOSE:
To provide a mechanism for patients established with Family Health Services (FHS) to receive telephone advice from qualified personnel regarding non-emergency, yet urgent medical or dental questions outside of usual business hours.

DEFINITIONS:
Usual Business Hours: Hours of operation approved by the Community Healthcare Council that are accessible to patient populations served by FHS health centers.

Qualified Personnel: A licensed physician, dentist, physician's assistant, or nurse practitioner qualified by training, experience and certification to assess a patient's need for emergency medical care.

Non-Emergency: Not of, relating to, or constituting a medical or dental emergency.

Urgent Medical Questions: Questions related to a non-life-threatening illness or injury.

BACKGROUND
It is the intent of FHS to comply with requirements outlined by the Health Resources and Services Administration (HRSA). FHS is a Federally Qualified Health Center (FQHC) and receives federal funding under the Health Center Program authorized by section 330 of the Pubic Health Services (PHS) Act (42 U.S.C. 254b) ("section 330"), as amended (including sections 330(e) and (h)). Requirements indicate health centers must have after hours coverage provided via telephone or face-to-face by an individual with the qualification and training necessary to exercise professional judgement in assessing a health center patient's need for emergency medical or dental care.

POLICY:
It is the policy of FHS that patients obtain professional and timely access to interactive clinical advice over the telephone with a medical or dental provider outside of usual business hours. Communication must be delivered in a manner that is culturally and linguistically appropriate.

It is the policy of FHS that clinical advice by telephone outside of usual business hours is communicated only to patients who are established with FHS health centers.

After Hours Coverage

Policy Number: 300.01

It is the policy of FHS that communication outside of usual business hours by telephone is documented in the patient's medical or dental record in a manner that is consistent with medical or dental and legal prudence.

PROCEDURE:

1. Patients can seek and receive clinical advice from an on-call FHS medical or dental provider by telephone when health center offices are closed.

2. FHS establishes a monthly schedule for on-call providers, which can be found in each health center location. A new schedule is also faxed and/or emailed to the answering service contracted by FHS monthly.

3. Patients are informed of the availability of After Hour coverage in the following ways:
    a. Pamphlet provided to patient after establishing care with an FHS health center.
    b. Notification of services is posted on the front door of the health centers.
    c. Notification is included on the recorded phone message heard whenever patients call.
    d. Notification is available on the FHS website.

4. When patients call an FHS Health Center during usual business hours they hear a recorded message provided in both English and Spanish informing them of the following:
    a. To call 911 if experiencing a medical emergency.
    b. The Health Centers usual business hours.
    c. The medical advice phone number for Partnership HealthPlan of California members.
    d. Directions to obtain a medication refill.
    e. Directions to speak with an FHS on-call provider after usual business hours.

5. All after hour dental calls shall be addressed by the Dental Manager/Director. Documentation for dental calls are recorded on an on-call log sheet as well as in the Electronic Dental Record (EDR). Available call response options may include the following:
    a. Non-emergency and non-urgent dental calls- Patient shall be asked to call the dental center during usual business hours to schedule an appointment.
    b. Non-emergency, yet urgent dental calls- The on-call dental provider will notify the Office Supervisor or Lead Dental Assistant the next business day to contact the patient to schedule a same day appointment.
    c. Emergency dental calls- Patient's will be directed to the dental center to receive immediate after-hour treatment and the on-call provider will call the Lead Dental Assistant to meet at the center.
    d. Necessary prescriptions will be sent to patient's pharmacy of choice.

6. When requesting to speak with the on-call provider, the patient is first connected to the answering service contracted by FHS and provides the operator with their full name, date of birth, the primary provider name, and the reason for the call.

7. The answering service operator identifies the correct on-call provider and contacts him or her.

8. The on-call provider contacts the patient within 45 minutes of receiving the call and provides the patient with advice related to their needs. All communications are documented in the patient's medical record within 24 hours, in a manner that is consistent with medical or dental and legal prudence.

9. If there is no response by the on-call provider to the answering service operator's call within 45 minutes, the operator will perform one or more of the following steps, listed in sequential order:
    a. Complete a second attempt to contact the on-call provider.
    b. Attempt to contact the on-call provider at their secondary contact number.
    c. Contact the appropriate medical director.
    d. Attempt to contact the medical director on their secondary contact number.

    The operator will report unsuccessful attempts to contact the on-call provider by emailing the FHS Chief Operations Officer the next morning.

10. Patient follow up by Health Center staff may be required once after-hour services have been utilized. Follow-up care may include the following:
    a. On-call provider shall have the ability to make urgent same-day or next day appointments in any of the FHS health centers.
    b. On-call provider may determine the patient needs urgent/emergent care and direct them to call 9-1-1 or go to the nearest emergency room.
    c. If patient is advised to call 9-1-1 or go to the nearest emergency room, on the next business day, utilizing the Electronic Medical Record (EMR), the on-call provider shall task appropriate health center staff (Nurse, MA, or Case Manager) to confirm patient's status.
    d. Health Center staff shall request discharge paperwork and hospital medical records for either an Emergency Room (ER) visit or Hospitalization be faxed to the health center after patient discharge.
    e. Health Center staff shall schedule a follow-up appointment for the patient with their Primary Care Provider (PCP) after the ER visit or following hospital discharge.

11. Tracking of patient calls received outside of usual business hours will be maintained in the Nextgen Electronic Medical Record System. A report of patient calls received will be provided monthly to FHS Administration. Tracking of patient calls is also maintained by the contracted answering service and shall be obtained upon request.

All communication between the on-call provider and the patient shall be thoroughly documented in the patient's record, including the date and time.

Family Health Services strives to employ and make available providers who can speak in the language of its patients. In the event a patient cannot be accommodated with a provider fluent in

the patient's language, the provider is responsible for initiating a three-way conference call with the FHS or Partnership Health Plan's interpreter service in accordance to the FHS Language Access Policy. All calls will be handled in a manner that is culturally appropriate.

As with any form of patient communication and documentation, unprofessional remarks or comments in telephone communications are prohibited. Confidentiality of patient information is required to maintain the integrity of protected health information (PHI).

REFERENCED POLICIES	-After Hours Coverage Policy last revised 6/15/2016 -Health Resources and Services Administration (HRSA) Health Center Program Compliance Manual -Language Access Policy last revised 5/2/2014
REFERENCED FORMS	Answernet Inc, Purchase Order #D0121810 last renewed 7/23/2018
REFERENCES	

_____ _____

Chair - Community Healthcare Board **Date**

_____ _____

Vice-Chair - Community Healthcare Board **Date**

Use of funding from the Health Resources and Services Administration

Policy Number: 900.01

Effective Date	April 17, 2019
Frequency of Review	Annually
Last Reviewed	April 1, 2019
Last Updated	October 17, 2018
Author	Andrew Obando
Responsible Department	Administration

PURPOSE:
This policy is intended to establish and support guidelines for the proper allocation and use of grant-related funding provided by the Health Resources and Services Administration (HRSA) in accordance with the Public Health Services Act and Solano County fiscal and personnel policies.

DEFINITIONS:
Health Resources and Services Administration The Health Resources and Services Administration (HRSA), an agency of the U.S. Department of Health and Human Services, is the primary federal agency for improving health care to people who are geographically isolated, economically or medically vulnerable.

BACKGROUND
It is the policy of Solano County Health and Social Services to uphold compliance with government regulations. FHS is a Federally Qualified Health Center (FQHC) and receives federal funding under the Health Center Program authorized by section 330 of the Public Health Service (PHS) Act (42 U.S.C. 254b) ("section 330"), as amended (including sections 330(e) and (h)). The program is administered by the federal Health Resources and Services Administration (HRSA).

POLICY:
1. All disbursements of HRSA grant funds will comply with all existing standards and principles of auditing and accounting as well as regulations/guidelines pertinent to the grant. This includes, but is not limited to the following:
   - 2CFR Part 225 Cost Principles for State, Local, and Indian Tribal Governments
   - OMB Circular A-133 Audits of States, Local Governments and Non-Profit Organization
   - 45 CFR part 75 - Uniform Administrative Requirements, Cost Principles, and Audit Requirements for HHS Awards
   - HHS Grants Policy Statement

2. Family Health Services follows the terms and conditions of the respective agreements and grant awards with regard to the applicable administrative and fiscal requirements, and will annually assess the applicable requirements, including but not limited to HRSA Grants Policy Bulletins.

3. Allowable costs/cost principles are set forth in 2CFR Part 225, Cost Principles for State, Local and Indian Tribal Governments.

   2CFR Part 225 for federal grants prohibit the use of grant funds on certain types of expenditures, including, but not limited to:
   - Alcoholic Beverages
   - Entertainment
   - Campaigning
   - Lobbying
   - Fines & penalties
   - Fund-raising

4. Use of HRSA funds must follow the requirements included in the Grants Policy Bulletin Number 2018-04: Legislative Mandates in Grants Management for FY 2018 mandated by the FY 2018 Consolidated Appropriations Act 2018 (Public Law 115-141).

   Specifically, FY2018 Legislative Mandates limit the use of funds as follows:

   Division H, Title II

   (1) Salary Limitation (Section 202)
      a. None of the funds appropriated in this title shall be used to pay the salary of an individual, through a grant or other extramural mechanism, at a rate in excess of Executive Level II.
      b. The Executive Level II salary is currently set at $189,600.

   (2) Gun Control (Section 210)
      a. None of the funds made available in this title may be used, in whole or in part, to advocate or promote gun control.

   Division H, Title V

   (3) Anti-Lobbying (Section 503)
      a. No part of any appropriation contained in this Act or transferred pursuant to section 4002 of Public Law 111–148 shall be used, other than for normal and recognized executive legislative relationships, for publicity or propaganda purposes, for the preparation, distribution, or use of any kit, pamphlet, booklet, publication, electronic communication, radio, television, or video presentation designed to support or defeat the enactment of legislation before the Congress or any State or local legislature or legislative body, except in presentation to the Congress or any State or local legislature itself, or designed to support or defeat any proposed or pending regulation, administrative action, or order issued by the executive branch of any State or local government, except in presentation to the executive branch of any State or local government itself.

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

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

(4) Acknowledgment of Federal Funding (Section 505)

a. When issuing statements, press releases, requests for proposals, bid solicitations and other documents describing projects or programs funded in whole or in part with Federal money, all grantees receiving Federal funds included in this Act, including but not limited to State and local governments and recipients of Federal research grants, shall clearly state – (1) the percentage of the total costs of the program or project which will be financed with Federal money; (2) the dollar amount of Federal funds for the project or program; and (3) percentage and dollar amount of the total costs of the project or program that will be financed by non-governmental sources.

(5) Restriction on Abortions (Section 506)

a. None of the funds appropriated in this Act, and none of the funds in any trust fund to which funds are appropriated in this Act, shall be expended for any abortion.

b. None of the funds appropriated in this Act, and none of the funds in any trust fund to which funds are appropriated in this Act, shall be expended for health benefits coverage that includes coverage of abortion.

c. The term ‘‘health benefits coverage’’ means the package of services covered by a managed care provider or organization pursuant to a contract or other arrangement.

(6) Exceptions to Restriction on Abortions (Section 507)

a. The limitations established in the preceding section shall not apply to an abortion – (1) if the pregnancy is the result of an act of rape or incest; or (2) in the case where a woman suffers from a physical disorder, physical injury, or physical illness, including a life-endangering physical condition caused by or

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

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

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

d. (1) None of the funds made available in this Act may be made available to a Federal agency or program, or to a State or local government, if such agency, program, or government subjects any institutional or individual health care entity to discrimination on the basis that the health care entity does not provide, pay for, provide coverage of, or refer for abortions.

(2) In this subsection, the term ''health care entity'' includes an individual physician or other health care professional, a hospital, a provider-sponsored organization, a health maintenance organization, a health insurance plan, or any other kind of health care facility, organization, or plan.

(7) Ban on Funding Human Embryo Research (Section 508)

a. None of the funds made available in this Act may be used for – (1) the creation of a human embryo or embryos for research purposes; or (2) research in which a human embryo or embryos are destroyed, discarded, or knowingly subjected to risk of injury or death greater than that allowed for research on fetuses in utero under 45 CFR 46.204(b) and section 498(b) of the Public Health Service Act (42 U.S.C. 289g(b)).

b. For purposes of this section, the term ''human embryo or embryos'' includes any organism, not protected as a human subject under 45 CFR 46 as of the date of the enactment of this Act, that is derived by fertilization, parthenogenesis, cloning, or any other means from one or more human gametes or human diploid cells.

(8) Limitation on Use of Funds for Promotion of Legalization of Controlled Substances (Section 509)

a. None of the funds made available in this Act may be used for any activity that promotes the legalization of any drug or other substance included in schedule I of the schedules of controlled substances established under section 202 of the Controlled Substances Act except for normal and recognized executive-congressional communications.

b. The limitation in subsection (a) shall not apply when there is significant medical evidence of a therapeutic advantage to the use of such drug or other

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

(9) Restriction of Pornography on Computer Networks (Section 520)

a. None of the funds made available in this Act may be used to maintain or establish a computer network unless such network blocks the viewing, downloading, and exchanging of pornography.

b. Nothing in subsection (a) shall limit the use of funds necessary for any federal, state, tribal, or local law enforcement agency or any other entity carrying out criminal investigations, prosecution, or adjudication activities.

(10) Restriction on Funding ACORN (Section 521)

a. None of the funds made available under this or any other Act, or any prior Appropriations Act, may be provided to the Association of Community Organizations for Reform Now (ACORN), or any of its affiliates, subsidiaries, allied organizations, or successors.

(11) Restriction on Purchasing of Sterile Needles (Section 529)

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

Division E, Title VII

(12) Confidentiality Agreements (Section 743)

a. None of the funds appropriated or otherwise made available by this or any other Act may be available for a contract, grant, or cooperative agreement with an entity that requires employees or contractors of such entity seeking to report fraud, waste, or abuse to sign internal confidentiality agreements or statements prohibiting or otherwise restricting such employees or contractors from lawfully reporting such waste, fraud, or abuse to a designated investigative or law enforcement representative of a Federal department or agency authorized to receive such information.

b. The limitation in subsection (a) shall not contravene requirements applicable to Standard Form 312, Form 4414, or any other form issued by a Federal department or agency governing the nondisclosure of classified information.

PROCEDURE:

1. This policy and procedure shall be reviewed annually to ensure adherence with applicable HRSA Grants Policy Bulletins, regulations, and requirements. Revisions to this policy and procedure to ensure applicable and appropriate adherence as necessary will

be approved and adopted by the Community Healthcare Board, the health center's governing board.

2. Authorization and approval of purchases and use of funds is delegated to management and supervisory staff according to the Solano County Purchasing and Contracting Policy.

3. All FHS management and supervisory staff, up to and including the health center executive director, with any level of delegated authority to commit the County to use of funds or purchases for good and services will receive training not less than annually on the applicability of this policy.

4. Prior to any claims for HRSA funds submitted through the US Department of Health and Human Services' hosted Payment Management System, the Executive Director, or designee, will review to ensure appropriate application of this policy.

5. In accordance with Sections 25250 and 25253 of the Government Code of the State of California, Solano County publishes a complete set of financial statements in conformity with generally accepted accounting principles and audited in accordance with generally accepted auditing standards by a firm of licensed certified public accountants.

6. To ensure compliance with legal requirements of federal awards, in accordance with OMB Circular A-133, Solano County undergoes a Single Audit by an independent auditor to report not only on fair representation of the financial statements, but on Solano County's internal controls over compliance involving the administration of federal awards.

REFERENCED POLICIES	Solano County Purchasing and Contracting Policy
REFERENCED FORMS	None
REFERENCES	HRSA Grants Policy Bulletin 2019-02
	FY 2018 Consolidated Appropriations Act 2018 (Public Law 115-141)
	Department of Defense and Labor, Health and Human Services, and Education Appropriations Act, 2019
	Continuing Appropriations Act, 2019
	45 CFR part 75 - Uniform Administrative Requirements, Cost Principles, and Audit Requirements for HHS Awards
	OMB Circular A-133 Audits of States, Local Governments and Non-Profit Organization
	2 CFR Part 225 Cost Principles for State, Local, and Indian Tribal Governments
	HHS Grants Policy Statement
	California Government Code Sections 25250 and 25253

Use of funding from the Health Resources and Services Administration

Policy Number: 900.01

_____	_____
Chair - Community Healthcare Board	**Date**
_____	_____
Vice-Chair - Community Healthcare Board	**Date**

SOLANO COUNTY

Solano County Family Health Services
Community Healthcare Board
Application

Today's Date 3-20-2019

How did you hear about this opportunity? Email

Contact Information

Name Carl Holmes

Address [redacted]

Preferred Phone [redacted] Type

Other Phone Type

Other Phone Type

E-mail Address [redacted]

Please share what you know about FHS?

I have been a patient over 20 years.

Please tell us why you would like to become involved with FHS:

For input to the Community from some one from the Community. As a patient with DM

What specific skills or experience do you bring to FHS? Please check all that apply to you.

- ☐ Banking
- ☐ Business
- ☐ Education
- ☑ Event Planning
- ☐ Finance
- ☐ Fundraising
- ☐ Governance
- ☑ Health Care
- ☐ Human Resources
- ☑ Labor Relations
- ☐ Legal Affairs
- ☑ Managed Care
- ☐ Philanthropy
- ☐ Real Estate
- ☐ Social Services
- ☐ Other

V.P. of Diabetic Society

Which Board/Volunteer Committees would you be interested in serving on?

☐ Board Development ☐ Operations ☐ Finance
☐ Quality Performance ☐ Provider Advisory

Board for Community Health

Have you served on a Board before? ✓ Yes ○ No

Have you worked at FHS within the past 2 years? ○ Yes ○ No

If yes, where? Please tell us a little about your Board experience and/ or employment with FHS.

Please list any FHS Board Members and/or FHS employees that know you and may serve as a reference for you. If not applicable, please write none.

[redacted]

In lieu of answering employment, community, and education experience, you may attach a resume or bio containing pertinent information about yourself that would be helpful to the Board of Directors.

Employment Experience:

Organization/ Community Experience:

Diabetic Society

Education (high school, college, trade school or other training):

The information below is helpful in determining whether or not your presence on the Board of Directors would satisfy the governance requirements of an FQHC. This information is optional and will not disqualify you for consideration as a Board Member.

Do you presently derive any income from the healthcare industry? ○ Yes ◉ No

Have you or a member of your household obtained care from FHS within the past 2 years? ◉ Yes ○ No

Are you or have you ever been homeless? ◉ Yes ○ No

Gender Male

Are you Hispanic or Latino? ○ Yes ◉ No

Please indicate how you identify yourself. (Select one or more)

- ☐ American Indian or Alaskan Native
- ☐ Asian
- ☒ Black or African American
- ☐ Native Hawaiian/Other Pacific Islander
- ☐ White
- ☐ Hispanic or Latino

Year of Birth 1969

Statement of Interest:

I agree and understand that by providing this information, I am merely expressing an interest in potential Board membership and that this form is not binding on myself or Solano County in any way. I understand that, by submitting this form, I am agreeing to be interviewed and considered as an interested board candidate.

I understand that Board members serve voluntarily (non-paid). I understand that a Board term is 3 years and I believe that, at this time, I could make such a commitment. I understand the expectation that Board members will attend all monthly Board meetings (usually held on the third Wednesday of every month beginning at 12:00am, meetings are approx. two hours) in a calendar year and participate as a member of at least one standing Board Committee.

I further agree and understand that, if I am presently a patient of FHS, my potential Board membership publicly identifies me as a patient of FHS to members of FHS's current Board and other FHS staff who may review this form. Thus, any and all other health information regarding my medical care at FHS remains confidential and protected. I, therefore, accept this disclosure, and do not hold Solano County responsible for this limited disclosure.

Signature [signature] Date: 3.20.209

Thank you for your interest in Solano County Family Health Services.
Should you have any questions, please call 707-784-4448.

Please print the completed application and submit to the Board of Directors,
by email to: abobando@solanocounty.com,
by mail to: Solano County Family Health Services, c/o Administration, 2201 Courage Drive, Fairfield, CA 94533,
or drop off at one of our clinic sites.

One of our Board Governance Committee members will contact you soon.

SOLANO COUNTY

Solano County Family Health Services
Community Healthcare Board
Application

Today's Date 3-20-19

How did you hear about this opportunity? Carol

Contact Information

Name Jim Jones

Address [redacted]

Preferred Phone [redacted] Type

Other Phone Type

Other Phone Type

E-mail Address [redacted]

Please share what you know about FHS?

Been a patient for 17 years here, I

Please tell us why you would like to become involved with FHS:

To understand and Advocate for patients and poor people in need. Especially The homeless

What specific skills or experience do you bring to FHS? Please check all that apply to you.

- ☐ Banking
- ☐ Business
- ☐ Education
- ☐ Event Planning
- ☐ Finance
- ☐ Fundraising
- ☐ Governance
- ☐ Health Care
- ☐ Human Resources
- ☐ Labor Relations
- ☐ Legal Affairs
- ☐ Managed Care
- ☐ Philanthropy
- ☐ Real Estate
- ☐ Social Services
- ☐ Other

Which Board/Volunteer Committees would you be interested in serving on?

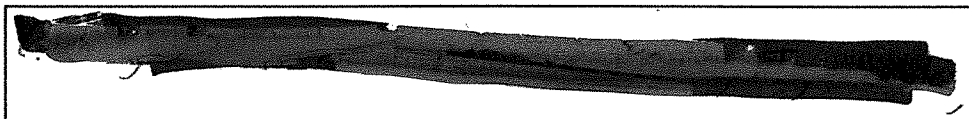
☐ Board Development ☐ Operations ☐ Finance
☐ Quality Performance ☐ Provider Advisory

Have you served on a Board before? ○ Yes ○ No

Have you worked at FHS within the past 2 years? ○ Yes ○ No

If yes, where? Please tell us a little about your Board experience and/ or employment with FHS.

Please list any FHS Board Members and/or FHS employees that know you and may serve as a reference for you. If not applicable, please write none.



In lieu of answering employment, community, and education experience, you may attach a resume or bio containing pertinent information about yourself that would be helpful to the Board of Directors.

Employment Experience:

A+/NetT Tech - Gateway Computer
clerk - Trader Joes
Manager - Nutrition Shoppe Health Foods

Organization/ Community Experience:

Education (high school, college, trade school or other training):

Smith Cotton High Sedalia, MO
Computer school - CSA, Vacaville

The information below is helpful in determining whether or not your presence on the Board of Directors would satisfy the governance requirements of an FQHC. This information is optional and will not disqualify you for consideration as a Board Member.

Do you presently derive any income from the healthcare industry? ○ Yes ⊘ No

Have you or a member of your household obtained care from FHS within the past 2 years? ⊘ Yes ○ No

Are you or have you ever been homeless? ⊘ Yes ○ No

Gender Male

Are you Hispanic or Latino? ○ Yes ⊘ No

Please indicate how you identify yourself. (Select one or more)

- ☐ American Indian or Alaskan Native
- ☐ Asian
- ☐ Black or African American
- ☐ Native Hawaiian/Other Pacific Islander
- ☒ White
- ☐ Hispanic or Latino

Year of Birth 1966

Statement of Interest:

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Signature [signature] Date: 3-20-19

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One of our Board Governance Committee members will contact you soon.

SOLANO COUNTY

Solano County Family Health Services
Community Healthcare Board
Application

Today's Date MAR 29, 2019

How did you hear about this opportunity? Email

Contact Information

Name John Diaz

Address [redacted]

Preferred Phone [redacted] Type [redacted]

Other Phone Type

Other Phone Type

E-mail Address [redacted]

Please share what you know about FHS?

Currently I am a patient.

Please tell us why you would like to become involved with FHS:

I want to give input from a patient point of view

What specific skills or experience do you bring to FHS? Please check all that apply to you.

- ☐ Banking
- ☐ Business
- ☐ Education
- ☐ Event Planning
- ☐ Finance
- ☐ Fundraising
- ☐ Governance
- ☐ Health Care
- ☐ Human Resources
- ☐ Labor Relations
- ☐ Legal Affairs
- ☐ Managed Care
- ☐ Philanthropy
- ☐ Real Estate
- ☐ Social Services
- ☑ Other: Volunteer work / Logistics

Which Board/Volunteer Committees would you be interested in serving on?

☐ Board Development ☐ Operations ☐ Finance
☐ Quality Performance ☐ Provider Advisory

Have you served on a Board before? ○ Yes ☑ No

Have you worked at FHS within the past 2 years? ○ Yes ☑ No

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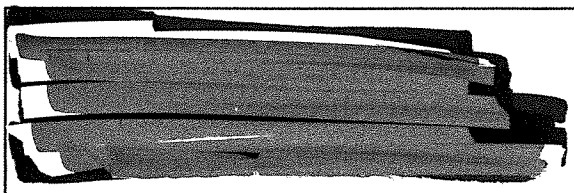

In lieu of answering employment, community, and education experience, you may attach a resume or bio containing pertinent information about yourself that would be helpful to the Board of Directors.

Employment Experience:

7½ years Military (Active)
7½ years RESERVES
11 years Retail

Organization/ Community Experience:

Education (high school, college, trade school or other training):

A.S. Degree from Solano C.C.

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Have you or a member of your household obtained care from FHS within the past 2 years? ☑ Yes ☒ No

Are you or have you ever been homeless? ○ Yes ☑ No

Gender Male

Are you Hispanic or Latino? ☑ Yes ○ No

Please indicate how you identify yourself. (Select one or more)

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- ☐ Asian
- ☐ Black or African American
- ☐ Native Hawaiian/Other Pacific Islander
- ☐ White
- ☑ Hispanic or Latino

Year of Birth 1955

Statement of Interest:

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Signature [signature] Date: MAY 20, 2019

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