County of Solano
Community Healthcare Board
Regular Meeting

April 19, 2023
1:00 pm – 2:00 pm
2101 Courage Drive, Fairfield, CA 94533
Room Location: Multi-Purpose Room

AGENDA

1) CALL TO ORDER – 1:00 PM

a) Welcome
b) Roll Call

2) APPROVAL OF THE APRIL 19, 2023 AGENDA

3) PUBLIC COMMENT

This is the opportunity for the Public to address the Board on a matter not listed on the Agenda, but it must be within the subject matter jurisdiction of the Board. If you would like to make a comment, please announce your name and the topic you wish to comment and limit comments to three minutes.

CONSENT CALENDAR

4) CLINIC OPERATIONS REPORTS

a) Staffing Update
b) Credentialing Update
c) HRSA Grants Update (UDS)
d) Revenue Cycle
e) Clinic Operational Metrics

REGULAR CALENDAR

5) APPROVAL OF MINUTES

Approval of the March 15, 2023 Draft Minutes

6) CLINIC OPERATIONS REPORTS

a) Grievances/Compliments
b) Compliance
c) Finance
d) Referrals
e) Major Project Updates
f) QI Update

7) PROJECT DIRECTOR / CLINIC OPERATIONS OFFICER REPORT

a) Health Center HRSA Project Officer Update – Dona Weissenfels
b) Health Center Activities, Internal & External Update

8) BUSINESS GOVERNANCE

a) Review and approve the Quarterly Financial Report – Nina Delmendo
   i) **ACTION ITEM:** The Board will consider approval of the Quarterly Financial Report
b) The Board will approve acceptance of the Partnership HealthPlan (PHP) Health Equity Unit of Service Award of $2000.00.
   i) **ACTION ITEM:** The Board will consider approval to accept the PHP Health Equity Unit of Service Award of $2000.00
c) Review and approve the revised Family Health Services Financial Policies listed below.
   i) **ACTION ITEM**: The Board will consider approval of the Financial Policies listed below:
   100.01 – Insurance & Eligibility Verification
   100.02 – Cash Handling
   100.04 – Claims Processing
   100.05 – Coding
   100.06 – Other Health Insurance/Private Insurance
   100.07 – Void/Deleted Payments
   100.08 – Fee Waiver & Payment Plans
   100.10 – Patient Registration
   100.11 – Billing and Collections
   100.12 – Fee Schedule
   100.13 – Dental Appliances
   100.14 – Bad Debt Write Off
   100.15 – Back Office Claims Processing
   100.16 – Non-Sufficient Funds

9) DISCUSSION

a) Board Member Application received from Charla Griffith.
   i) The Executive Committee reviewed the Board Member Application submitted by Charla Griffith and recommends the Board's approval for Charla Griffith to be appointed as a Community Healthcare Board Member.
   ii) **ACTION ITEM**: The Board will consider Charla Griffith to be appointed as a Community Healthcare Board Member.
b) Discuss the Community Healthcare Board Self-Assessment.

10) BOARD MEMBER COMMENTS

11) ADJOURN: TO THE COMMUNITY HEALTHCARE BOARD MEETING OF:

DATE: May 17, 2023
TIME: 12:00 p.m. – 2:00 p.m.
LOCATION: Multi-Purpose Room
2201 Courage Drive
Fairfield, CA 94533

DISABLED ACCOMMODATION: Meeting facilities are accessible to persons with disabilities. If you have a disability which requires an accommodation or an alternative means to assist you in attending, observing, or commenting on this meeting, or an alternative agenda document format, please contact Patricia Zuniga, Community Healthcare Board Clerk at (707) 784-8775 or by email at PDZuniga@SolanoCounty.com to request arrangements for accommodation.

Community Health Care Board

Family Health Services Staffing Update

CHB Meeting Date: April 19, 2023

Number of Active Candidates - County
Clinic Physician **Extra Help** - 1
Clinic Physician Supervisor - 1
Health Education Specialist - 2
Health Education Specialist **Extra Help** - 2
Office Assistant II- 1
Physician Assistant - 1

Number of Active Candidates - Touro
Physician Assistant - 3
Clinic Physician (Board Cert) - 1
Pharmacist - 1

Number of Active Candidates - Locum Tenens
Nurse Practitioner - 1

Number of Active Candidates - Volunteer
Physician Assistant (Board Cert) - 1

Open County Vacancies
Clinic Physician (Board Cert) - 1
Clinic Physician (Board Cert) **Extra Help** - 1
Clinic Physician Supervisor - 1
Clinic Registered Nurse - 1
Dental Assistant (Registered) - 1
Dentist Manager **Extra Help** - 1
Health Services Manager - 1
Medical Assistant - 2
Medical Records Technician, Sr **Extra Help** - 2
Mental Health Clinician (Licensed) - 1
Nurse Practitioner/Physician Assistant - 3

Interviews in Progress
Dentist Manager (Extra Help) - TDB
Medical Assistant - TBD
Mental Health Clinician Licensed - TBD

Recently Hired Staff
Medical Assistant - 3/20/2023

FHS Community Healthcare Board – Status Report DRAFT April 2023:
FHS Credentialing, Provider Enrollment and Sanction Screening Activities

Excluded Parties/Sanction Screening: 127

Month	Sanction Screening Number Screened/Verified	Sanction Screening Number Ineligible
March 2023 TOURO	Touro Providers: 9	Exclusions Found: 0
March 2023 County – H&SS Employees/Candidates	H&SS Employees: 118	Exclusions Found: 0
Totals	TOTAL SCREENED: 127	Exclusions Found: 0

Credentialing: 13

Month	Number of Candidates' Credentials Verifications - (Re-)Started -	Number of Candidates' Partnership Provider Enrollments - Submitted for Partnership Approval -
March 2023 TOURO	Active/Open: 4 Physician Assistants (PAs): 4	Submitted to Partnership: -2- Approved by Partnership: -1- Pending Submission to Partnership: 2
March 2023 LOCUM	Active/Open: 3 Physician Assistant (PA): 1 Clinic Physician: 1 Nurse Practitioner: 1 (New)	Submitted to Partnership: -0- Approved by Partnership: -0- Pending Submission to Partnership: 3
March 2023 County H&SS Employees/ Candidates	Active/Open: 6 Dentist Manager: 1 Physician Assistant –1 Medical Assistant - 1 Clinic Physician – 2 Supervising Physician - 1	Submitted to Partnership: -2- Approved by Partnership: -0- Pending Submission to Partnership: 0

Provider and Site Enrollment and Re-Credentialing/Re-Validation:

Partnership – NEW Provider Enrollments

New Provider Enrollments: ACTIVE - Pending Submission: 3 (2 Touro PAs, 1 NP)
Submitted: 1 Pending Approval: 1
Approved: None During this Reporting Period

Partnership – Provider Re-Credentialing

Provider Re-Credentialing: 1 – submitted Pending Approval: 1
Approved: None During this Reporting Period

Denti-Cal – Provider Revalidations

None During this Reporting Period

NPI Program/Site Revalidations – CMS (N = +/- 38)

None During this Reporting Period

Technical Assistance – PAVE (Medi-Cal) and PECOS (Medicare) Sites: Upon Request

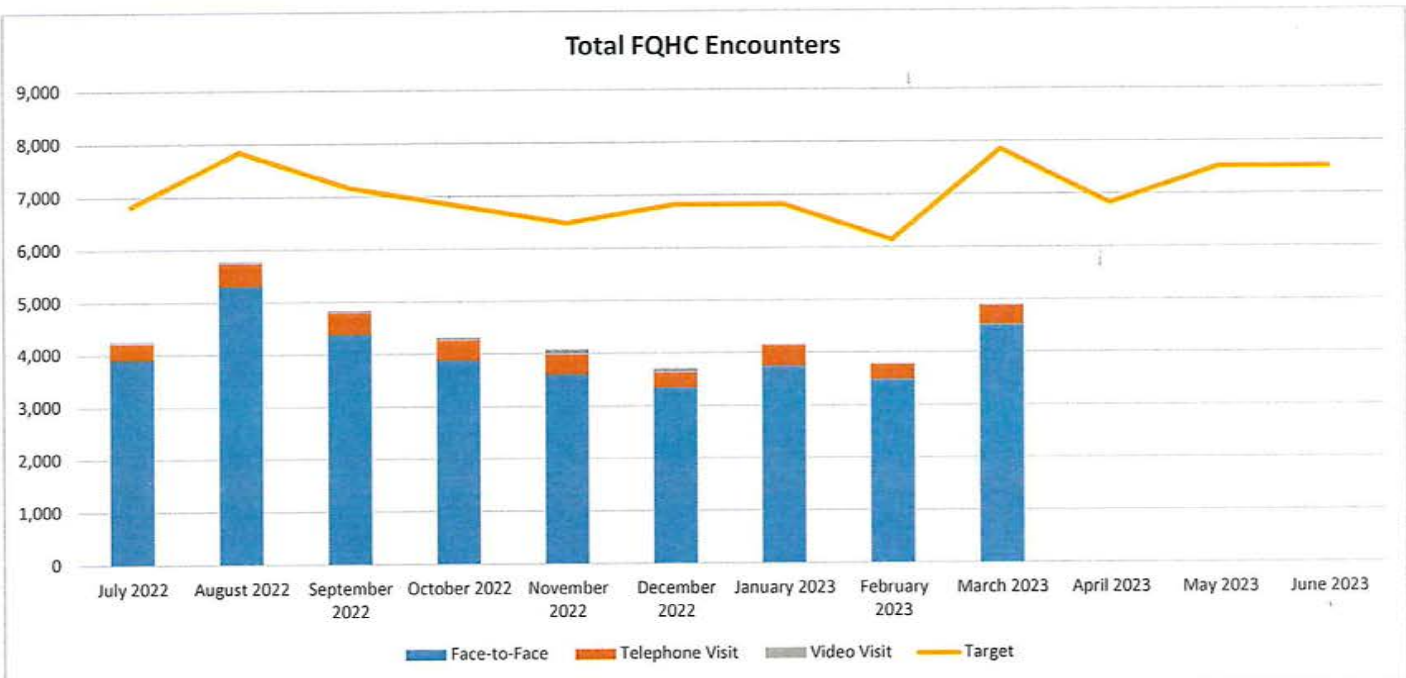
Clinic Operations Report: Health Resources and Services Administration (HRSA) Grant Updates

- Family Health Services (FHS) utilized the total *Fiscal Year 2021/2023 American Rescue Plan Act (ARPA) Funding for Health Centers* (H8FCS40398) of *$3,789,500* over the grant's performance period of *April 1, 2021 to March 31, 2023*. The funding was successfully utilized toward the following approved budget categories: Personnel, Fringe Benefits, Equipment (NextGen Managed Cloud Service and NextGen Managed Telehealth Schedule), Contractual (Facktor Health) and Other (Transportation Services – UberHealth). H8F grant close out activities are in progress and no issues are anticipated.

- FHS staff successfully replied to the Uniform Data System (UDS) Reviewer's comments and data revision requests. The revised UDS Report – 2022 was completed, submitted and accepted by the Reviewer prior to the final, March 31st deadline. It is currently under review by HRSA's Bureau of Primary Health Care (BPHC).

- The Ryan White (RW) Services Report (RSR) 2022 was submitted prior to the final, March 27th deadline. It captured the RW Part B HIV Care Program (HCP) non-medical services and RW Part C Early Intervention Services (EIS) (e.g., medical case management, specialty care) FHS provided to people living with HIV/AIDS (PLWHA) during 2022. It is currently under review by HRSA's HIV/AIDS Bureau (HAB).

SOLANO COUNTY HEALTH AND SOCIAL SERVICES
FAMILY HEALTH SERVICES
Total FQHC Encounters
July 2022 - June 2023

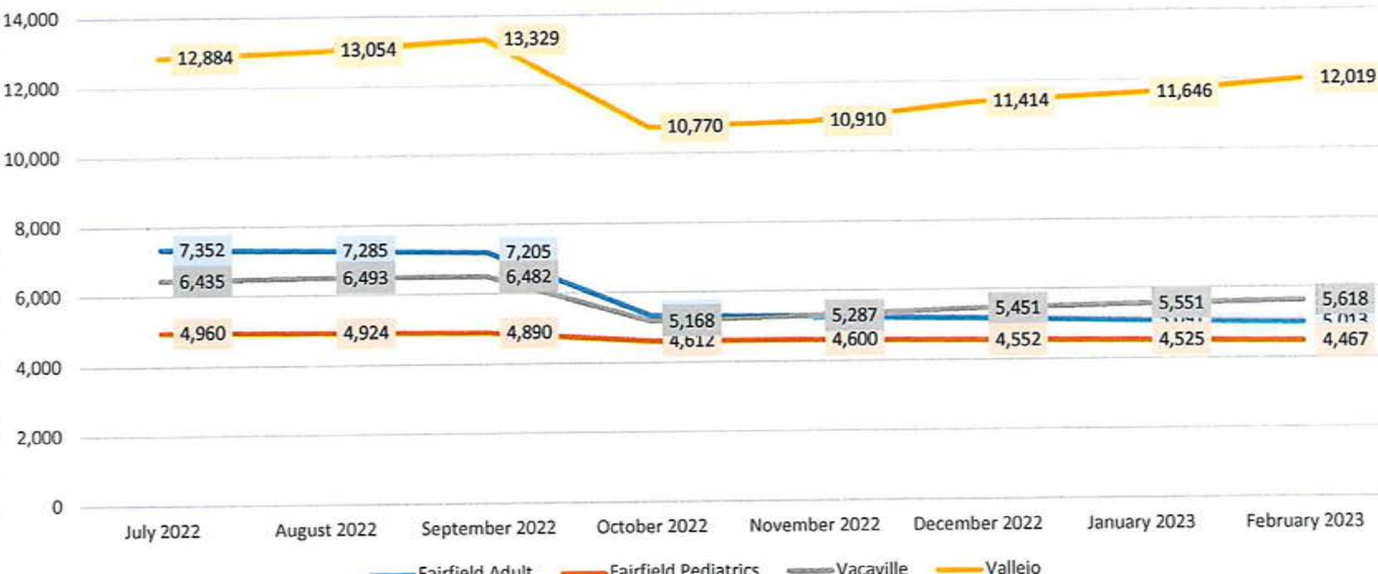


	a	*b*	*c*	*d = (a+b+c)*	*e*	*f = (d-e)*
		Telemedicine				
	Face-to-Face	**Telephone Visit**	**Video Visit**	**Total Encounters**	**Target**	**Difference**
July 2022	3,909	321	19	4,249	6,834	(2,585)
August 2022	5,309	441	28	5,778	7,859	(2,081)
September 2022	4,387	413	41	4,841	7,175	(2,334)
October 2022	3,878	383	47	4,308	6,834	(2,526)
November 2022	3,606	379	79	4,064	6,492	(2,428)
December 2022	3,353	281	63	3,697	6,834	(3,137)
January 2023	3,757	392	14	4,163	6,834	(2,671)
February 2023	3,504	266	14	3,784	6,150	(2,366)
March 2023	4,531	350	17	4,898	7,859	(2,961)
April 2023					6,834	
May 2023					7,517	
June 2023					7,517	
YTD Total	36,234	3,226	322	39,782	84,739	(23,089)

SOLANO COUNTY HEALTH AND SOCIAL SERVICES
FAMILY HEALTH SERVICES
Encounter Status by Payer Mix
July 2022 - June 2023

	Approved/Paid						
	Medi-Cal & Medi-Medi	Medicare Only	Private Insurance	Self-Pay/ Uninsured	Denied	Pending	Total Encounters
July 2022	3,963	27	7	238	14	0	4,249
August 2022	5,430	27	10	287	21	3	5,778
September 2022	4,512	21	9	274	21	4	4,841
October 2022	3,990	25	2	264	20	7	4,308
November 2022	3,758	19	1	258	15	13	4,064
December 2022	3,429	22	2	206	9	29	3,697
January 2023	3,729	18	3	246	6	161	4,163
February 2023	2,196	18	4	212	6	1,348	3,784
March 2023	307	3		274	3	4,311	4,898
April 2023							
May 2023							
June 2023							
YTD Total	31,314	180	38	2,259	115	5,876	39,782
	78.7%	0.5%	0.1%	5.7%	0.3%	14.8%	

SOLANO COUNTY HEALTH AND SOCIAL SERVICES
FAMILY HEALTH SERVICES
Total Partnership Capitated Patients
July 2022 - June 2023



	Fairfield Adult	Fairfield Pediatrics	Vacaville	Vallejo	Total
July 2022	7,352	4,960	6,435	12,884	31,631
August 2022	7,285	4,924	6,493	13,054	31,756
September 2022	7,205	4,890	6,482	13,329	31,906
October 2022	5,338	4,612	5,168	10,770	25,888
November 2022	5,272	4,600	5,287	10,910	26,069
December 2022	5,189	4,552	5,451	11,414	26,606
January 2023	5,091	4,525	5,551	11,646	26,813
February 2023	5,013	4,467	5,618	12,019	27,117
March 2023	4,964	4,401	5,615	12,099	27,079
April 2023					
May 2023					
June 2023					

<u>Clinic Operations Report:</u> Clinic Metrics

Queue Management (Q-Matic) Stats – March 2023

Clinic Site	Patients Served
Fairfield	
Lab	94
Medical (Adult)	1,171
Subtotal	*1,265*
Vacaville	
Dental	792
Medical (Adult & Peds)	1,007
Subtotal	*1,799*
Vallejo	
Dental & Medical (Adult & Peds)	2,164
Lab	56
Subtotal	*2,220*
TOTAL	***5,284***

County of Solano
Community Healthcare Board
DRAFT

REGULAR GOVERNING BOARD MEETING MINUTES

Wednesday, March 15, 2023
In Person Meeting

Members Present:

At Roll Call: Mike Brown, Ruth Forney, Gerald Hase, Deborah Hillman, Anthony Lofton, Don O'Conner, Tracee Stacy, Sandra Whaley, Robert Wieda, and Brandon Wirth

Members Absent: None.

Staff Present:

Dona Weissenfels, Cynthia Coutee, Rebecca Cronk, Nina Delmendo, Cheryl Esters, Valerie Flores, Janine Harris, Raechel Leas, Krista McBride, Dr. Reza Rajabian, Danielle Seguerre-Seymour, Noelle Soto, Kelly Welsh, Cherry Violanda, Kristine Gual (PHC), and Patricia Zuñiga

1) **Call to Order – 12:05 p.m.**
   a) Welcome
   b) Roll Call

2) **Approval of the March 15, 2023 Agenda**

   Motion: To approve the March 15, 2023, Agenda.

   Motion by: Tracee Stacy and seconded by Sandra Whaley

   Discussion: None.

   Ayes: Mike Brown, Ruth Forney, Gerald Hase, Deborah Hillman, Anthony Lofton, Don O'Conner, Tracee Stacy, Sandra Whaley, Robert Wieda, and Brandon Wirth

   Nays: None

   Abstain: None

   Motion Carried.

3) **Public Comment**

   None.

Regular Calendar

4) **Approval of Minutes**

   i) Approval of the January 18, 2023 Draft Minutes

   Motion: To approve the January 18, 2023 Minutes

   Motion by: Ruth Forney and seconded by Anthony Lofton

Discussion: Chair Brandon Wirth mentioned to the Board Members that there were three (3) sets of draft minutes to approve and reminded them if a Board Member was not present at any of those meetings, they would ask to abstain, for those specific meetings they didn't attend.

Ayes: Mike Brown, Ruth Forney, Gerald Hase, Deborah Hillman, Don O'Conner, Sandra Whaley, Robert Wieda, and Brandon Wirth

Nays: None

Abstain: Anthony Lofton and Tracee Stacy

Motion Carried.

ii) Approval of the February 15, 2023 Draft Minutes

Motion: To approve the February 15, 2023 Minutes

Motion by: Mike Brown and seconded by Ruth Forney

Discussion: None.

Ayes: Mike Brown, Ruth Forney, Gerald Hase, and Brandon Wirth

Nays: None

Abstain: Deborah Hillman, Anthony Lofton, Don O'Conner, Tracee Stacy, Sandra Whaley, and Robert Wieda

Motion Carried

iii) Approval of the February 28, 2023 Draft Minutes

Motion: To approve the January 18, 2023 Minutes

Motion by: Tracee Stacy and seconded by Sandra Whaley

Discussion: None.

Ayes: Mike Brown, Ruth Forney, Gerald Hase, Deborah Hillman, Anthony Lofton, Don O'Conner, Tracee Stacy, Sandra Whaley, and Brandon Wirth

Nays: None

Abstain: Robert Wieda

Motion Carried

5) Clinic Operations Reports

Dona addressed the Board and the participants and announced a change in the reports. She met with the Family Health Services (FHS) Leadership, and they are moving toward written reports,

instead of stating and sharing reports at length during the meetings. The written reports would be included in the monthly agenda packet to allow the Board Members an opportunity to review them before the meeting. Thus, the Board Members can ask for clarification or any questions pertaining to the reports during the meeting.

a) Staffing Update – Given by Project Manager, Noelle Soto. She announced there were two (2) Medical Assistants hired and one started on February 21, 2023 in HIV Team and the other will start on March 20, 2023 in the general clinic. There is a Clinic Physician in background and there are no interviews scheduled at this time.

b) Credentialing Update – Given by Project Manager, Raechel Leas. There were 127 County employees screened with no exclusions. They completed credentialing on ten (10) employees. One Provider was approved and enrolled by Partnership. No one was re-credentialed in February. There was no one in dental validated for Denti-Cal or re-validated.

c) HRSA Grants Update (UDS) – Given by Project Manager, Noelle Soto. She mentioned that for the grants update, both the Uniform Data System (UDS) and the Ryan White Reports, The initial reports were submitted in February and the final submissions are due at the end of March.

d) Grievances/Compliments – Dona mentioned a compliment FHS received, submitted by a patient. The Hindi patient was very grateful for the translation iPad used during their visit. They felt they had a voice to communicate with the provider and understood everything said during the visit. (Please see the details noted below, in the first bullet item in Agenda Item 6a.)

e) Compliance – There was no Compliance Report given.

f) Referrals – There was no Referrals Report given.

g) Finance – Given by Policy & Financial Analyst, Janine Harris. She reminded everyone about the upcoming FHS Finance Committee Meeting on Wednesday, March 22, 2023 at 1:30pm. The meeting invite was sent out and It was scheduled to be in person in the Multi-Purpose Room at 2201 Courage Drive. The agenda packets would be mailed out and also posted on the CHB Web Page for the Board Members to review prior to the meeting.

h) Major Project Updates

i) QI Update

j) Clinic Operational Metrics (Clinic Health Services Managers)

There was discussion from the Board Members about the pros and cons of providing written reports in advance. Chair Brandon Wirth stated that of the reports listed, there may not be any reports and the list could be amended. Cheryl Esters, Compliance & QA Officer mentioned that the written reports are necessary as support documentation for audit purposes. The CHB Clerk announced that all written reports were required to be submitted to her eight (8) days prior to a Board Meeting, in order to include them in the agenda packet and perform proper noticing on time.

6) Project Director/Clinic Operations Officer Report – Dona Weissenfels

a) Health Center HRSA Project Officer Update
- Dona announced that all the FHS clinics received translation iPads, provided by PHC and they would be used during a clinic visit and provide a portable way for translation. It was a joint team effort and multiple collaborations, spear headed by Rebecca Cronk, the Vallejo Health Services Clinic Manager. Dona read a letter from a medical assistant that works at the Vallejo clinic, who shared the story of a Hindi couple, patients at the Vallejo clinic. The

couple expressed that after ten (10) years as patients at the FHS clinic, this was the first time they felt heard and really understood the office visit and understood all their medical needs. The medical assistant expressed how heartfelt the experience was and thanked Rebecca for providing the translation iPads. Cheryl Esters thanked the FHS effort along with the effort of the Compliance Team and the IT Team and it took a couple months and was a very successful project. Chair Brandon Wirth, mentioned that the letter read by Dona was an example of a compliment.

- Dona mentioned staffing at the clinics. She stated that they are having Provider recruitment issues and that Dr. Leary, the Chief Medical Officer, was unable to attend the meeting, because she was interviewing possible Locum Tenens provider candidates. Dona mentioned that they are expanding the number of recruiting agencies. There is a lot of competition in the field, and it is important that the candidates understand our patient population and the enormous needs they have. The top priority is to recruit providers.
- Dona also mentioned with the physician shortage, she expressed concern that the clinics are not taking care of the assigned members from PHC that they should. She had a meeting with PHC earlier in the week to ask that PHC temporarily close their panels of enrolling new patients starting April 1, 2023. PHC asked for the exception of previous patients for continuity of care, and it was agreed to accept those patients. Dona shared the number of patients assigned at the clinics. At Fairfield Adult there are 5,000 patients, at Fairfield Pediatrics there are almost 5,000, at the Vallejo there are 12,000 and at Vacaville there are almost 6,000, so the clinics are above the maximum capacity in comparison with the limited number of providers on site.
- Dona gave an update about the new electronic health record, OCHIN Epic. They are in the pre-contract phase and on task. The hopeful start date is possibly in the second quarter of 2024, and it will be a fresh start yet a challenge when it is implemented.

b) Health Center Activities, Internal & External Update

- Dona mentioned FHS is requesting an agenda item, requesting five (5) additional positions in the Call Center and Quality Team, and a Nurse Manager, which will be presented to the Board of Supervisors at a future meeting. Chair Brandon Wirth expressed the importance of the Board to advocate on behalf of the FHS and encouraged Board Members to attend the meeting when presented to the Board of Supervisors. Dona will ask the Board Clerk to notify the Board Members of the date when this item will be presented and so the Board Members could attend to support the request of adding the positions.
- Dona mentioned that the preparation of the Strategic Planning is on target and the 2023 County Needs Assessment was on the agenda for board approval, which is part of the Strategic Plan.
- Dona stated they are reviewing the Quest contract. Quest provides the lab technician at the clinics. FHS wants to provide expanded laboratory clinic hours at the Fairfield Adult Clinic.
- Dona gave an update about the Fairfield Adult Clinic restoration. Carpet has been ordered for the lobby and will hopefully arrive soon. When the carpet is scheduled to be installed, the clinic lobby will be closed for about three (3) days and patients will still be seen and enter the clinic from a different entrance. Most of the repairs are completed.

7) **Business Governance**

a) Review and approve the 2023 Community Needs Assessment – Dona Weissenfels

- Please reference the document titled, *"2023 Community Needs Assessment"* for detailed information.

i) ACTION ITEM: The Board will consider approval of the 2023 Community Needs Assessment.

Motion: To approve the 2023 Community Needs Assessment.

Motion by: Robert Wieda and seconded by Ruth Forney

Discussion: Board Member Ruth Forney asked that a small change be made in the Governance section. It states that Brandon Wirth as the President. She asked that the title of "President" be updated as "Chair". She also asked to clarify Pharmaceuticals and Dona clarified that Pharmaceuticals handled at the clinics do not fall under "Services". Ruth also discussed transportation services with Dona that at one time bus passes were issued in the past and she shared a story of how high rental costs are.

Ayes: Mike Brown, Ruth Forney, Gerald Hase, Deborah Hillman, Anthony Lofton, Don O'Conner, Tracee Stacy, Sandra Whaley, Robert Wieda, and Brandon Wirth.

Nays: None

Abstain: None

Motion Carried.

b) Discuss recent changes at the Global Center for Success in Vallejo, a Family Health Services (FHS) Primary Care Outreach site. Request Board approval to close the location. – Dona Weissenfels.

- Dona mentioned the site was located at Mare Island in Vallejo had been closed for a while. It was due to provider shortage and removal of the end of the life cycle, of the computer equipment, which was removed and the equipment was not replaced due to funds. Also, patient access was taken into consideration in making the request to close the site. She asked that the Board consider that the site be closed. She also mentioned that FHS has a mobile medical clinic and when staffing levels improve the mobile clinic will be back in service and can provide medical care where needed.

i) ACTION ITEM: The Board will consider approval to close the Global Center for Success location in Vallejo. Medical Services will be provided via Mobile Medical Clinics when staffing levels improve.

Motion: To approve closing of the Global Center for Success location in Vallejo.

Motion by: Tracee Stacy and seconded by Robert Wieda

Discussion: None.

Ayes: Mike Brown, Ruth Forney, Gerald Hase, Deborah Hillman, Anthony Lofton, Don O'Conner, Tracee Stacy, Sandra Whaley, Robert Wieda, and Brandon Wirth

Nays: None

Abstain: None

Motion Carried.

c) Review and approve the Family Health Services (FHS) Quality Reports – Dona Weissenfels
Dona presented the 2022 CAHPS Survey. The Survey is conducted annually by Partnership HealthPlan (PHC) on assigned members to Family Health Services. The reports are annual patient experience scorecards, measuring domains such as provider communication and access to care.
   - Included in the Board's Packets were the full reports: "2022 Survey for PHC Child CG-CAHPS 3.0 Survey Solano County H&SS" and "2022 Survey for PHC Adult CG-CAHPS 3.0 Survey Solano County H&SS". Please reference the handout for detailed information.
   i) ACTION ITEM: The Board will consider approval of the Family Health Services (FHS) Quality Reports.

Motion: To approve the Family Health Services (FHS) Quality Reports.

Motion by: Sandra Whaley and seconded by Anthony Lofton.

Discussion: None.

Ayes: Mike Brown, Ruth Forney, Gerald Hase, Deborah Hillman, Anthony Lofton, Don O'Conner, Tracee Stacy, Sandra Whaley, Robert Wieda, and Brandon Wirth

Nays: None

Abstain: None

Motion Carried.

d) Review and approve the Family Health Services (FHS) Patient Grievance/Complaint Process Policy Number: 500.05 – Rebecca Cronk
   - Rebecca Cronk, Health Services Clinic Manager of Vallejo Clinic reviewed the policy.
   - Please reference the document titled, "Family Health Services (FHS) Patient Grievance/Complaint Process Policy Number 500.05" for detailed information.
   i) ACTION ITEM: The Board will consider approval of the Family Health Services (FHS) Patient Grievance/Complaint Process Policy Number 500.05.

Motion: To approve the Family Health Services (FHS) Patient Grievance/Complaint Process Policy Number 500.05.

Motion by: Tracee Stacy and seconded by Sandra Whaley

Discussion: None.

Ayes: Mike Brown, Ruth Forney, Gerald Hase, Deborah Hillman, Anthony Lofton, Don O'Conner, Tracee Stacy, Sandra Whaley, Robert Wieda, and Brandon Wirth

Nays: None

Abstain: None

Motion Carried.

8) Unfinished Business

a) Receive status update on the Community Healthcare Board Self-Assessment Form and provide any necessary direction.

County of Solano
Community Healthcare Board
DRAFT

- Chair Brandon Wirth notified the Board Members that the Community Healthcare Board Self-Assessment form was included in their agenda packets and asked them to review the form and think about any changes that should be made to the form. It will be addressed at agendized at a Board Meeting in the future.

9) Board Member Comments

- Board Member Tracee Stacy asked about a Parking Lot item, Health Center Marketing Campaign & Website Design, from a previous meeting. Board Member Ruth Forney, clarified that at the last month's meeting Dona mentioned that the clinics should have an event acknowledging the FHS Health Centers in observance of National Health Centers Week in August. She will work with Ruth and a subcommittee will be formed in the future.
- Chair Brandon Wirth, asked to add Health Center Week be added as a Discussion item at a future meeting.
- Board Member Tracee Stacy asked about the Kindergarten Round Ups and whether they plan to have them this year. They were a huge success in the past. Dona responded and notified the Board that Public Health Division is handling this event with Dr. Shandi Fuller as the lead in this effort. Dona stated that FHS Leadership is attending meetings and will find out their role.
- Board Member Tracee Stacy asked if Mental Health sends the suicide and overdose statistics to FHS, because since January there have been 13 suicides and there were also overdoses from Fentanyl and 2 cases were homeless. Dona responded that FHS Clinics have been participating in the Fentanyl awareness program.
- Chair Brandon Wirth asked where Board Member Tracee Stacy received the information and Tracee stated that she serves on the Suicide Prevention Team.

10) Closed Session

Public Employee Performance Evaluation (Pursuant to Government Code § 54957) Title: HRSA Project Director.

a) HRSA Project Director Evaluation Discussion
b) Present Evaluation to HRSA Project Director

11) Adjourn: To the Community Healthcare Board Meeting of:

DATE: April 19, 2023
TIME: 1:00 p.m. – 2:00
Location: Multi-Purpose Room
2101 Courage Drive
Fairfield, CA 94533

Meeting was adjourned at 2:18 p.m.

Handouts:

- January 18, 2023 CHB Draft Minutes
- February 15, 2023 CHB Draft Minutes
- February 28, 2923 CHB Draft Minutes
- 2023 Community Needs Assessment
- 2022 Survey for Partnership0 HealthPlan of California Child CG-CAHPS 3.0 Survey Solano County H&SS
- 2022 Survey for Partnership0 HealthPlan of California Adult CG-CAHPS 3.0 Survey Solano County H&SS
- Family Health Services Patient Grievance Process Policy Number: 500.05
- Medical Services Family Health Services Community Healthcare Board Self-Assessment April 2022

	COUNTY OF SOLANO EXPENDITURE AND REVENUE REPORT DEPT: 7580 FAMILY HEALTH SERVICES MARCH 31, 2023					
		A	B	C	D	
	Category Subobject	Description	FY 2022/23 Mid Year Budget	3/31/23 YTD Actuals	% of Actual Spending Against WB (Col C divided by Col B)	COMMENTS
		EXPENDITURES				
	1000	SALARIES AND EMPLOYEE BENEFITS				
1	0001110	SALARY/WAGES REGULAR	11,986,565	7,975,625	66.54%	
2	0001121	SALARY/WAGES-EXTRA HELP	72,851	39,504	54.23%	
3	0001131	SALARY/WAGES OT/CALL-BACK	66,217	51,852	78.31%	
4	0001141	SALARY/WAGES PREMIUM PAY	32	32	100.66%	
5	0001142	SALARY/WAGES STANDBY PAY	42,540	28,651	67.35%	
6	0001210	RETIREMENT-EMPLOYER	2,892,344	2,013,155	69.60%	
7	0001212	DEFERRED COMP-COUNTY MATCH	29,087	8,437	29.01%	
8	0001213	OPEB COSTS	231,629	152,108	65.67%	
9	0001220	FICA-EMPLOYER	782,414	566,048	72.35%	
10	0001230	HEALTH INS-EMPLOYER	1,960,432	1,247,160	63.62%	
11	0001231	VISION CARE INSURANCE	18,363	11,917	64.90%	
12	0001240	COMPENSATION INSURANCE	269,010	269,010	100.00%	
13	0001241	LT DISABILITY INSURANCE ER	4,247	3,040	71.59%	
14	0001260	DENTAL INS-EMPLOYER	127,174	80,688	63.45%	
15	0001270	ACCRUED LEAVE CTO PAYOFF	56,118	44,366	79.06%	
16	0001290	LIFE INSURANCE-EMPLOYER	14,689	10,041	68.36%	
17	1000	SALARIES AND EMPLOYEE BENEFITS	18,553,712	12,501,635	67.38%	Salaries are lower thatn anticipated as compared to MidYear due to continued vacancies in the clinic.
18						
19	2000	SERVICES AND SUPPLIES				
20	0002021	COMMUNICATION-TELEPHONE SYSTEM	88,892	59,770	67.24%	
21	0002022	COMMUNICATION-TELEPHONE AMC	13,861	6,506	46.94%	
22	0002025	CELLULAR COMMUNICATION SERVICE	14,190	9,172	64.64%	
23	0002028	TELEPHONE SERVICES	19,046	12,048	63.26%	
24						
25	0002035	HOUSEHOLD EXPENSE	25,633	17,028	66.43%	
26	0002050	INSURANCE-RISK MANAGEMENT	2,149	2,140	99.58%	
27	0002051	LIABILITY INSURANCE	246,890	246,890	100.00%	
28	0002057	MALPRACTICE INSURANCE	592,301	-	0.00%	Charges for malpractice insurance will post in June and will be based on actual costs.
29	0002103	INTERPRETERS	2,938	705	24.00%	
30	0002120	MAINTENANCE EQUIPMENT	33,703	12,678	37.62%	
31	0002122	FUEL & LUBRICANTS	2,135	878	41.12%	
32	0002140	MAINTENANCE-BLDGS & IMPROVE	2,136	1,602	75.00%	
33	0002151	DRUGS & PHARMACEUTICAL SUPP	268,791	126,153	46.93%	
34	0002153	MEDICAL/DENTAL SUPPLIES	338,613	207,182	61.19%	
35	0002170	MEMBERSHIPS	3,000	1,998	66.60%	
36	0002171	PROFESSIONAL LICENSES & CERT	10,198	5,757	56.45%	
37	0002176	FEES AND PERMITS	7,788	3,556	45.66%	
38	0002178	CASH SHORTAGE	-	220	#DIV/0!	
39	0002180	BOOKS & SUBSCRIPTIONS	2,212	-	0.00%	
40	0002200	OFFICE EXPENSE	59,930	37,166	62.02%	
41	0002201	EQUIPMENT UNDER $1,500	18,710	4,811	25.71%	
42	0002202	CONT ASSETS COMPUTER RELATED	135,922	131,646	96.85%	
43	0002203	COMPUTER COMPONENTS <$1,500	33,253	1,368	4.11%	
44	0002204	COMPUTER RELATED ITEMS:<$500	3,500	1,971	56.31%	
45	0002205	POSTAGE	60	-	0.00%	
46	0002206	CONT ASSET-NON COMP RELATED	413,449	74,785	18.09%	
47	0002207	ERGONOMIC UNDER $1500	6,302	883	14.02%	
48	0002215	MANAGED PRINT COST PER COPY	12,761	7,814	61.23%	
49	0002216	MAINTENANCE/SERVICE CONTRACTS	11,756	11,756	100.00%	
50	0002221	RECORDS STORAGE	4,558	1,459	32.02%	
51	0002226	MEDICAL/DENTAL SERVICE	239,000	126,353	52.87%	
52	0002245	CONTRACTED SERVICES	946,760	343,692	36.30%	Actuals are lower than expected due to timing of payments to contractors.
53	0002250	OTHER PROFESSIONAL SERVICES	79,500	26,589	33.45%	
54	0002255	CREDIT CARD PROCESSING FEES	1,842	833	45.25%	
55	0002260	DATA PROCESSING SERVICES	1,800	1,800	100.00%	
56	0002261	SOFTWARE MAINTENANCE & SUPPORT	572,572	382,010	66.72%	
57	0002263	H&SS DOIT TIME STUDY COSTS	1,191,334	266,418	22.36%	

		A	B	C	D	
	Category Subobject	Description	FY 2022/23 Mid Year Budget	3/31/23 YTD Actuals	% of Actual Spending Against WB (Col C divided by Col B)	COMMENTS
58	0002264	HSS CDP COSTS	331,299	248,473	75.00%	
59	0002266	CENTRAL DATA PROCESSING SVCE	708,468	533,523	75.31%	
60	0002270	SOFTWARE	-	5,170	#DIV/0!	
61	0002271	SOFTWARE RENTAL / SUBSCRIPTION	36,496	10,570	28.96%	
62	0002280	PUBLICATIONS AND LEGAL NOTICES	2,805	-	0.00%	
63	0002285	RENTS & LEASES - EQUIPMENT	12,142	7,962	65.58%	
64	0002295	RENTS & LEASES-BUILDINGS/IMPR	2,400	1,800	75.00%	
65	0002310	EDUCATION & TRAINING	7,260	8,607	118.55%	
66	0002312	SPECIAL DEPARTMENTAL EXPENSE	16,541	6,687	40.43%	
67	0002335	TRAVEL EXPENSE	-	516	#DIV/0!	
68	0002336	TRAVEL OUT-OF-STATE	-	1,122	#DIV/0!	
69	0002337	MEALS/REFRESHMENTS	2,800	300	10.71%	
70	0002338	EMPLOYEE RECOGNITION	3,850	1,520	39.48%	
71	0002339	MANAGEMENT BUSINESS EXPENSE	2,800	1,463	52.23%	
72	0002350	COUNTY GARAGE SERVICE	(5,183)	(9,641)	186.02%	
73	0002355	PERSONAL MILEAGE	14,018	7,621	54.37%	
74	0002360	UTILITIES	188,751	132,522	70.21%	
75	0002361	WATER	27,293	13,542	49.62%	
76	2000	SERVICES AND SUPPLIES	6,759,225	3,107,397	45.97%	Overall service and supplies appear lower than projected in part due to timing of charges posting, e.g. contractor payments and malpractice insurance.
77						
78	3000	OTHER CHARGES				
79	0003121	INDIGENT CARE	25,820	18,410	71.30%	
80	0003153	CONTRACTED DIRECT SERVICES	857,568	248,861	29.02%	Actuals are lower than expected due to timing of payments to contractors.
81	0003158	FOOD FOR INDIGENT CLIENS	157	157	100.02%	
82	0003160	TRANSPORTATION FOR CLIENTS	29,689	14,090	47.46%	
83	0003690	INTERFUND SERVICES USED-COUNTY	6,775	-	0.00%	
84	0003694	INTERFUND SVCES-PROFESSIONAL	624,678	219,735	35.18%	
85	0003695	INTERFUND SVCES-MNT MATERIALS	2,300	26	1.13%	
86	0003696	INTERFUND SVCES-SMALL PROJECTS	15,738	1,274	8.10%	
87	0003697	INTERFUND SVCES-POSTAGE	29,677	14,329	48.28%	
88	0003698	INTERFUND SVCES-MNT LABOR	6,061	6,024	99.40%	
89	0003701	CONTRIB - NON COUNTY AGENCIES	5,000	3,003	60.06%	
90	0003710	COUNTYWIDE ADMIN OVERHEAD	896,007	896,007	100.00%	
91	3000	OTHER CHARGES	2,499,470	1,421,914	56.89%	
92						
93	4000	FIXED ASSETS				
94	0004303	EQUIPMENT	51,500	-	0.00%	
95	4000	FIXED ASSETS	51,500	-	0.00%	We expect to see charges when the equipment purchased is received. These items were paid with HRSA Capital Grant funds.
96						
97	5000	OTHER FINANCING USES				
98	0005040	TRANS OUT-POBs	182,699	120,240	65.81%	
99	5000	OTHER FINANCING USES	182,699	120,240	65.81%	
100						
101	7000	INTRA FUND TRANSFERS				
102	0007010	INTRA-FUND TRANSFER	2,313,095	1,088,657	47.06%	
103	0007023	INTRAFUND SVCES-PERSONNEL	81,128	50,363	62.08%	
104	0007024	INTRAFUND SVCES-PROFESSIONAL	118	144	122.03%	
105	7000	INTRA FUND TRANSFERS	2,394,341	1,139,164	47.58%	
106						
107		TOTAL EXPENDITURES	30,440,947	18,290,351	60.08%	

	Category Subobject	A Description	B FY 2022/23 Mid Year Budget	C 3/31/23 YTD Actuals	D % of Actual Spending Against WB (Col C divided by Col B)	COMMENTS
108		REVENUES				
109						
110						
111	9500	INTERGOVERNMENTAL REVENUES				
112	0009543	PRIOR YEAR REV-STATE & OTHERS	-	104	#DIV/0!	Error and will be corrected prior to the next report.
113	0009567	COVID-19 FEDERAL DIRECT	3,993,877	1,846,425	46.23%	Actuals do not reflect the 2nd Quarter grant drawdown for the Base Grant, COVID funding and Ryan White Part C.
114	0009572	FEDERAL AID	2,060,644	902,259	43.79%	
115	9500	INTERGOVERNMENTAL REVENUES	6,054,521	2,748,788	45.40%	
116						
117	9600	CHARGES FOR SERVICES				
118	0009603	PHOTO/MICROFICHE COPIES	2,631	1,601	60.84%	
119	0009643	PRIVATE PAY PATIENT	94,845	87,434	92.19%	
120	0009657	INSURANCE PAYMENTS	22,884	16,462	71.94%	
121	0009661	MEDI-CAL SERVICES	9,512,099	6,682,156	70.25%	Actuals have been adjusted to reflect potential payback for the FY2022/23 Medi-Cal reconciliation.
122	0009662	MEDICARE SERVICES	47,919	499,538	1042.46%	
123	0009667	CMSP SERVICES	-	300	#DIV/0!	Error and will be corrected prior to the next report.
124	0009670	MANAGED CARE SERVICES	4,474,780	3,323,728	74.28%	
125	9600	CHARGES FOR SERVICES	14,155,158	10,611,218	74.96%	Revenue projections were adjusted at MidYear to provide a more realistic projection. Actuals may be lower at year end due to unanticipated provider vacancies.
126						
127	9700	MISC REVENUES				
128	0009703	OTHER REVENUE	1,551,155	214,394	13.82%	We expect to receive the QIP payment at the end of April or early May.
129	9700	MISC REVENUES	1,551,155	214,394	13.82%	
130						
131	9800	OTHER FINANCING SOURCES				
132	0009807	TRANSFER IN-COUNTY CONTRIB	1,337,437	1,003,078	75.00%	
133	0009811	OPERATING TXR IN - ARPA	220,850	220,850	100.00%	
134	TOTAL	OTHER FINANCING SOURCES	1,558,287	1,223,928	78.54%	
135						
136		TOTAL REVENUE	23,319,121	14,798,327	63.46%	
137						
138						
139		TOTAL EXPENDITURES VS TOTAL REVENUES				
140						
141			FY 2022/23 Mid Year Budget	3/31/23 YTD Actuals		
142		TOTAL EXPENDITURES	30,440,947	18,290,351		
143		TOTAL REVENUE	23,319,121	14,798,327		
144						
145		DEFICIT/(SURPLUS)	7,121,826	3,492,023		
146						
147						
148						
149		USE OF 1991 REALIGNMENT				
150						
151	0009519	STATE VLF 1991 REALIGNMNT - PH	7,121,826	3,492,023		

* A portion of 1991 Realignment is used to fund costs for the uninsured/underinsured and the cost of Public Health functions performed at the clinics.

MEASURE DESCRIPTION
Parent Organization (PO) submission of proposed plan and adoption of internal best practices that support a Health Equity initiative. May include existing best practices in place.

Measure Requirements
Submission will demonstrate Health Equity characteristics PCPs can successfully integrate as a core strategy.

<u>Promising Practices</u>

1. Make Health Equity a leader-driven priority
2. *Identify specific health disparities, then act to close the gaps*
3. Confront institutional racism
4. Develop processes that support equity (health systems/dedicated, resources, governance structure to oversee)
5. Partner with community organizations

2. Identify specific health disparities, then act to close the gaps

Submission would describe efforts to operationalize activities that support health equity work. For example:

- a. *Current member intake/annual review form that collects member's self-identified demographic information, such as race, ethnicity, address, birth sex and gender identity, sexual orientation, housing status, preferred language.*
- b. *Current workflows to provide care for patients in their preferred language.*
- c. *Current patient needs assessment that collected information from patients about barriers to health such as food or housing insecurity, healthy and safe communities, disability status, lack of transportation.*

The mission of the Solano County Family Health Services (FHS) Clinics is to coordinate and provide cost effective healthcare, promote self-reliance, and safeguard the physical, emotional, and social well-being of the indigent, uninsured, underinsured, and homeless members of Solano County. Together with fellow healthcare partners and community-based organizations FHS strives to facilitate continued access to comprehensive, culturally competent, high-quality primary health care resources and services in and around Solano County.

As an awardee of the Health Resources and Services Administration (HRSA) Health Center Program (HCP), FHS receives funding to provide medical, behavioral health and dental care for indigent, uninsured, underinsured, and homeless members of Solano County. A requirement of HCP is to submit an annual calendar year comprehensive data report, HCP Uniform Data System (UDS), on our patient characteristics, services provided, clinical processes and health outcomes, patients' use of services, staffing, costs, and revenues. Through our annual UDS submissions, we track and trend the health equity gaps and needs of our patient population while assessing areas of need and opportunities for improvement. In addition, the FHS patient population's characteristics and health outcomes are monitored in relation to the county, state and national population trends.

Since the Calendar Year 2021 HCP UDS submission and review, FHS developed an improvement project to address the collection and reporting of FHS patients' race, ethnicity, sexual orientation and gender identity (SOGI), as well as housing status, income and preferred language. Through an internal workgroup, FHS was able to review discrepancies in collection methodology at each clinic site and implement a revised Front Desk Welcome Packet in English, Spanish and Tagalog. Simultaneously, in anticipation of the Coronavirus-19 (COVID-19) State of Emergency ending, FHS began an intradepartmental health education improvement project with Solano County Employment and Eligibility, Nutrition Services Bureau and Public Health Administration to address the resumption of annual Medi-Cal redetermination requirements.

Through informative mailers regarding Medi-Cal redetermination, targeted education and outreach regarding Pediatric Well-Child Visits and Vaccination Schedules in English, Spanish and Tagalog will be sent to community members and FHS patients. Pediatric Well-Child Visits will be actively tracked, and data collected regarding rescheduled and no-show appointments. By determining reasons why appointments were rescheduled and/or not kept, FHS can determine how to decrease barriers to care and work towards a goal of completing 75% of assigned children's Well-Child Visits during the measurement year.

Prior to the COVID-19 Pandemic, transportation and food insecurity had been listed as barriers to care in Solano County community health needs assessments. To address the increased barrier to care as a result of the Pandemic, federal COVID-19 funding allowed FHS to expand food distribution at each clinic site through the Mobile Food Pharmacy (MFP) and healthcare related transportation options through UberHealth. During Fiscal Year 2022 Quarter 1 (Jul, Aug, and Sep), the MFP provided 1,291 boxes of non-perishable food to FHS patients and 173,391 pounds of fresh produce to community members. 317 UberHealth rides were provided to FHS patients enabling them to receive primary, specialty referral and supplemental healthcare services.

These projects are examples of FHS' current and planned continuous quality improvement activities. They demonstrate how providing care workflows in a patients' preferred languages and community needs assessments assist in closing the gaps in health equity.

Addressing Institutional Racism within Solano Family Health Services (FHS)

February 23, 2023

1. Diversity, Equity and Inclusion Trainings

Currently in our organization, we must complete required Diversity, Equity and Inclusion (DEI) Trainings every 2 years. This is monitored by our Human Resources (HR) and Compliance Departments. All staff are required to complete these trainings. There are also opportunities to discuss implicit bias, microaggressions and/or experiences with racism during breakout sessions with providers or during provider meetings. There can also be discussions about how race impacts our work and how we show up to work for our patients. We will also consider asking our patients how they have experienced racism – if it's been in our clinic or within other institutions an attempt to create solutions for how to combat that discrimination. We can also provide education to our patients as to how we can assist in dismantling those barriers – whether with a visiting home health nurse, cultural competency continuing medical education courses (CMEs), and linking them to services such as legal aid, housing assistance, and/or employment opportunities, to name a few.

2. Read Out and Read Program

In our pediatric clinics, we partner with the Solano County's Reach Out and Read Program. Over a six-month period, Jan 2022 to June 2022, we distributed 265 books to babies at their well-child visits at our **Fairfield** site. The children ranged in age from 6 months to 5 years. We had approximately 600 babies seen for well-child visits and of those, 265 children received books. The distribution rate was 44%. In the future, our goal is to increase our book distribution rate to 1:1, ensuring at each and every well-child visit, the 6-month-old to 5year-old is given a book.

Demographics At **our Fairfield Pediatric** location, 99% of our patients are on Medi-Cal insurance. The demographics are 64% being Hispanic, 11% African American, 7% White, 7% Asian, 6% Multiracial/Bi-racial and 4% Unknown.

Languages In tracking the languages spoken at Fairfield, the percentages are 53% English, 42% Spanish, 2% Punjabi/Farsi/Urdu, 1% Arabic and 1% Unknown. In Fairfield, I specifically gave a 4 year-old Punjabi girl a book in Punjabi. Both she and her dad were very pleased!

At our **Vacaville** location, the **demographics** of our pediatric patients are 49% Hispanic, 16% White, 11% African American, 11% Asian, 9% Multiracial/Bi-racial and 4% Unknown. Languages spoken for Vacaville are 69% English, 24% Spanish, *5% Punjabi/Farsi/Urdu* and 2% Unknown. In our Vacaville location, we gave out 50 books to 35 patients, making our percent distribution rate 143%.

Our goal is to start tracking the book we give prior to each well-child visits part of pre-visit planning and Quality Improvement (QI) work and the preferred language and culture of the book. Then on each subsequent visit, we are not giving the same book again and we have some idea of what books certain patients like/prefer. We can record the books and make updates as needed in the electronic medical record (EMR) system.

3. Historical Contributions of African American Midwives

To discuss the oft marginalized and written out of the mainstream medical narrative, we will have a presentation on the racial inequities in health care that have contributed to the disparities in health care we still see today. During the next two to three months, we will host a "Lunch and Learn" on **The Contributions of African American Midwives in the Rural Southern United States from 1920s to 1950s.** Attached is a copy of the presentation. This will provide the team an opportunity to have a discussion with providers and staff within our FHS department on ways that we can deconstruct some of the historical wrongs of the past. We can then use some of those ideas to forge a better and brighter future.

Link to the Contributions of Midwives to AA Health-PPT 2.21.23

4. Coloring Books for Children

We in the Pediatric Department started giving these out to all children during Black History Month this year. This pilot project was implemented within in the past 2 weeks, from February 10-February 23, 2023, in our Fairfield location. The children were very excited to receive their coloring books and we actually ran out of **"30 coloring books"** over a 2-week period. We will start implementing and tracking at our Vacaville, Vallejo and Dental clinics as well on Monday, February 27 and continue till March 27, 2023, at least. Attached are sample pages for the children to color. Yesterday, in my role as a provider, I personally handed out *3 coloring books to white children, ages 3, 4 and 11 years, as well as 2 Hispanic children ages 6 and 10 years.* All children learn from coloring, about spatial relationships, colors, and it is also a **non-screen time activity** for them to engage in. Even some of our adult medical assistants wanted the coloring books for themselves. The coloring book also helps foster the learning process and promotes education.

Name: ______ Date: ______

George Washington Carver
c.1861 - January 5, 1943

- During his time, Carver was one of the most prominent inventors and scientists.
- Using the peanut, Carver discovered over 300 products, which included plastics, gasoline, and dyes.
- As a great plant biologist, Carver made many groundbreaking discoveries, focusing on certain crops such as sweet potatoes, peanuts, pecans, and soybeans.
- In 1916, Carver was given a rare honor for any American by becoming a member of the British Royal Society of the Arts.
- *He became the first African American to have a national monument dedicated to him.*
- *Carver's laboratory was located at Tuskegee Institute in Alabama.*

Name: ______ Date: ______

Katherine Johnson, Mary Jackson and Dorothy Vaughan

In 2016 the story of Katherine, Dorothy Vaughan and Mary Jackson was told in the box office smash Hidden Figures.

Name: ______ Date: ______

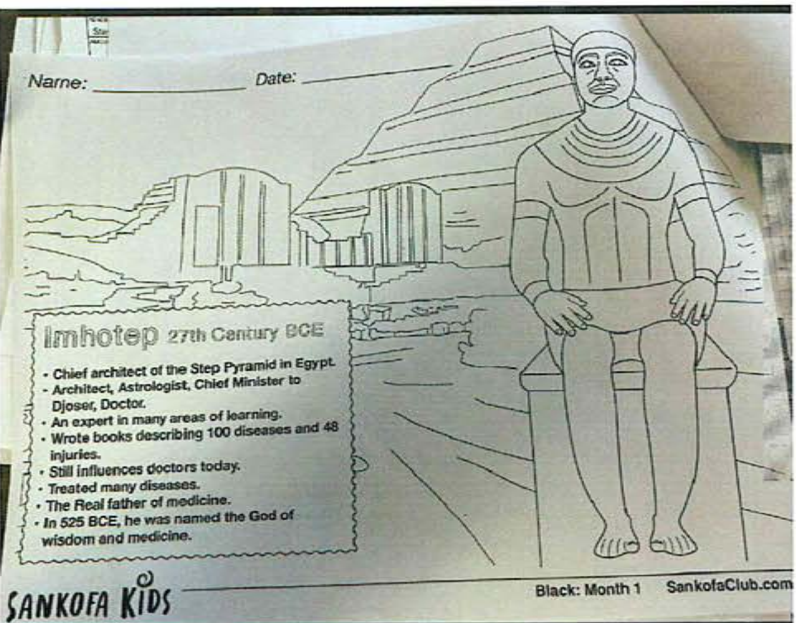
Percy Julian
April 11, 1899 - April 19, 1975

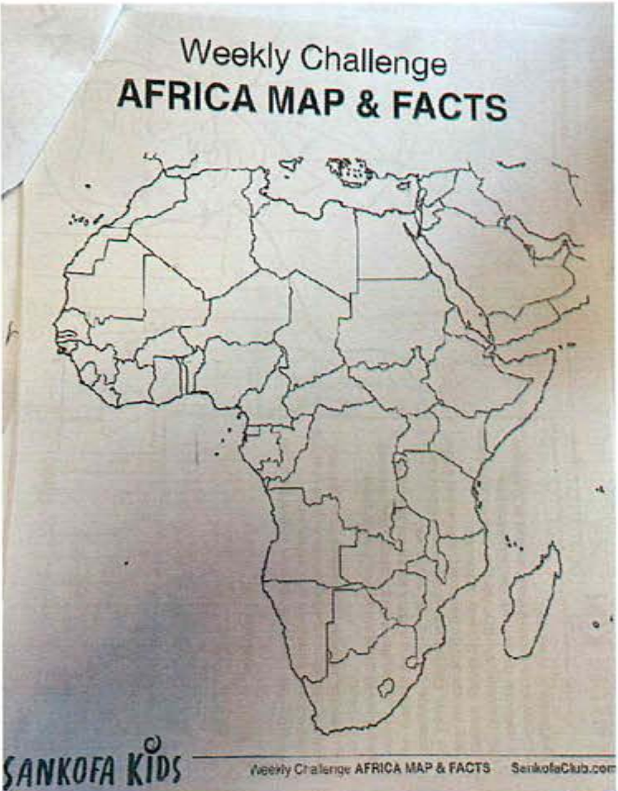
- *Research chemist and pioneer in the chemical synthesis of medicinal drugs from plants.*
- *First to synthesize the natural product physostigmine used to treat glaucoma and a pioneer in the industrial large-scale chemical synthesis of human hormones.*
- *His work laid the foundation for the steroid drug industry's production of cortisone, other corticosteroids, and birth control pills.*
- *Started his own company to synthesize steroid intermediates from the wild Mexican yam.*
- *Received more than 130 chemical patents.*
- *One of the first African-Americans to receive a doctorate in chemistry; first African-American chemist inducted into the National Academy of Sciences.*

Name: ______ Date: ______

The Dogons
c. 900-1400 - Present

- The Dogon live in Mali, in West Africa.
- Experts at astronomy (studying the stars).
- Pass down knowledge through oral history.
- Show great respect for young, old, men and women through their culture.
- Their oral history describes Sirius B, a star that is not visible with the naked eye, which makes their knowledge of it a mystery.
- This star was only discovered in recent times with telescopes and modern equipment.


Name: Date:
Imhotep 27th Century BCE
· Chief architect of the Step Pyramid in Egypt.
· Architect, Astrologist, Chief Minister to Djoser, Doctor.
· An expert in many areas of learning.
· Wrote books describing 100 diseases and 48 injuries.
· Still influences doctors today.
· Treated many diseases.
· The Real father of medicine.
· In 525 BCE, he was named the God of wisdom and medicine.
SANKOFA KIDS
Black: Month 1
SankofaClub.com


Weekly Challenge
AFRICA MAP & FACTS
SANKOFA KIDS
Weekly Challenge AFRICA MAP & FACTS
SankofaClub.com

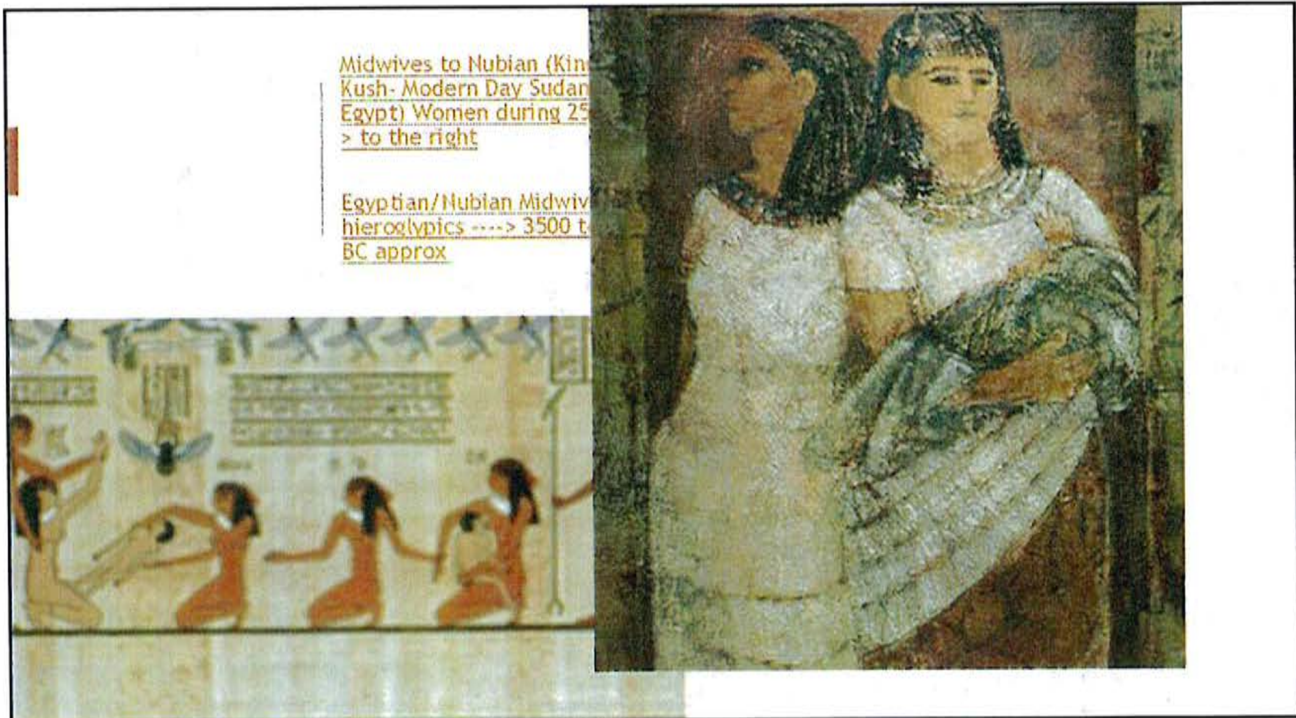
The Contributions of African American Midwives to Promote Health & Wellness of African American

Women & Children in the Southern United States

1790-1990

Michelle Stevens, M.D.
In Honor of Women's History Month
Supervising Pediatric Physician
Solano County Family Health
March 29, 2023

1



2

Questions to Consider Through Presentation

- What were some of the methods used by African American midwives to improve infant survival?
- What were/are some reasons why similar racial/ethnic heritage improve outcomes? Why or why not?
- What do you see about how these midwives provided care to mothers and children ?
- What do you think we can learn and apply from these midwives to improve the care we provide today?

3

Historical Context

- 1619- First Africans brought to the New World
- 1619- African Midwives brought their expertise and knowledge to the New World

1620-1865 African American population 19 to 4 million in 240 years

- Racial Health Disparities

4

Historical Context

- POST RECONSTRUCTION- 1865-1878
- 1896- Plessy vs. Ferguson
- 1920-1950 AA Midwives delivered 80-95% of AA babies in the mostly
- Rural Southern United States- population
- 1946- Congress passes Hospital Survey and ConstructionAct aka Hill-Shipley Act

5

to find rare agency and power through her role as a midwife. Rose-Aimée Potens was born in New Orleans in 1792, at a time when Spain ruled the colony. Under Spanish law, enslaved people could buy their freedom, and so Potens' mother Charlotte-Brion was able to free herself in 1794. It then took her 17 years to scrape together the money to purchase and free her two daughters.

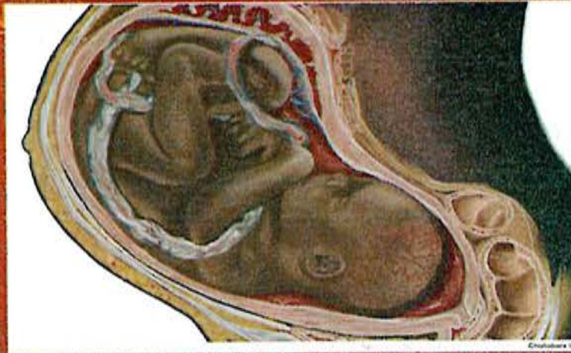
Once free, Potens carved a place for herself as a midwife, one of the few roles where Black women could control their own destiny. Serving both white and Black women on the enormous plantation of Marius Pons Bringier, Potens earned both money and esteem; even slave

Enslaved Women as Midwives

6

Diversity in Medicine

- A vial image of a Black fetus is highlighting the need for diversity in medical illustrations | CNN



7

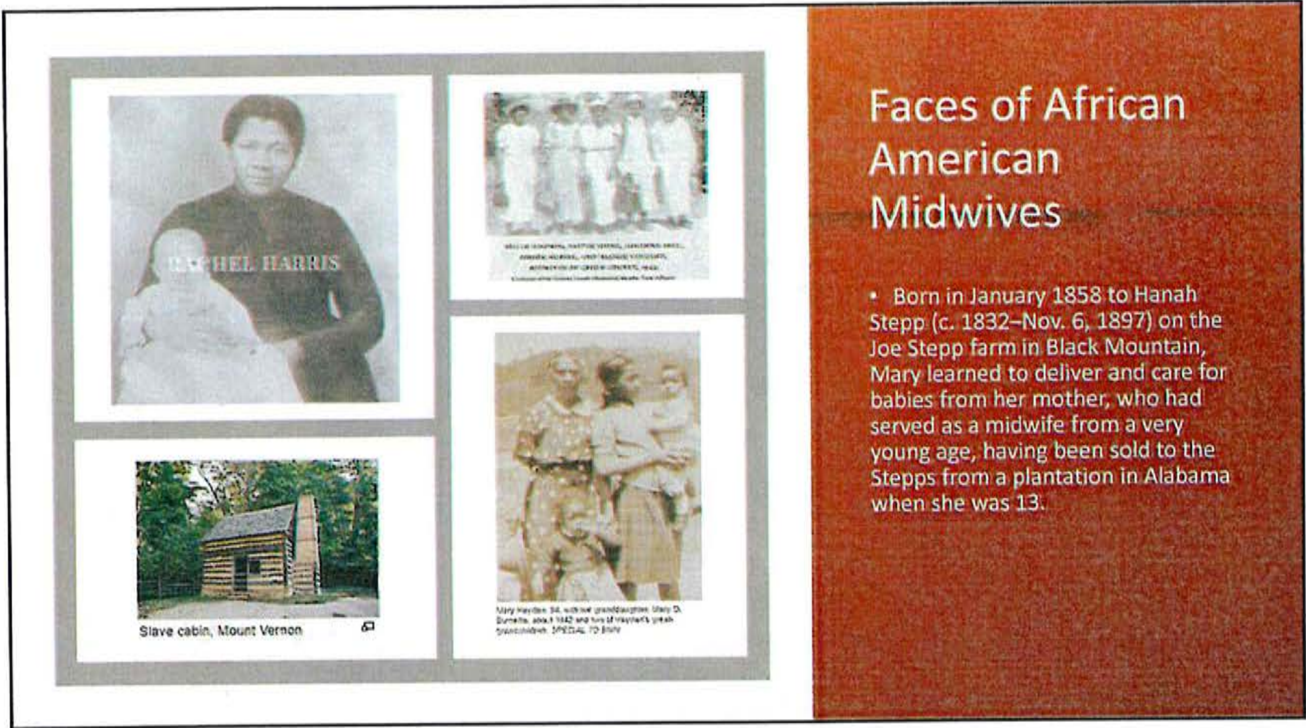
Historical Midwives Perspective

- https://www.npr.org/templates/story/story.php?storyId=5061075

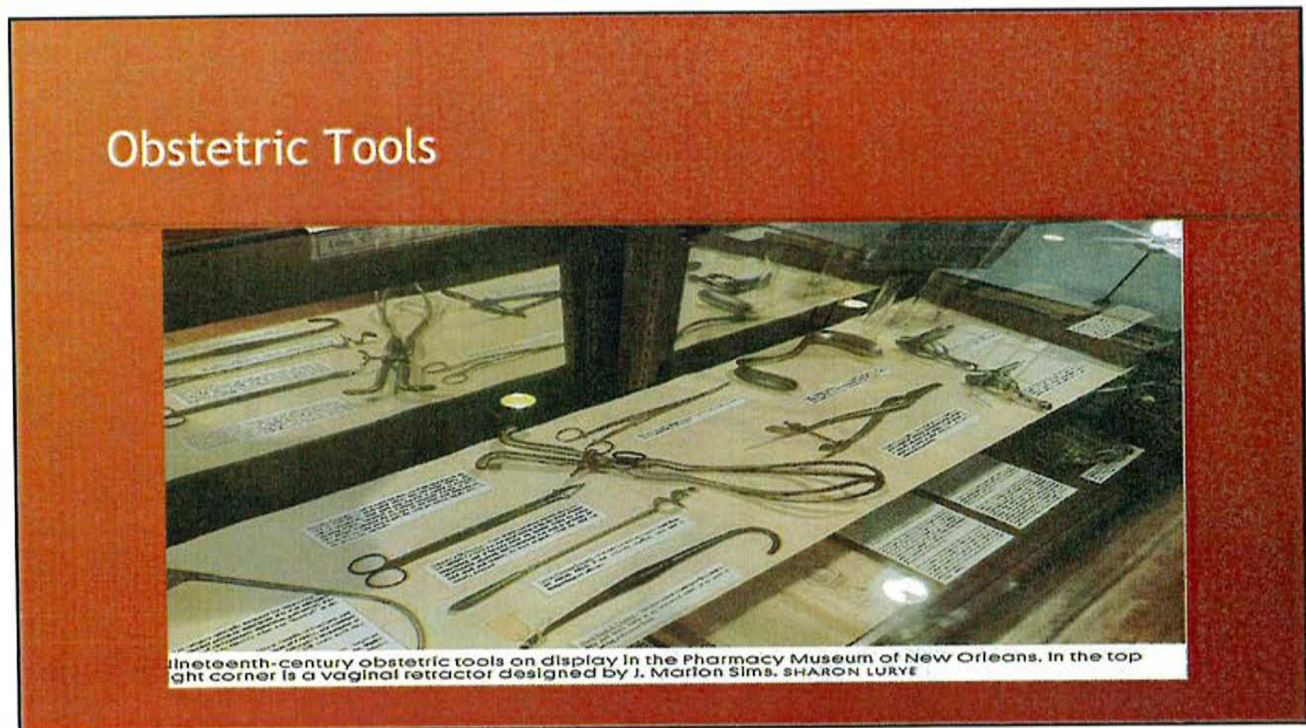
- Who were the midwives?
- What was their motivation to do this work?
- Where did they practice?
- What resources were readily available to them?
- How did they get to their mothers?
- Asking the question in AA families- are there midwives?

During the summer of 1794, an enslaved woman named Kate petitioned George Washington with an unusual request. She wished to become a paid midwife to "serve the negro women (as a Grany) on [his] estate."

8



9



10

Midwives

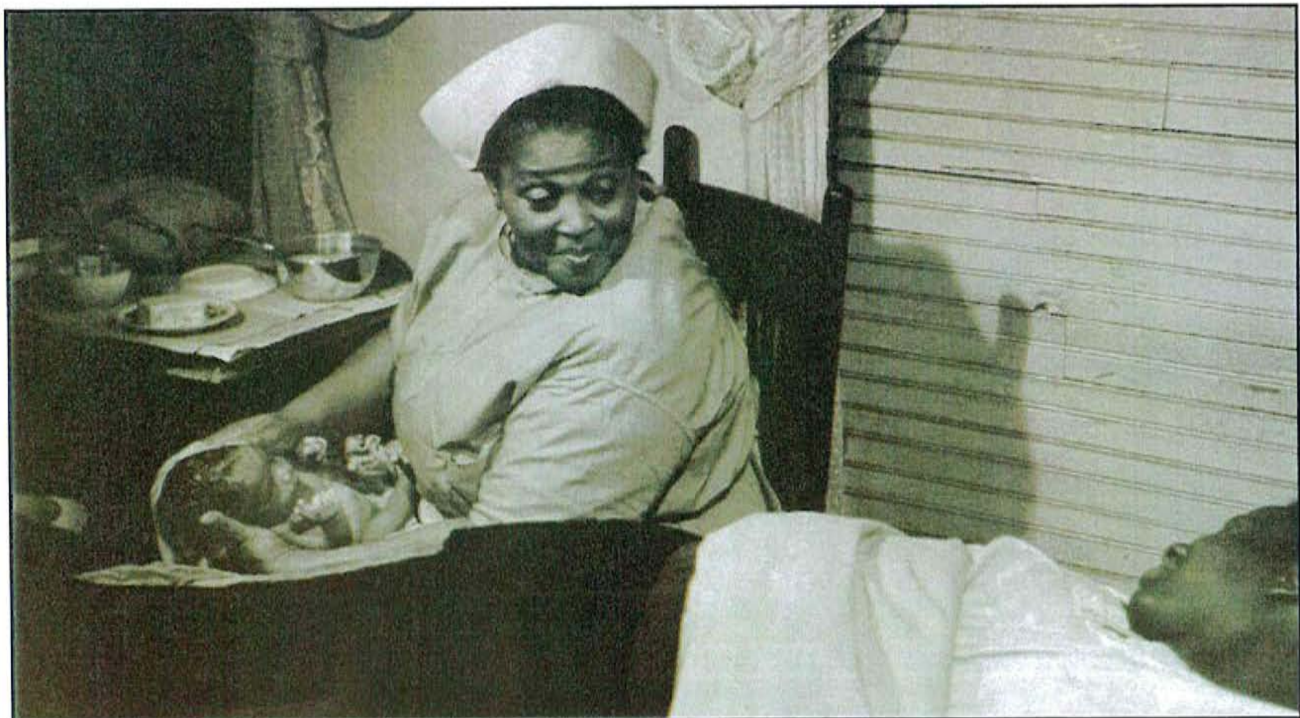
- https://sophia.smith.edu/making-democracy-real/in-the-hands-
- of-midwives/
- Video of Maude Callen Midwife Maude Callen YouTube Video
  - Rural North Carolina-
- https://www.searchablemuseum.com/midwives-tradition-and-transition
- Mississippi Midwives Decreased Maternal Mortality in Mississippi

BLACK HISTORY MONTH

Mary Coley was a granny midwife that served during the 1930's-1960's. She delivered over 3,000 babies. Rest in Power.

WWW.BLACKBIRTHJUSTICE.ORG

11



12

Mrs. Dora Green, traditional midwife, Eufaula, Alabama, late 1930s. WPA Writers' Project. Courtesy of Alabama Department of Archives and History, Montgomery.

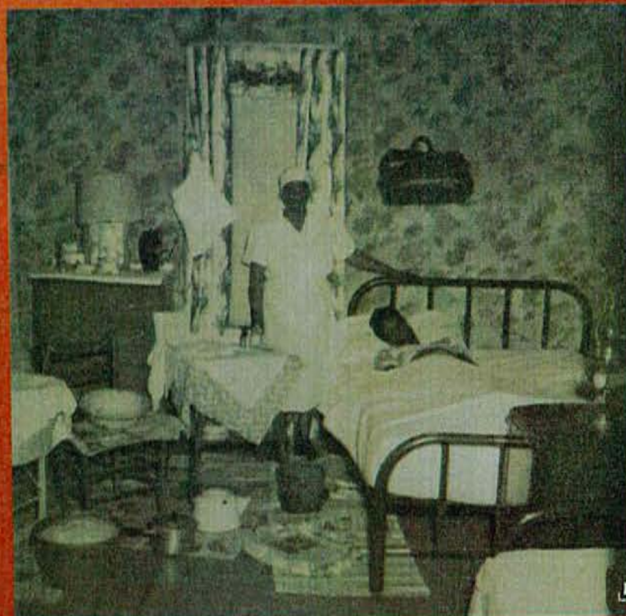
Black midwives were in and of the community

- Population of Eufaula, AL 1940
- 6500 people

13

Traditional Midwifery

1950s Mississippi



14

Midwive Maude Callen with Mother & Children

Maude Callen Photo

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Historical Trauma Timeline

- 1619-Present Day

- Health care was Separate and UNEQUAL,
- often having to enter from back door, wait till end of day to be seen
- Educational options were Separate and "equal"
- African Americans Working Conditions in the Jim Crow Segregated South
- Were the Social Determinants of Health equal across race/gender lines?

16

Health Outcomes by AA Midwives

- In Mississippi- from 1931-1947- Reduction in MM by close to 50%
- In Southern United States- improved rate of survival of infants
- Midwives were from the community, of the community and for the community
- Addressed SDOH in a supportive & encouraging way
- Medical Professionals who often were distrusted, sterilizers, racist, and did not provide care to disenfranchised AA due to their social position

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What Can We Learn regarding Distrust

- Trust in Medicine for African Americans DOES NOT equal having an MD
- Racist Idealogies in the South- vis a vis Dr. Sims "Father of Obstretics" Black Women DON'T feel pain, non-anesthesized surgeries on ENSLAVED WOMEN
- Sexual exploitation of AA women at the hands of White Men led to more mistrust and leary eyes of AA women and men--

WHAT IS THE IMPACT ON BLACK WOMENS HEALTH?

2022- Black women are 3-4 times more likely to die in childbirth than NH White women--

18

Mothers of Modern Gynecology

Betsey, Lucy and Anarcha https://wams.nyhistory.org/a-nation-divided/antebellum/anarcha-betsy-lucy/

Anarcha Westcott, age 13, endured 30 "untested" surgeries

Betsey, enslaved woman, operated on without anesthesia

Lucy, enslaved woman, leased to Dr. Sims for 5 years

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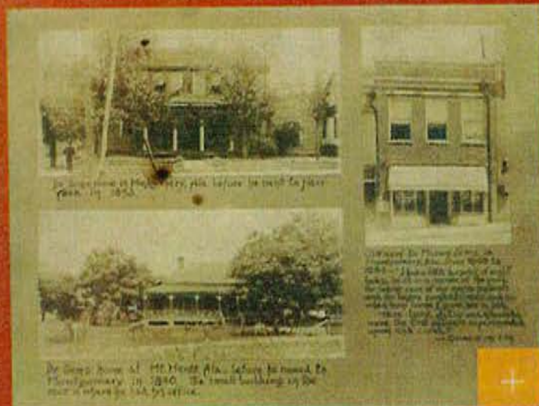
Dr. Sims "Ex-Father of Gynecology"



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Distrust & Mistrust of Medical Establishment

"AN UNPARALLELED OPPORTUNITY"

The USPHS planned for a six month study, to record observations "on a group of 400 syphilitic male Negroes who have received no treatment and a comparable group who have received adequate therapy" ("Annual Report of the Surgeon General" 1938).

*"The recent **syphilis control** demonstration carried out in Macon County, with the financial assistance of the **Julius Rosenwald Fund**,*

- Surgeon General H. S. Cumming, in a letter to Tuskegee Institute director R. R. Moton (1932)

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Future Ideas

- Encourage and train Black women to become midwives
- Provide the support and structure to give holistic care options
- LISTEN TO AA WOMEN WHEN THEY SPEAK-
- Many AA MD's, NPs, High SES, Low SES report not being heard
- ACT on their CONCERNS and TREAT and ASSESS
- FOLLOW UP AND FOLLOW UP AND FOLLOW UP
- Continue to provide cultural & implicit bias training

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Future Ideas

- Bring this marginalized and oft excluded history to the center
- Future research
- Examine the self-determination, self-efficacy, empowerment and resilience of this community
- Ask more questions...

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Comments, Suggestions, Questions?

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Family Health Services

Insurance & Eligibility Verification

Policy Number: 100.01

Effective Date	March 1, 2019
Frequency of Review	Annual
Last Reviewed	April 7, 2023
Last Updated	April 7, 2023
Author	Janine Harris
Responsible Department	Revenue Cycle Management

PURPOSE:
The purpose of this policy is to describe requirements for verifying insurance eligibility 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. Refer to the Sliding Fee Scale Discount Program policy and procedure.

DEFINITIONS:
Other Health Coverage (OHC) - Private insurance, commercial insurance, Kaiser, Tri-Care, out-of-network managed Medi-Cal, Medicare Part C.

Share of Cost (SOC) – Monthly dollar amount defined by Medi-Cal that subscriber must pay or agree to pay towards medical expenses before Medi-Cal eligibility begins, similar to a private insurance co-payment or deductible.

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 insurance eligibility for each patient upon scheduling an appointment, pre-registration, and check-in. Same-day appointments, next-day appointments, or walk-in appointments will be verified upon scheduling and check-in. FHS staff will notify patients if documentation is needed to complete verification of insurance eligibility. Some examples include: copy of insurance card, social security number, insurance policy number, etc.

If the patient is a candidate for FHS's Sliding Fee Scale Discount program, FHS staff will inform the patient of the necessary documentation to complete the application for the program. See the Sliding Fee Scale Discount program policy and procedure for further information on the program.

FHS staff responsible for calling patients with appointment reminders will review the patient's insurance and request a pre-authorization from insurance companies, as required by a patient's insurance policy, during pre-registration. Pre-registration will be done two or three business days prior to the scheduled appointment. FHS staff will remind the patient to bring required documentation to the appointment, such as the insurance card or sliding fee scale application documentation.

Front office and call center staff will educate patients on insurance and, if applicable, related third-party coverage options available to them. If the patient has a balance due, front office or billing and collections staff will request applicable payments from patients, while ensuring that no patient is denied service based on inability to pay. If the patient qualifies for a fee waiver, as described in the Fee Waiver policy and procedure, front office or billing and collections staff will inform the patient as described in the Fee Waiver policy and procedure.

PROCEDURE:

1. Front office staff will provide methods for appropriate and sensitive evaluation of each patient's ability to pay for services rendered.
    a. Financial screening of each patient shall not impact health care delivery.
    b. Screening will include exploration of patient's possible qualifications for specialized payer programs. Staff will encourage patients to apply for appropriate funding programs and facilitate an application when appropriate.
    c. Practice managers, Revenue Cycle Manager, and Executive Director are authorized to waive patient fees due to expressed financial hardship or disputes, as described in the fee waiver policy.

2. Payers
    a. General Payers:
        i. Medi-Cal: Most Medi-Cal patients are insured through Solano County's managed care provider, Partnership HealthPlan of California (PHC). PHC members must be:
            1. Assigned to FHS for their primary care; or
            2. Direct members, or
            3. Pre-authorized to be seen by an FHS provider.
        ii. State Only Medi-Cal: Most State Only Medi-Cal patients have restricted benefits or are transitioning to the managed care program.
        iii. Medicare (non-managed care type): Most patients qualify due to age and/or disability or may be a dependent of an aged and/or disabled person.
        iv. OHC:
            1. FHS does not accept Kaiser patients.
            2. Other OHC's are not generally accepted according to Private Insurance Policy #100.06. Courtesy billing for OHC is available, however, patient is responsible for any costs not covered by non-contracted insurance providers.

   b. Specialized Payers: the following payer types are government funded programs and require application screening to determine eligibility:
      i. Family Planning, Access, Care and Treatment (FPACT) program: State program for family planning services. Covers sexually transmitted infection (STI) checks, birth control methods and emergency contraception.
      ii. Every Woman Counts (EWC): Breast and cervical cancer screening and diagnostic services. Covers clinical breast exam, screening and diagnostic mammogram, pelvic exam and pap.
      iii. Child Health and Disability Prevention (CHDP) Program (Gateway): Well care visits, including immunizations, for children who are uninsured/underinsured. The age limit is 18 years and 11 months. Grants 60 days of full Medi-Cal benefits while the family formally applies for on-going insurance.
      iv. County Medical Services Program (CMSP): Provides limited-term health coverage for uninsured low-income, indigent adults who are not otherwise eligible for other publicly funded health care programs.
   c. Self-Pay Payers
      i. Uninsured patients, or patients with non-contracted insurance types, are responsible to pay for visit costs, including ancillary services. Uninsured patients are encouraged to apply for the Sliding Fee Scale Discount Program, as described in the Sliding Fee Scale Discount Program policy and procedure.

3. Verification of Eligibility and Benefits Determination by Payer
   a. Medi-Cal
      i. Eligibility Verification: Verification of coverage, restrictions, and Share of Cost (SOC) must be obtained through the Medi-Cal website (which is integrated to the Electronic Health Record System). Patients who may be eligible for Medi-Cal, but are not enrolled, will be encouraged to apply.
      ii. Benefits Determination: Once the eligibility is verified, benefit type must be reviewed. There are several types of Medi-Cal benefits, ranging from full scope to restricted services. For additional information, the Medi-Cal provider manual can be referenced for benefit rulings. If coverage indicates that the patient is a member of PHC, then eligibility and assignment must also be verified via the PHC provider web portal (which is integrated to the Electronic Health Record System).
   b. Partnership HealthPlan of California (PHC)
      i. Eligibility Verification: Information regarding eligibility of coverage must be obtained through the PHC provider web portal (which is integrated to the Electronic Health Record System).
      ii. Benefits Determination: All Medi-Cal benefit rulings apply to PHC patients assigned to FHS; however, PHC may offer more benefits than State Medi-Cal (see PHC provider manual).
   c. Medicare
      i. Eligibility Verification: Information regarding eligibility of coverage must be obtained through the Real Time Services (RTS) integrated in the Electronic

Health Record System. Some Medicare patients have supplemental insurance coverage that may include commercial insurance or Medi-Cal coverage.

ii. Benefits Determination: Medicare typically requires an annual deductible that must be met prior to accessing benefits; however, FHS's FQHC status allows waiver of the deductible.

d. Other Government Funded Programs
   i. Eligibility Verification: Government funded programs have eligibility period limitations, ranging from one day to one year. Eligibility periods for FPACT, EWC, and CHDP/Gateway can be obtained through the Medi-Cal eligibility portal.
   ii. Benefits Determination:
      1. FPACT: covers all birth control methods offered at the FHS health centers, STI screenings and treatments as part of the primary benefits. For secondary benefits, review FPACT Benefits Grid located on the Medi-Cal website.
      2. EWC: covers annual cervical and breast cancer screenings as part of the primary benefits. For secondary benefits, review the covered procedure list located on the Medi-Cal website.
      3. CHDP/Gateway: grants full scope Medi-Cal benefits on a temporary basis to allow application processing for Medi-Cal.

e. OHC
   i. Although Family Health Services (FHS) does not typically contract with private insurance if a patient with private insurance is seen the following steps must be followed to allow appropriate billing to occur.
   ii. Eligibility Verification: Eligibility will be verified using the patient's insurance card. A copy of the insurance card will be taken and scanned into the practice management system.
   iii. Benefits Determination: As insurance plan benefits vary significantly, it is the patient's responsibility to understand their insurance benefits prior to obtaining services. Since understanding health insurance benefits can be challenging, as a courtesy, FHS staff may assist the patients with obtaining coverage information.

4. Enrollment: Other State Funded Programs
   a. FHS is a qualified provider allowed to screen, verify, and enroll uninsured and underinsured patients in State funded programs using guidelines set forth by each of the following programs:
      i. FPACT: Patients are residents of California that demonstrate a need for family planning services, but have no other source of family planning coverage, and qualify for the program based on family income. Medi-Cal patients with an unmet share of cost may also be eligible. In accordance with FPACT guidelines, eligibility determination and enrollment are conducted by FHS staff (patient completes an application) with point of service activation, granting the applicant up to one year of benefits for family planning and reproductive health services. Qualified applicants are given a membership

card and informed about program benefits, state-wide access, as well as the renewal process.

ii. EWC: Provides free clinical breast exams, mammograms, pelvic exams, and pap tests to California's underserved population. The mission of the EWC program is to save lives by preventing and reducing the devastating effects of cancer for Californians through education, early detection, diagnosis and treatment, and integrated preventive services, with special emphasis on the underserved. Income qualification and age-related service information are available at the EWC website.
   1. FHS staff will screen patients for eligibility in accordance with program guidelines. The EWC application packet is completed by the patient, and the completed application is processed by FHS staff via the online portal. Patients are issued a paper membership card granting up to one year of benefits for breast and/or cervical services and given information regarding program benefits and the program renewal process. They are also instructed to present their membership card when obtaining services outside of FHS, such as a mammogram.

iii. CHDP/Gateway: Provides complete health assessments for the early detection and prevention of disease and disabilities for low-income children and youth. A health assessment consists of a health history, physical examination, developmental assessment, nutritional assessment, dental assessment, vision and hearing tests, a tuberculin test, laboratory tests, immunizations, health education/anticipatory guidance, and referral for any needed diagnosis and treatment.
   1. In accordance with current CHDP guidelines, FHS staff will pre-screen patients for program eligibility and provide a program application to eligible patients. Staff enters the completed application via the CHDP Gateway online portal and prints two paper cards, with one card signed by the participant's parent or guardian, along with a verbal explanation from FHS staff that the child is fully covered by Medi-Cal until the expiration date printed on the card. It is the parent's responsibility to follow-up with the County's Employment and Eligibility division regarding further application requirements for ongoing Medi-Cal eligibility.

iv. Ryan White HIV/AIDS Program (RWHAP)
   1. For patients receiving Ryan White HIV/AIDS Program funded services, the annual cap on charges related to HIV care will be as described in the Ryan White Part C/North Bay AIDS Center Sliding Fee Scale and Billing Caps policy and procedure.

5. Patient Information Policy
   a. Exchange of Information
      i. Patients are asked registration questions verbally upon scheduling an appointment, pre-registration, and/or check-in. Information is collected on all new patients and updated at least every 12 months. Patient eligibility, address

and phone number must be confirmed at each visit. Necessary demographic information must be collected for program and agency-wide reporting purposes.

b. Patient Scheduling
   i. Appointment requests may be made in person or over the phone. At the time of an appointment request, staff will confirm the patient's demographics, including but not limited to, name, date of birth, phone number, and insurance. The patient's reason for the appointment should be requested to determine appointment type and duration.

c. No Show and Late Cancels Defined
   i. No show appointment: Patient does not arrive for a scheduled appointment.
   ii. Late cancel appointment: Patient cancels appointment less than 24 hours prior.

d. Follow-up
   i. If deemed necessary by the medical provider, FHS staff will follow up with patients unable to attend a previously scheduled appointment to schedule another appointment or determine if the health issue has been resolved.

6. Sliding Fee Scale (SFS) Discount Program
   a. SFS is available to uninsured or underinsured patients who qualify according to family size and income [individuals/families living at or below 200% of the Federal Poverty Guidelines (FPG)]. Patients must first be screened for other public insurance eligibility.
   b. Patients interested in applying for this program are required to complete an application and provide proof of household income and identification, as described in the Sliding Fee Scale Discount Program policy and procedure.

7. Patient Account Balances
   a. Patients with account balances of $5.00 or more are sent a monthly statement. FHS registration staff will review the patients account balance upon check-in and if the patient has a balance due, will ask the patient if they would like to make a payment on their account. The patient will be referred to accounting staff to make the payment. If the accounting staff is not available, registration staff will accept the payment, as described in the FHS Cash Handling policy and procedure.

8. Collections
   a. FHS staff will make every reasonable effort to collect reimbursement for services provided to patients. This includes collection at the time of service.

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.

REFERENCED POLICIES	Sliding Fee Scale Discount Program Policy #100.03 Fee Waiver Policy #100.08 Ryan White Part C/North Bay AIDS Center Sliding Fee Scale and Billing Caps Cash Handling Policy #100.02 Private Insurance Policy #100.06
REFERENCED FORMS	Child Health and Disability Prevention (CHDP/Gateway) Family Planning, Access, Care and Treatment (FPACT) Every Woman Counts (EWC)
REFERENCES	Health Center Program Compliance Manual

______________________________ ______________________________

Chair - Community Healthcare Board **Date**

______________________________ ______________________________

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

Family Health Services

Cash Handling

Policy Number: 100.02

Effective Date	March 1, 2019
Frequency of Review	Annual
Last Reviewed	April 7, 2023
Last Updated	April 7, 2023
Author	Janine Harris
Responsible Department	Revenue Cycle Management

PURPOSE:

The purpose of this policy is to describe requirements for cash handling in Family Health Services (FHS). FHS staff are expected to comply with this policy and procedure.

DEFINITIONS:

Cash – Currency, coin, check, money order, traveler's checks, credit card, or debit card.

Cash Collection Points – Designated area where cash is received. FHS cash collection points include: 1119 East Monte Vista Avenue, Vacaville; 2201 Courage Drive, Fairfield; 2101 Courage Drive, Fairfield; 365 Tuolumne Street, Vallejo.

BACKGROUND

It is the policy of Family Health Services to uphold compliance with the Department of Health and Social Services cash handling policy and procedure to ensure adequate safeguarding over the County's cash collections.

POLICY:

It is the intent of FHS to follow the Department's policy to establish internal controls over cash handling to ensure adequate safeguarding.

FHS staff shall abide by the Department's policy, including depositing collections daily with the County Treasurer's office and not using payments accepted or the change fund to make disbursements or refunds. Checks will be endorsed upon receipt of the check and receipts will be issued to patients for payments made.

Segregation of duties is essential. A supervisor or manager will verify each deposit to ensure all collections received to pay for services provided are posted to the electronic health records system. Payments received for medical record or copy fees shall be tracked in the Daily Log.

Manual receipts will be tracked to ensure all manual receipts are accounted for daily.

Change funds assigned to designated cash collection points will be verified daily to ensure the cash in the change fund is fully accounted for.

PROCEDURE:

1. Accepted Forms of Payment
    a. Currency/Coins: Currency/coins are counted in front of the patient and a receipt is provided. Currency/coins are deposited daily using established County procedures. Currency/coin transactions are documented on the Daily Log and the log is submitted to the back-office billing and collections team at the end of each day.
    b. Credit/Debit Cards: Credit/debit card is processed using the credit card terminal and a receipt is provided. Credit card transactions are documented on the Daily Log and the log is submitted to the back-office billing and collections team at the end of each day.
    c. Personal Checks: Checks are verified with the patient's name, the back of the check is stamped (endorsed) with the Solano County bank account information for the deposit, and a receipt is provided. A copy of the front of the check is kept with the daily deposit backup. Checks are deposited daily using established County procedures. Check transactions are documented on the Daily Log and the log is submitted to the back-office billing and collections team at the end of each day.
    d. Money Orders/Traveler's Checks: The back of the money order/traveler's check is stamped (endorsed) with the Solano County bank account information for the deposit, and a receipt is provided. A copy of the front of the money order/traveler's check is kept with the daily deposit backup. Money orders/traveler's checks are deposited daily using established County procedures. Money Orders/traveler's Checks are documented on the Daily Log and the log is submitted to the back-office billing and collections team at the end of each day.
2. Posting Payments to Patient's Account
    a. Front office accounting clerks will open a batch in the electronic health records system, which will allow them to post payments to patient's accounts.
    b. Payments are posted, upon receipt, in the electronic health records system batch to the patient's account by the front office accounting clerk.
    c. Receipts may be generated and printed from electronic health records system upon posting to the patient's account and provided to the patient or a manual receipt may be provided.
    d. At the end of each day, payments and the electronic health records system batch are reconciled by the accounting clerk. The reconciliation is reviewed and signed by a supervisor or manager.
    e. Payments are logged on the Daily Log and the log is submitted to the back-office billing and collections team at the end of each day. The back-office billing and collections team will use the Daily Log to prepare a deposit permit for credit card transactions and to verify all payments are posted to the County's accounting system, OneSolution.
    f. The deposit bag, deposit ticket, and deposit permit for the collections are prepared at the end of each day, following the established Department procedures. The deposit bag is locked in the safe until the courier arrives the next morning to pick up the deposit bag and deliver it to the County Treasurer's office.
3. Cut-off Time for Same Day Payment Posting

a. Payments received after 3:30 pm may be posted to the patient's account the following business day to allow the accounting clerk sufficient time to reconcile and prepare the daily deposit.

4. Receipts for payment
   a. Manual receipts are written in instances of the electronic health records system down time, or if the accounting clerk is unavailable, out of the office or if the accounting clerk position assigned to the clinic is vacant. A receipt is written from a pre-numbered receipt book assigned to the front office supervisor. The white copy of the receipt is given to the patient, the yellow copy is given to the front office accounting clerk, and the pink copy will stay in the book.
      i. Pre-numbered receipts shall be used in order and reconciled daily to ensure all receipts are accounted for and all payments are posted to the electronic health records system.
      ii. The accounting clerk will track the manual receipts on the Manual Receipt log and reconcile the log with the manual receipts daily.
      iii. The Medical Billing Supervisor or Policy & Financial Analyst will conduct random reviews of the Manual Receipt Log to ensure compliance.
      iv. Any receipts that are not accounted for must be reported immediately to the Policy & Financial Analyst.
   b. Electronic receipts are generated and printed from electronic health records system upon payment posting by accounting clerks and are given to the patient upon collection of payment. If an electronic receipt is generated and provided to the patient, a manual receipt is not required.
5. Storage of Collections
   a. Upon receipt, collections are placed in the locked cash drawer or safe until the end of the day when the deposit is prepared.
   b. After the deposit bag is prepared, it is stored in the safe until picked up by the courier.
6. Refunds
   a. Refunds requested by front office accounting clerks will be sent to the Medical Billing Supervisor. The change fund in the clinics will not be used to issue refunds.
7. Non-Sufficient Funds (NSF) Returned Checks
   a. NSF returned checks are received by the Medical Billing Supervisor. The Medical Billing Supervisor will prepare the journal to reverse the payment in the County's accounting system, according to the NSF Policy #100.16. The Medical Billing Supervisor will forward the information to the appropriate front office accounting clerk, who will reverse the payment and add the County approved NSF fee on the patient's account.
8. Void and Deleted Transactions
   a. All voided and deleted transactions shall be approved by a supervisor or manager.
9. Cash Drawer/Change Fund
   a. FHS staff will identify a custodian of the change fund, typically the accounting clerk assigned to the location, and backup custodian of the change fund, typically the office

supervisor assigned to the location, for each change fund at each cash collection point.

b. The custodian of the change fund or backup will be responsible for counting the change fund at the start and end of each day. The custodian of the change fund and backup shall abide by the policy and forms signed when designated as the custodian.

Knowledge of a violation or potential violation of this policy must be reported directly to the FHS Revenue Cycle Manager and the FHS Clinic Operations Officer, or to the employee compliance hotline.

REFERENCED POLICIES	Health & Social Services Department Cash Handling Policy Non-Sufficient Funds Policy # 100.16
REFERENCED FORMS	
REFERENCES	

______________________________ ______________________________
Chair - Community Healthcare Board **Date**

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

Family Health Services

Claims Processing

Policy Number: 100.04

Effective Date	May 1, 2019
Frequency of Review	Annual
Last Reviewed	April 7, 2023
Last Updated	April 7, 2023
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:

Front Office Billing and Collections – Accounting clerks located in the health centers who report to the Medical Billing Supervisor. Processes primary billing, sliding fee scale applications, and other primary billing functions.

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 the charges have been submitted by the provider. If charges have not been submitted by the provider, the Accounting Clerks will attempt to bill it each day until charges have been submitted. After three days, the Accounting Clerk will send the provider a reminder email requesting for the charges to be entered. All encounters that providers have submitted charges for will be billed and claims will be submitted within 14 business days.

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 Medical Billing Supervisor for review and correction, as stated in the Coding policy, #100.05.

Claims Processing

Policy Number: 100.04

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 or telehealth 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 narrative and 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 Medical Billing Supervisor. Non-coding 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.

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.

Family Health Services

Claims Processing

Policy Number: 100.04

REFERENCED POLICIES	Coding Policy # 100.05
REFERENCED FORMS	
REFERENCES	

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Chair - Community Healthcare Board **Date**

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

Family Health Services

Coding

Policy Number: 100.05

Effective Date	July 1, 2019
Frequency of Review	Annual
Last Reviewed	April 7, 2023
Last Updated	April 7, 2023
Author	Janine Harris
Responsible Department	Revenue Cycle Management

PURPOSE:
The purpose of this policy is to describe requirements for Medical Coding procedures for Family Health Services (FHS) billing and collections staff. FHS staff are expected to comply with this policy and procedure.

DEFINITIONS:
Medical Coding – transformation of healthcare diagnosis, procedures and medical services into Current Procedural Terminology (CPT), International Statistical Classification of Diseases and Related Health Problems, 10th revision (ICD-10) and Healthcare Common Procedure Coding System (HCPCS) codes.

Medical Billing – processing, submitting and following up on claims to receive payment for services rendered by a provider.

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 process and submit claims for medical billing according to the Claims Processing Policy & Procedure, policy number 100.04. Back office Accounting Clerks will process and submit claims for medical billing according to the Back Office Claims Processing Policy & Procedure, policy number 100.15. Any coding errors that prevent the billing from passing the claim edits will be sent to the FHS Medical Billing Supervisor. Serving as FHS's Certified Professional Coder for medical billing errors, the Medical Billing Supervisor will review the coding error and correct, as appropriate.

Coding

Policy Number: 100.05

PROCEDURE:

1. Front office Accounting Clerks will send coding errors to the FHS's Certified Professional Coder (CPC) for review and correction.
   a. Examples include: CPT or ICD-10 inconsistent with the patient's age, missing ICD-10, missing modifier, or other claim edits that are related to CPT, ICD-10, or HCPCS.
2. Back office Accounting Clerks will send coding denials to the FHS's Certified Professional Coder (CPC) for review and correction.
   a. Examples include: CPT or ICD-10 inconsistent with the patient's age, missing ICD-10, missing modifier, or other claim edits that are related to CPT, ICD-10, or HCPCS.
3. The CPC will review the patient's chart, as necessary.
4. If documentation supports a coding change, the CPC will update the code and submit the claim for billing.
5. The CPC will make an encounter note documenting the change and justification for the change.
6. If documentation is not sufficient to make a coding correction, the CPC will contact the provider who documented the visit for clarification and direction on the coding change.
   a. If documentation does not support a coding change, CPC will determine the appropriate resolution.
7. Upon approval by the provider, the CPC will make the change, document with an encounter note, and submit the claim for billing.

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	Claims Processing Policy # 100.04 Back Office Claims Processing Policy # 100.15
REFERENCED FORMS	
REFERENCES	

Chair - Community Healthcare Board **Date**

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

Other Health Insurance/Private Insurance

Policy Number: 100.06

Effective Date	July 1, 2019
Frequency of Review	Annual
Last Reviewed	April 7, 2023
Last Updated	April 7, 2023
Author	Janine Harris
Responsible Department	Revenue Cycle Management

PURPOSE:

The purpose of this policy is to describe requirements for accepting other health insurance or private insurance 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. Refer to the Sliding Fee Scale Discount Program policy and procedure, #100.03.

DEFINITIONS:

OHC – Private insurance, commercial insurance, Kaiser, Tri-Care, out-of-network managed Medi-Cal, Medicare Part C, etc.

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 (FHS) does not accept private health insurance, commercial insurance, Kaiser, Tri-Care, out-of-network managed Medi-Cal, Medicare Part C, or other insurance. FHS accepts Medi-Cal, Partnership HealthPlan of California (PHC) patients capitated to FHS, PHC Direct Members, and Medicare.

FHS shall verify insurance eligibility for each patient upon scheduling an appointment, pre-registration, and check-in, as described in the Insurance Eligibility policy and procedure, #100.01. If there is a patient who is a PHC patient and capitated to FHS but shows another primary insurance that FHS does not accept, FHS will refer the patient to the primary insurance to determine where they can be seen. FHS staff will contact PHC to request PHC changes the patient's capitation from FHS since FHS does not accept the patient's primary insurance.

Other Health Insurance/Private Insurance

Policy Number: 100.06

PROCEDURE:

1. FHS staff shall verify insurance eligibility upon scheduling an appointment, pre-registration, and check-in. If the patient has an OHC, FHS staff shall refer the patient to the OHC.
2. FHS does not contract with any OHC. If there is a patient who is capitated to FHS by PHC, FHS staff shall refer the patient to the OHC and contact PHC to request PHC changes the patient's capitation since FHS does not accept their primary insurance.
3. If an established FHS patient obtains OHC coverage after establishing care with FHS, FHS shall inform the patient that FHS does not accept their primary insurance and refer them to their OHC to determine where they can establish care. FHS staff shall contact PHC to request PHC changes the patient's capitation.

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.

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

Chair - Community Healthcare Board **Date**

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

Family Health Services

Void/Deleted Payments

Policy Number: 100.07

Effective Date	July 1, 2019
Frequency of Review	Annual
Last Reviewed	April 7, 2023
Last Updated	April 7, 2023
Author	Janine Harris
Responsible Department	Revenue Cycle Management

PURPOSE:
The purpose of this policy is to describe requirements for voided or deleted payments in Family Health Services (FHS). FHS staff are expected to comply with this policy and procedure.

DEFINITIONS:
Cash – Currency, coin, check, money order, traveler's checks, credit card, or debit card.

Cash Collection Points – Designated area where cash is received. FHS cash collection points include: 1119 East Monte Vista Avenue, Vacaville; 2201 Courage Drive, Fairfield; 2101 Courage Drive, Fairfield; 365 Tuolumne Street, Vallejo; 275 Beck Avenue, Fairfield.

BACKGROUND
It is the policy of Family Health Services to uphold compliance with the Department of Health and Social Services cash handling policy and procedure to ensure adequate safeguarding over the County's cash collections.

POLICY:
It is the intent of FHS to follow the Department's policy to establish internal controls over cash handling to ensure adequate safeguarding. FHS staff shall abide by the Department's policy, including depositing collections daily with the County Treasurer's office and not using collections to make disbursements or refunds.

If a payment is made in error, FHS staff shall void or delete the payment from the electronic health records system batch, described in the Cash Handling policy & procedure #100.02, upon review and approval by a supervisor or manager. The person who accepted the payment will not be the same person to approve the void or delete.

Payments made in error may include a payment made prior to a service being performed and the service was not able to be performed, as long as the payment was made the same day as the service was unable to be performed. If the transaction has already been included in the batch and deposited, as described in the Cash Handling policy & procedure #100.02, a refund request will be submitted and the payment will not be voided or deleted.

Family Health Services

Void/Deleted Payments

Policy Number: 100.07

PROCEDURE:

1. FHS staff shall accept payments for services, as described in the Cash Handling policy and procedure #100.02.
2. If a payment is accepted on a patient's account but the service was not performed, FHS staff will request a supervisor or manager approval to void or delete the payment.
   a. If the supervisor or manager accepted the payment, another supervisor or manager must approve the void or delete.
   b. Example: A patient presents for a TB test. Payment is collected. The TB test could not be performed. The patient may request their payment be returned to them.
3. The payment is voided or deleted from the batch in electronic health records system upon approval by the supervisor or manager. The patient's original method of payment is returned to them.
   a. If the patient paid with a check, the original check is returned to them. Credit cards will be refunded on the credit card. Cash is returned only if the patient paid with cash.
4. The backup for the voided or deleted payment will be attached to the batch report at the end of the day, signed by the person making the deposit, and verified by the supervisor or manager verifying the deposit.

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	Cash Handling Policy # 100.02
REFERENCED FORMS	
REFERENCES	

Chair - Community Healthcare Board **Date**

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

Family Health Services

Fee Waiver & Payment Plans

Policy Number: 100.08

Effective Date	May 1, 2019
Frequency of Review	Annual
Last Reviewed	April 7, 2023
Last Updated	April 7, 2023
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 all patients.

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, mental health 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. Patients may request a new fee waiver, payment plan, or sliding fee scale application at any time based on changes to the patient's situation, such as changes to income or family size. All requests will be reviewed by Family Health Services staff.

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 a Provider sees a need to offer a fee waiver based on special circumstances, it may be offered to the patient.
      i. *Specific circumstances when the health center will waive or reduce fees, and payments for one or multiple visits that would normally be required by the health center due to any patient's inability to pay:*
         1. Homelessness
         2. Domestic Violence Situations
         3. Financial Hardship (Based on Self -Declaration)
         4. Provider, Nurse, or Clerical Error (ex. SFS never offered, EWC or FPACT non-covered service performed)
         5. Dislocation due to natural disasters, or state of emergencies.

   b. Patients who apply for a fee waiver should complete the fee waiver request form. However, if the patient is unable to complete the form, a Provider, Accounting Clerk, or Office Supervisor may complete the fee waiver form on behalf of the patient, in consultation with the patient. The Practice Manager, or Revenue Cycle Manager must then review and approve the fee waiver request.
   c. Fee waiver forms will be scanned into Electronic Health Record System (EHR) 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 EHR 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, Bad Debt Write Off Policy - #100.14 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.
3. Appeal Process
   a. If a patient would like to appeal the decision to qualify for a fee waiver or a sliding fee scale discount, as described in the Sliding Fee Scale Discount Policy #100.03, the patient shall complete a new fee waiver request or sliding fee scale program application and if applicable, submit supporting documentation to support the appeal request. The patient shall submit the paperwork to the accounting clerk in the front office. The accounting clerk will review the request and may:

i. Qualify the patient for the program based on updated information provided by the patient,
ii. Review the documentation with the Practice Manager or Revenue Cycle Manager to make the final determination.

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

REFERENCED POLICIES	Sliding Fee Scale Discount Program Policy # 100.03 Bad Debt Write Off Policy # 100.14
REFERENCED FORMS	Payment Plan Agreement Fee Waiver
REFERENCES	

Chair - Community Healthcare Board **Date**

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

Family Health Services

Patient Registration

Policy Number: 100.10

Effective Date	May 1, 2019
Frequency of Review	Annual
Last Reviewed	April 7, 2023
Last Updated	April 7, 2023
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 Discount 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).

Patient Registration

Policy Number: 100.10

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 required demographic information, any 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 the electronic health records system 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 Discount 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	Insurance Eligibility Policy #100.01 Sliding Fee Scale Discount Program Policy #100.03 Fee Waiver and Payment Plans Policy #100.08
REFERENCED FORMS	
REFERENCES	

Chair - Community Healthcare Board **Date**

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

Family Health Services

Billing and Collections

Policy Number: 100.11

Effective Date	July 1, 2019
Frequency of Review	Annual
Last Reviewed	April 7, 2023
Last Updated	April 7, 2023
Author	Janine Harris
Responsible Department	Revenue Cycle Management

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

DEFINITIONS:
Front Office Billing and Collections – Accounting Clerks located in the health centers who process primary billing, sliding fee scale applications, and other primary billing functions.

Back Office Billing and Collections – Accounting Clerks located in the administrative division who report to the Back-Office Accounting Supervisor. Processes secondary and tertiary billing, uploads all claims, submits patient statements for printing and mailing, works denials, and other secondary and tertiary billing functions.

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 shall process primary medical billing, collect payments, and assist patients with sliding fee scale, payment plan agreements, fee waivers, and other medical billing related tasks. Back office Accounting Clerks shall post Explanation of Benefits, collect payments, assist patients who call regarding their statements, work secondary and tertiary medical billing claims, work denials, submits patient statements for printing and mailing, submits all claims for processing, and works receivables and bad debt.

PROCEDURE:
1. Front office Accounting Clerks shall:
    a. Process primary billing each day for the previous day.
        i. Medical billing errors shall be corrected by front office Accounting Clerks.
        ii. Coding errors related to medical billing shall be sent to the Medical Billing Supervisor for correction.

   b. Collect payments and assist patients with sliding fee scale applications, payment plan agreements, and fee waivers.
   c. Assist patients in person and via telephone, as needed, regarding the patients account, balances, and other medical billing questions that arise.
2. Back office Accounting Clerks shall:
   a. Process secondary and tertiary medical billing claims.
   b. Review, work and post Explanation of Benefits (EOBs).
   c. Work denials.
   d. Work on aged accounts receivables and bad debt.
   e. Assist patients in person and via telephone, as needed, regarding the patients account, balances, and other medical billing questions that arise.
   f. Submit patient statements for printing and mailing and collects payments.

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	Insurance Eligibility Policy # 100.01 Cash Handling Policy # 100.02 Sliding Fee Scale Discount Program Policy # 100.03 Claims Processing Policy # 100.04 Coding Policy # 100.05 OHC/Private Insurance Policy # 100.06 Void/Deleted Payments Policy # 100.07 Fee Waiver & Payment Plans Policy # 100.08 Patient Registration Policy # 100.10 Dental Appliances Policy # 100.13 Bad Debt Write Off Policy # 100.14 Back Office Claims Processing Policy # 100.15 Non-Sufficient Funds Policy # 100.16
REFERENCED FORMS	
REFERENCES	

Chair - Community Healthcare Board **Date**

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

Family Health Services

Fee Schedule

Policy Number: 100.12

Effective Date	May 1, 2019
Frequency of Review	Annual
Last Reviewed	April 7, 2023
Last Updated	April 7, 2023
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 Analyst (PFA)/Revenue Cycle Manager (RCM) will:
   a. Prepare the cost per unit based on Relative Value Units
      i. RCM 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. Using the CPT usage report, assign the local 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.
      vi. 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.
      vii. 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.
e. 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.
f. 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.
g. 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.

2. 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.

3. 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 System.

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.

Fee Schedule

Policy Number: 100.12

REFERENCED POLICIES	100.03 Sliding Fee Scale Discount Program
REFERENCED FORMS	
REFERENCES	

Chair - Community Healthcare Board **Date**

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

Family Health Services

Dental Appliances

Policy Number: 100.13

Effective Date	June 1, 2019
Frequency of Review	Annual
Last Reviewed	April 7, 2023
Last Updated	April 7, 2023
Author	Dr. Reza Rajabian, Janine Harris
Responsible Department	Dental, Revenue Cycle Management

PURPOSE:

The purpose of this policy is to describe the requirements for providing dental appliances to Family Health Services (FHS) patients. FHS staff are expected to comply with this policy and procedure.

At no time will a patient be denied services because of an inability to pay. See policy 100.03 – Sliding Fee Scale Discount Program.

DEFINITIONS:

Dental Appliance – Dentures and Crowns

Treatment Authorization Request (TAR) – Form completed to request pre-approval of treatment and dental appliances, reviewed and approved by the Dentist Manager

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 shall provide dental services regardless of a patient's ability to pay. The Sliding Fee Scale Discount Program is available for all patients to apply for, according to policy 100.03 – Sliding Fee Scale Discount Program.

Dental appliances are provided to patients per the Medi-Cal criteria, once in a five-year period, as described in the Medi-Cal Dental Program Provider Handbook. Exceptions are requested on the Treatment Authorization Request (TAR) and considered for approval by the Dentist Manager or delegated authority. Medical and dental necessity will be considered during the review process.

For Private Pay patients, Medi-Cal criteria is followed when determining if the patient qualifies for the dental appliance.

Dental Appliances

Policy Number: 100.13

PROCEDURE:

1. FHS staff will provide a cost estimate to patients for dental appliances as requested by a dentist.
    a. For appliances that are pre-authorized by Medi-Cal, this step is not required.
2. Upon approval of the cost estimate by the patient, a TAR is completed by FHS staff. The TAR is sent to the Dentist Manager for approval or denial.
3. FHS staff will notify the patient upon approval or denial of the TAR.
4. If the TAR is approved, FHS staff will discuss a payment plan with the patient to ensure the appliance is paid in full by the time the appliance is provided to the patient.
5. If the appliance is not paid-in-full by the scheduled appointment, the appointment will be postponed pending payment of the appliance.
    a. In case of crowns, the crown preparation procedure is initiated after appliance is paid-in-full.

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

REFERENCED POLICIES	100.03 – Sliding Fee Scale Discount Program
REFERENCED FORMS	Treatment Authorization Request (TAR)
REFERENCES	Medi-Cal Dental Program Provider Handbook https://www.denti-cal.ca.gov/DC_documents/providers/provider_handbook/handbook.pdf

Chair - Community Healthcare Board **Date**

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

Family Health Services

Bad Debt Write Off

Policy Number: 100.14

Effective Date	January 1, 2020
Frequency of Review	Annual
Last Reviewed	April 7, 2023
Last Updated	April 7, 2023
Author	Janine Harris
Responsible Department	Revenue Cycle Management

PURPOSE:

The purpose of this policy is to describe conversion of delinquent self-pay account to bad debt and bad debt write off for Solano County 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 or a refusal to pay, as described in the Sliding Fee Scale Discount Program policy #100.03.

DEFINITIONS:

Bad Debt – Self-Pay accounts 120 days delinquent and/or all returned mail accounts with no forwarding address.

Prelisting – Marking delinquent accounts in Electronic Health Records (EHR) system for conversion to Bad Debt

Conversion – Processing of prelisted accounts to Bad Debt in Electronic Health Records (E H R) system for submission to outside Collection Agency

Write Off – Cancellation of Bad Debt accounts in Electronic Health Records (EHR) system

Inability to Pay – If services rendered to a patient are not covered by insurance or a public program, patients may undergo financial screening to determine what degree patients are able or unable to pay based on the Sliding Fee Scale. Based on financial screening, as discussed in the Sliding Fee Scale Discount Program policy #100.03, patients are assigned a discount percentage based on the Board-approved sliding fee schedule. This discount scale (established based on family size and household income) is the determining factor of ability to pay and not determined by the individual patient.

Refusal to Pay – A patient who has the ability to pay but is unwilling to pay the amount owed, as expressed verbally by the patient or if the patient does not make an effort to pay upon receipt of monthly statements from FHS.

Bad Debt Write Off

Policy Number: 100.14

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:

Solano County Family Health Services (FHS) follows the Health & Social Services Collection Policy, as approved by the Solano County Board of Supervisors on January 11, 1994.

FHS shall submit monthly statements to patients who have self-pay obligations of $5 or more. Statements will show the rolling balance due to FHS. FHS abides by the Health and Social Services collection policy, which places the patient's account as delinquent without payment made within the last 120 days.

Accounts 120 days delinquent, $50 and over, will be prelisted, converted and written off by FHS Back Office Billing & Collections (B&C) staff. Accounts with balances under $50 will be written off by FHS B&C staff.

All returned mail statements with no forwarding address will be immediately sent to collection agency if $50 or over or written off if under $50.

Statements include a message alerting patient that balances not paid 90 days from date of service will be sent to a collection agency.

Payments received from the collection agency will be posted to the recovered bad debt account.

PROCEDURE:

1. Accounts 120 days delinquent, $50 or more - B&C staff will take the following steps:
    a. Verify if patient is covered under Ryan White program (diagnosis code B20)
    b. If so, skip to step 4.

a. Review patient eligibility for date of service.
    i. If it is determined that patient has eligibility for date of service charges will be billed to insurance.
b. Review to ensure Sliding-Fee-Scale Discount was applied, if applicable.
    i. Apply Sliding-Fee-Scale Discount if applicable and restart 120 day count
c. Verify that patient has been provided 120 days to make payments on charge.
d. Verify that patient has not made a payment on account in 120 days.
e. Prelist charge for bad debt
f. Convert charge to bad debt; conversion is completed at least twice monthly.
g. Submit Bad Debt to outside collection agency; submission is completed at least twice monthly.

h. Write off bad debt in EHR system
    i. Tracking description: "Bad Debt Final Write Off"
    ii. Adjust code: "Bad Debt Final Write Off"

2. Accounts 120 days delinquent, under $50 - B&C staff will take the following steps:
    a. Review patient eligibility for date of service.
        i. If it is determined that patient has eligibility for date of service charges will be billed to insurance.
    b. Review to ensure Sliding-Fee-Scale Discount was applied, if applicable.
        i. Apply Sliding-Fee-Scale Discount if applicable and restart 120 day count.
    c. Verify that patient has been provided 120 days to make payments on charge.

    d. Verify that patient has not made a payment on account in 120 days.
    e. Write off bad debt in EHR system
        i. Tracking description: "Bad Debt Under $50 BOS"
        ii. Adjust code: "Bad Debt Write Off BOS Under $50"

3. Returned mail statements with no forwarding address - B&C staff will take the following steps:
    a. Review patient eligibility for date of service.
        i. If it is determined that patient has eligibility for date of service charges will be billed to insurance.
    b. Review to ensure Sliding-Fee-Scale Discount was applied, if applicable.
        i. Apply Sliding-Fee-Scale Discount if applicable.
    c. Review chart documents to verify address was entered correctly.
    d. Add alert to account to verify patient's address.
    e. Depending on dollar value of debt follow procedure 1 or 2 listed above.

4. Ryan White patients:
    a. Review patient eligibility for date of service.
        i. If it is determined that patient has eligibility for date of service charges will be billed to insurance.
    b. Review to ensure Sliding-Fee-Scale Discount was applied, if applicable.
        i. Apply Sliding-Fee-Scale Discount if applicable.
    c. Verify that patient has been provided 120 days to make payments on charge.
    d. Verify that patient has not made a payment on account in 120 days
    e. Write off Ryan White debt in EHR system
        i. Tracking description: "Ryan White"
        ii. Adjust code: "Ryan White"

5. Vaccine for Children (VFC) Program patients:
    a. Review patient eligibility for date of service.
        i. If it is determined that patient has eligibility for date of service charges will be billed to insurance.

b. Review to ensure Sliding-Fee-Scale Discount was applied, if applicable.
    i. Apply Sliding-Fee-Scale Discount if applicable.
c. VFC charges are suppressed from private pay statements and cannot be sent to bad debt per VFC Program requirements.
d. Charges should be adjusted at time of service if patient is unable to pay.

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	Sliding Fee Scale Discount Program Policy #100.03 Health & Social Services Collection Policy: Board of Supervisor Agenda Item #20, Board Meeting Dated January 11, 1994, Subject: Report on Primary Care Clinic Addressing Fiscal Issues, Controls, Adding Staff and New Operating Policies Ryan White Part C / North Bay AIDS Center Sliding Fee Scale and Billing Caps VFC Program Requirements - https://files.medi-cal.ca.gov/pubsdoco/medsupply/Medi-Cal_coverage_immunizations_faq.asp
REFERENCED FORMS	
REFERENCES	

Chair - Community Healthcare Board **Date**

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

Family Health Services

Back Office Claims Processing

Policy Number: 100.15

Effective Date	July 1, 2019
Frequency of Review	Annual
Last Reviewed	April 7, 2023
Last Updated	April 7, 2023
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) back office operations. FHS staff are expected to comply with this policy and procedure.

DEFINITIONS:
Back Office Billing and Collections – Accounting Clerks located in the administrative division who report to the Medical Billing Supervisor. Processes secondary and tertiary billing, uploads all claims, submits patient statements for printing and mailing, works denials, and other secondary and tertiary billing functions.

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 back office Accounting Clerks will submit secondary and tertiary claims for billing twice weekly 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 based on prior payer Explanation of Benefits (EOB) posting.

All pending electronic claims (primary, secondary or tertiary) will be uploaded to the clearing house twice weekly. All pending paper claims (primary, secondary or tertiary) will be printed and mailed weekly or as the prior payer EOB is processed.

Self-Pay statements are mailed to patients monthly. Unpaid charges are handled according to the Bad Debt Write Off policy, #100.14.

Back office Accounting Clerks are not coders. Any coding errors that prevent the billing from passing the claim edits will be sent to the FHS Certified Professional Coder (CPC) for review and correction, as stated in the Coding policy, #100.05.

Back Office Claims Processing

Policy Number: 100.15

PROCEDURE:

1. Encounter to Claim Process
   a. Back office Billing and Collections team will mass bill secondary and tertiary claims twice weekly.
   b. Back office Billing and Collections team will submit pending electronic primary, secondary and tertiary claims twice weekly.
   c. Back office Billing and Collections team will print and mail pending paper primary, secondary and tertiary claims weekly or as the prior payer EOB is processed.
   d. Back office Billing and Collections team will work EOB denials for rebill, claim correction, appeal, tasking to front office or for adjustment.
2. Self-Pay Statements Process
   a. Back office Billing and Collections team will submit pending self-pay charges to the electronic health records system EDI Department twice per month. Self-pay patients fall into the first or second statement run but will only receive one statement per month.
   b. Back office Billing and Collections team will submit unpaid self-pay charges to outside collection agency according to the Bad Debt Write Off policy, #100.14.

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	Coding Policy # 100.05 Bad Debt Write Off Policy # 100.14
REFERENCED FORMS	
REFERENCES	

Chair - Community Healthcare Board **Date**

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

Family Health Services

Non-Sufficient Funds

Policy Number: 100.16

Effective Date	January 1, 2020
Frequency of Review	Annual
Last Reviewed	April 7, 2023
Last Updated	April 7, 2023
Author	Janine Harris
Responsible Department	Revenue Cycle Management

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

DEFINITIONS:
NSF (Non-Sufficient Funds) refers to the status of a checking account that does not have enough money to cover transactions.

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:
Health and Social Services (H&SS) shall make all efforts to collect funds due in cash from any patient who has paid by check that has been returned due to Non-Sufficient Funds (NSF).

PROCEDURE:
1. H&SS receives notification from the County Treasurer's office that a check has been returned due to non-sufficient funds. The FHS back office Billing & Collections staff or Medical Billing Supervisor receives notification and prepares a journal entry to reverse the transaction in the County's accounting system.
2. The Medical Billing Supervisor or back office staff notifies front office Billing & Collections staff to reverse the payment in the electronic health records and to notify the patient.
3. Front office accounting clerks reviews the patients record and notifies the patient in writing of a $35 returned check fee that is applied for every NSF occurrence in accordance with the County Approved Fee Schedule.
4. Front office accounting clerks will post a $35 NSF fee to the patient's account and reverse the payment that was returned.

5. Patients with outstanding NSF balances will not be turned away and will continue to receive services, per the Sliding Fee Scale Discount Program Policy #100.03.

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	Sliding Fee Scale Discount Program Policy # 100.03
REFERENCED FORMS	
REFERENCES	

Chair - Community Healthcare Board **Date**

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