APPROVED BY THE SNCHC GOVERNING BOARD
NOVEMER 19, 2024

MINUTES

SOUTHERN NEVADA COMMUNITY HEALTH CENTER
GOVERNING BOARD MEETING
October 15, 2024, 2024 – 2:30 p.m.
Meeting was conducted In-person and via Microsoft Teams
Southern Nevada Health District, 280 S. Decatur Boulevard, Las Vegas, NV 89107
Red Rock Trail Room A

MEMBERS PRESENT:	Jose L. Melendrez, Chair *(via Microsoft Teams)* Donna Feliz-Barrows, Vice-Chair *(in-person)* Scott Black *(via Microsoft Teams)* Erin Breen (*via Microsoft Teams)* Ashley Brown *(via Microsoft Teams* Marie Dukes *(via Microsoft Teams)* Sara Hunt *(in-person)* Brian Knudsen *(via Microsoft Teams)* Blanca Macias-Villa *(via Microsoft Teams)*
ABSENT:	Luz Castro Jasmine Coca
ALSO PRESENT:	Donna Laffey
LEGAL COUNSEL:	Edward Wyner, Associate General Counsel
CHIEF EXECUTIVE OFFICER:	Randy Smith
STAFF:	Emily Anelli, Tawana Bellamy, Todd Bleak, Donna Buss, Tabitha Johnson, David Kahananui, Ryan Kelsch, Fermin Leguen, Cassius Lockett, Cassondra Major, Jonas Maratita, Kimberly Monahan, Luann Province, Yin Jie Qin, Kim Saner, Felicia Sgovio, Justin Tully, Donnie Whitaker, Merylyn Yegon

I. CALL TO ORDER and ROLL CALL
The Chair called the Southern Nevada Community Health Center (SNCHC) Governing Board Meeting to order at 2:32 p.m. Tawana Bellamy, Senior Administrative Specialist, administered the roll call and confirmed a quorum.

II. PLEDGE OF ALLEGIANCE

III. FIRST PUBLIC COMMENT: A period devoted to comments by the general public about those items appearing on the agenda. Comments will be limited to five (5) minutes per speaker. Please clearly state your name and address and spell your last name for the record. If any member of the Board wishes to extend the length of a presentation, this may be done by the Chair or the Board by majority vote.

Ms. Bellamy provided clear and complete instructions for members of the general public to call in to the meeting to provide public comment, including a telephone number and access code.

Seeing no one, the Chair closed the First Public Comment portion.

IV. ADOPTION OF THE OCTOBER 15, 2024 MEETING AGENDA *(for possible action)*

Chair Melendrez called for questions and there were none.

A motion was made by Member Feliz-Barrows, seconded by Member Knudsen, and carried unanimously to approve the October 15, 2024, Meeting Agenda, as presented.

V. CONSENT AGENDA: Items for action to be considered by the Southern Nevada Community Health Center Governing Board which may be enacted by one motion. Any item may be discussed separately per Board Member request before action. Any exceptions to the Consent Agenda must be stated prior to approval.

1. **APPROVE MINUTES – SNCHC GOVERNING BOARD MEETING**: September 17, 2024 *(for possible action)*

~~2. **Approve Credentialing and Privileging of Provider Michelle Jordan, DO;** direct staff accordingly or take other action as deemed necessary *(for possible action)*~~

Item V.2 was removed from the Consent Agenda.

A motion was made by Member Feliz-Barrows, seconded by Member Hunt, and carried unanimously to approve the Consent Agenda, as amended.

VI. REPORT / DISCUSSION / ACTION

Recommendations from the October 14, 2024 Finance and Audit Committee Meeting

1. **Receive, Discuss and Accept the August 2024 Year to Date Financial Report;** direct staff accordingly or take other action as deemed necessary *(for possible action)*

Donnie Whitaker, Chief Financial Officer, presented the August 2024 Year to date Financial Report, unaudited results as of August 31, 2024.

Revenue

- General Fund revenue (Charges for Services & Other) was $5.67M compared to a budget of $4.69M, a favorable variance of $978K.
- Special Revenue Funds (Grants) was $1.49M compared to a budget of $1.31M, a favorable variance of $174K.
- Total Revenue was $7.15M compared to a budget of $6.00M, a favorable variance of $1.15M.

Expenses

- Salary, Tax, and Benefits was $2.26M compared to a budget of $2.29M, a favorable variance of $23K.

- Other Operating Expense was $5.20M compared to a budget of $4.04M, an unfavorable variance of $1.17M.
- Indirect Cost/Cost Allocation was $1.30M compared to a budget of $1.28M, an unfavorable variance of $20K.
- Total Expense was $8.76M compared to a budget of $7.60M, an unfavorable variance of $1.16M.

Net Position: was ($1.61M) compared to a budget of ($1.60M), an unfavorable variance of $11K.

Ms. Whitaker further reviewed the following:

- All funds and Divisions by Type (Budget to Actual)
- Revenue and Expenses by Department (graphical diagram)
- Revenue by Department
- Expenses by Department
- Patient Encounters by Department as of August 2024
    - FY2024 Total: 4,793
    - FY2025 Total: 6,282
    - 31% year over year growth

The Chair called for questions and there were none.

A motion was made by Member Black, seconded by Member Feliz-Barrows, and carried unanimously to accept the August 2024 Year to Date Financial Report, as presented.

Recommendations from the October 9, 2024 Quality, Credentialing & Risk Management Committee Meeting

2. **Receive, Discuss and Accept the Third Quarter Risk Management Report;** direct staff accordingly or take other action as deemed necessary *(for possible action)*

   David Kahananui, FQHC Administrative Manager provided an overview of the Third Quarter Risk Management Report, including year to date performance. Mr. Kahananui advised that goal number 5 was added to align with FTCA's focus on clinical safety regarding obstetric care.

   The Chair called for questions and there were none.

   A motion was made by Member Feliz-Barrows, seconded by Member Breen, and carried unanimously to accept the Third Quarter Risk Management Report, as presented.

3. **Receive, Discuss and Accept the Third Quarter Risk Management Assessment;** direct staff accordingly or take other action as deemed necessary *(for possible action)*

   Mr. Kahananui provided an overview of the Third Quarter Risk Management Assessment. Mr. Kahananui shared that quarterly risk assessments are required by the Health Resources and Services Administration (HRSA) for annual Federal Tort Claims Act (FTCA) Redeeming.

   Mr. Kahananui further shared that the Q3 assessment was conducted with the Risk Assessment and Mitigation Tool, Infection Prevention and Control (IPC). Mr. Kahananui advised the tool is

provided by the Emergency Care Research Institute (ECRI), which is the organization recommended by HRSA for FTCA & Risk Management training and support. Mr. Kahananui further advised the IPC Risk Assessment will be performed annually to help prevent and mitigate potential malpractice liabilities that could result from poor infection prevention and control. Mr. Kahananui advised there were twenty-nine findings during the assessment.

Mr. Kahananui outlined three goals that would address and correct the findings.

- Goal 1: Crate an Infection Prevention and Control Policy that address all components required to resolve the deficiencies identified in the HRSA Risk Assessment and Mitigation Tool: Infection Prevention and Control (IPC).
- Goal 2: Name a new IPC Officer and a backup IPC Officer
- Goal 3: IPC daily procedures to be developed, documented, trained, and implemented with measurable metrics and a process for ongoing IPC monitoring and quality control.

Further from an inquiry from Member Feliz-Barrow, Mr. Kahananui shared there has not been an IPC Officer or an IPC policy for the health center.

A motion was made by Member Feliz-Barrows, seconded by Member Breen, and carried unanimously to accept the Third Quarter Risk Management Assessment, as presented.

Recommendations from the October 9, 2024, Executive Director Annual Review Committee Meeting

4. **Receive, Discuss and Approve the FY24 Summary of Accomplishments and FY25 Goals for the Chief Executive Officer;** direct staff accordingly or take other action as deemed necessary *(for possible action)*

   Mr. Smith provided a high-level review of the FY24 Summary of Accomplishments and FY25 Goals for the Chief Executive Officer.

   The Chair called for questions and there were none.

   A motion was made by Member Feliz-Barrows, seconded by Member Hunt, and carried unanimously to approve the FY24 Summary of Accomplishments and FY25 Goals for the Chief Executive Officer, as presented.

5. **Receive, Discuss and Approve the FY24 Evaluation Results of the Chief Executive Officer;** direct staff accordingly or take other action as deemed necessary *(for possible action)*

   Mr. Kahananui advised of the FY24 Evaluation Results of the Chief Executive Officer. Mr. Kahananui further advised the survey scores were compiled from participating Governing Board Members, but comments were provided by a mixture of Governing Board Members and Southern Nevada Health District staff.

   Out of eleven board members, seven completed the evaluation survey.

Questions	Weighted	Average Score
Q1: The CEO consistently demonstrates equitable and fair treatment of SNCHC employees, contractors, and volunteers.	15%	4.85

Q2: The CEO consistently provides thorough administrative leadership and oversite of SNCHC's compliance with HRSA program requirements.	40%	4.71
Q3: The CEO ensures that the SNCHC has a viable long-range strategy to achieve its mission and utilizes data to measure progress towards achieving programmatic, clinical, and financial goals	15%	5
Q4: The CEO appropriately utilizes financial and utilization data to ensure SNCHC is maximizing budgetary and human resources to achieve health center goals.	15%	4.85
Q5. The CEO properly represents SNCHC in the community and fosters the establishment of new community partners and develops existing partnerships.	15%	4.57
"General Strengths" Narratives - 2024	• Mr. Smith is an asset to the SNCHC. He has exhibited strong leadership skills as well as a clear vision of how to make the clinic even better. • Mr. Smith's dedication and passion of the SNCHC is demonstrated when presenting to the board. He is extremely knowledge, always prepared, and demonstrates team ownership of the success and challenges of growing a successful FQHC.	
"Areas for Growth" Narratives - 2024	• Mr. Smith could be stronger in properly representing SNCHC in the community and fostering the establishment of new community partners and developing existing partnerships.	
2024 Chief Executive Officer Annual Review Overall Weighted Score:	4.78 on a scale of 1 being poor to 5 being outstanding.	

Member Feliz-Barrows commented that Mr. Smith has done an excellent job and it showed by the comments that were made and the board really appreciates the dedication and passion Mr. Smith has for the position.

Mr. Smith thanked Member Feliz-Barrows and shared it is a privilege to be here and enjoys working with the board. Mr. Smith further shared that he enjoys how the health center board is structured and how it comes together as a community to set the direction of health center that is designed to care for those who are using it. Mr. Smith shared that he has a lot of gratitude for his team.

Chair Melendrez shared that it has been a pleasure and honor to work with and under Mr. Smith's guidance, leadership, and support. Chair Melendrez further shared he appreciates Mr. Smith's leadership style and his engagement with the board members, staff, and community partners.

The Chair called for any further questions or comments and there were none.

A motion was made by Member Feliz-Barrows, seconded by Member Hunt, and carried unanimously to approve the FY24 Evaluation Results of the Chief Executive Officer, as presented.

SNCHC Governing Board

6. **Receive, Discuss and Approve Governing Board Chair, 1st Vice Chair and 2nd Vice Chair Officer Appointments;** direct staff accordingly or take other action as deemed necessary *(for possible action)*

   The board was provided a summary of the Officer Appointment nominations.

   The Chair called for any further questions or comments and there were none.

   A motion was made by Member Breen, seconded by Member Macias-Villa, and carried unanimously to approve the Governing Board Chair, 1st Vice Chair and 2nd Vice Chair Officer Appointments, as follows.

CALENDAR YEAR 2025 OFFICER APPOINTMENTS		
Chair	**First Vice Chair**	**Second Vice Chair**
Donna Feliz-Barrows	Jasmine Coca	Sara Hunt

7. **Review, Discuss and Approve Committee Memberships;** direct staff accordingly or take other action as deemed necessary *(for possible action)*

   The board was provided a summary of the Committee Participation Interest Forms.

   A motion was made by Member Feliz-Barrows, seconded by Member Breen, and carried unanimously to approve the Committee Memberships, as follows.

CALENDAR YEAR 2025 COMMITTEE ASSIGNMENTS					
Executive Committee	**Executive Director Annual Review Committee**	**Finance and Audit Committee**	**Quality, Credentialing & Risk Management Committee**	**Nominations Committee**	**Strategic Planning Committee**
Donna Feliz-Barrows	Scott Black	Marie Dukes	Sara Hunt	Sara Hunt	Scott Black
Brian Knudsen	Donna Feliz-Barrows	Ashley Brown	Jose Melendrez	Donna Feliz-Barrows	Jasmine Coca
Jasmine Coca	Jose Melendrez	Jasmine Coca	Erin Breen	Jose Melendrez	Blanca Macias-Villa
		Blanca Macias-Villa		Erin Breen	

8. **Review, Discuss and Approve the 2025 Governing Board Meeting Schedule**; direct staff accordingly or take other action as deemed necessary *(for possible action)*

   The Governing Board was advised that the proposed meeting schedule for calendar year 2025 would be on the third Tuesday of each month at 2:30 p.m. except for December 2025.

   Further to an inquiry from Chair Melendrez, Mr. Smith advised that there should be enough time to reschedule the October 21, 2025, meeting if we needed to cancel the meeting.

   The Chair called for any further questions or comments and there were none.

   A motion was made by Member Feliz-Barrows, seconded by Member Breen, and carried unanimously to approve the 2025 Governing Board Meeting Schedule, as presented.

VII. **BOARD REPORTS:** The Southern Nevada District Board of Health members may identify and comment on Health District related issues. Comments made by individual Board members during this portion of the agenda will not be acted upon by the Southern Nevada District Board of Health unless that subject is on the agenda and scheduled for action. *(Information Only)*

Chair Melendrez shared the Nevada Minority Health & Equity Coalition (NMHEC) Impact Summit is on November 15, 2024, he hopes people can attend.

IX. **CEO & STAFF REPORTS** *(Information Only)*

- CEO Comments

  Mr. Smith shared an update on the Governing Board Retreat. Mr. Smith advised Ms. Bellamy will send the final details, including parking information and dietary needs, to the board members.

  Further to an inquiry from Member Feliz-Barrows, Mr. Smith shared Dr. Cassius Lockett, Deputy Health Officer, Administration, may be able to attend the retreat on behalf of Fermin Leguen.

X. **INFORMATIONAL ITEMS**

- Community Health Center (FQHC) September 2024 Operations Reports

XI. **SECOND PUBLIC COMMENT:** A period devoted to comments by the general public, if any, and discussion of those comments, about matters relevant to the Board's jurisdiction will be held. Comments will be limited to five (5) minutes per speaker. If any member of the Board wishes to extend the length of a presentation, this may be done by the Chair or the Board by majority vote.

Seeing no one, the Vice Chair closed the Second Public Comment period.

XII. **ADJOURNMENT**

The Vice Chair adjourned the meeting at 3:50 p.m.

Randy Smith
Chief Executive Officer - FQHC

/tab

AGENDA

SOUTHERN NEVADA COMMUNITY HEALTH CENTER
GOVERNING BOARD MEETING
October 15, 2024 – 2:30 p.m.
Meeting will be conducted In-person and via Microsoft Teams
Southern Nevada Health District, 280 S. Decatur Boulevard, Las Vegas, NV 89107
Red Rock Trail Room A

NOTICE

Microsoft Teams:
https://events.teams.microsoft.com/event/64041faa-9cfb-4318-8552-e3a2a50bbf6a@1f318e99-9fb1-41b3-8c10-d0cab0e9f859

To call into the meeting, dial (702) 907-7151 and enter Phone Conference ID: 694 401 935#

NOTE:
- Agenda items may be taken out of order at the discretion of the Chair.
- The Board may combine two or more agenda items for consideration.
- The Board may remove an item from the agenda or delay discussion relating to an item on the agenda at any time.

I. CALL TO ORDER & ROLL CALL

II. PLEDGE OF ALLEGIANCE

III. FIRST PUBLIC COMMENT: A period devoted to comments by the general public about those items appearing on the agenda. Comments will be limited to five (5) minutes per speaker. Please clearly state and spell your name for the record. If any member of the Board wishes to extend the length of a presentation, this may be done by the Chair or the Board by majority vote. There will be two public comment periods. To submit public comment on either public comment period on individual agenda items or for general public comments:

- **By Teams:** Use the Teams link above. You will be able to provide real-time chatroom messaging, which can be read into the record or by raising your hand. Unmute your microphone prior to speaking.
- **By telephone:** Call (702) 907-7151 and when prompted to provide the Meeting ID, enter 694 401 935#. To provide public comment over the telephone, please press *5 during the comment period and wait to be called on.
- **By email:** public-comment@snhd.org. For comments submitted prior to and during the live meeting, include your name, zip code, the agenda item number on which you are commenting, and your comment. Please indicate whether you wish your email comment to be read into the record during the meeting or added to the backup materials for the record. If not specified, comments will be added to the backup materials.

IV. ADOPTION OF THE OCTOBER 15, 2024 AGENDA *(for possible action)*

V. CONSENT AGENDA: Items for action to be considered by the Southern Nevada Community Health Center Governing Board which may be enacted by one motion. Any item may be discussed separately per Board Member request before action. Any exceptions to the Consent Agenda must be stated prior to approval.

1. **APPROVE MINUTES – SNCHC GOVERNING BOARD MEETING**: September 17, 2024 *(for possible action)*

2. **Approve Initial Credentialing and Privileging of Provider Michelle Jordan, DO;** direct staff accordingly or take other action as deemed necessary *(for possible action)*

VI. REPORT / DISCUSSION / ACTION

Recommendations from the October 14, 2024 Finance and Audit Committee Meeting

1. **Receive, Discuss and Accept the August 2024 Year to Date Financial Report**; direct staff accordingly or take other action as deemed necessary *(for possible action)*

Recommendations from the October 9, 2024 Quality, Credentialing & Risk Management Committee Meeting

2. **Receive, Discuss and Accept the Third Quarter Risk Management Report;** direct staff accordingly or take other action as deemed necessary *(for possible action)*

3. **Receive, Discuss and Accept the Third Quarter Risk Management Assessment;** direct staff accordingly or take other action as deemed necessary *(for possible action)*

Recommendations from the October 9, 2024 Executive Director Annual Review Committee Meeting

4. **Receive, Discuss and Approve the FY24 Summary of Accomplishments and FY25 Goals for the Chief Executive Officer;** direct staff accordingly or take other action as deemed necessary *(for possible action)*

5. **Receive, Discuss and Approve the FY24 Evaluation Results of the Chief Executive Officer;** direct staff accordingly or take other action as deemed necessary *(for possible action)*

SNCHC Governing Board

6. **Receive, Discuss and Approve Governing Board Chair, 1st Vice Chair and 2nd Vice Chair Officer Appointments;** direct staff accordingly or take other action as deemed necessary *(for possible action)*

7. **Review, Discuss and Approve Committee Memberships;** direct staff accordingly or take other action as deemed necessary *(for possible action)*

8. **Review, Discuss and Approve the 2025 Governing Board Meeting Schedule**; direct staff accordingly or take other action as deemed necessary *(for possible action)*

VII. **BOARD REPORTS**: The Southern Nevada Community Health Center Governing Board members may identify and comment on Health Center related issues or ask a question for clarification. Comments made by individual Board members during this portion of the agenda will not be acted upon by the Southern Nevada Community Health Center Governing Board unless that subject is on the agenda and scheduled for action. ***(Information Only)***

VIII. **CEO & STAFF REPORTS *(Informational Only)***

- CEO Comments

IX. **INFORMATIONAL ITEMS**

- Community Health Center (FQHC) September 2024 Operations Report

X. **SECOND PUBLIC COMMENT**: A period devoted to comments by the general public, if any, and discussion of those comments, about matters relevant to the Board's jurisdiction will be held. Comments will be limited to five (5) minutes per speaker. If any member of the Board wishes to extend the length of a presentation, this may be done by the Chair or the Board by majority vote. **See above for instructions for submitting public comment.**

XI. **ADJOURNMENT**

NOTE: Disabled members of the public who require special accommodations or assistance at the meeting are requested to notify the Administration Office at the Southern Nevada Health District by calling (702) 759-1201.

THIS AGENDA HAS BEEN PUBLICLY NOTICED on the Southern Nevada Health District's Website at https://snhd.info/meetings, the Nevada Public Notice website at https://notice.nv.gov, and a copy will be provided to any person who has requested one via U.S mail or electronic mail. All meeting notices include the time of the meeting, access instructions, and the meeting agenda. For copies of agenda backup material, please contact the Administration Office at 280 S. Decatur Blvd, Las Vegas, NV, 89107 or (702) 759-1201.

MINUTES

SOUTHERN NEVADA COMMUNITY HEALTH CENTER
GOVERNING BOARD MEETING
September 17, 2024, 2024 – 2:30 p.m.
Meeting was conducted In-person and via Microsoft Teams
Southern Nevada Health District, 280 S. Decatur Boulevard, Las Vegas, NV 89107
Red Rock Trail Room A

MEMBERS PRESENT:	Jose L. Melendrez, Chair *(via Microsoft Teams)* Donna Feliz-Barrows, Vice-Chair *(in-person)* Jasmine Coca, Second Vice-Chair *(in-person)* Scott Black *(via Microsoft Teams)* Erin Breen (*via Microsoft Teams)* Ashley Brown *(via Microsoft Teams* Luz Castro *(via Microsoft Teams)* Marie Dukes *(via Microsoft Teams)* Sara Hunt *(in-person)* Blanca Macias-Villa
ABSENT:	Brian Knudsen
ALSO PRESENT:	Trey Delap
LEGAL COUNSEL:	Edward Wyner, Associate General Counsel
CHIEF EXECUTIVE OFFICER:	Randy Smith
STAFF:	Emily Anelli, Tawana Bellamy, Todd Bleak, Andria Cordovez Mulet, Brian Felgar, Jason Frame, Tabitha Johnson, Cassius Lockett, Cassondra Major, Bernadette Meily, Brennen O'Toole, Yin Jie Qin, Justin Tully, Felicia Sgovio, Merylyn Yegon

I. CALL TO ORDER and ROLL CALL

The Chair called the Southern Nevada Community Health Center (SNCHC) Governing Board Meeting to order at 2:32 p.m. Tawana Bellamy, Senior Administrative Specialist, administered the roll call and confirmed a quorum.

II. PLEDGE OF ALLEGIANCE

III. RECOGNITION

1. **Southern Nevada Community Health Center**
   2024 Community Health Quality Recognition (CHQR) Badges – Access Enhancer, Health Disparities Reducer and Advancing HIT for Quality – Health Resources & Services Administration (HRSA)

The Chair recognized the Southern Nevada Community Health Center for being awarded three Community Health Quality Recognition Badges by HRSA, (1) Access Enhancer, (2) Health Disparities Reducer, and (3) Advancing Health Information Technology for Quality. These badges recognize Health Center Program awardees that have made notable achievements in the areas of access, quality, health equity, health information technology, and social risk factors screening using Uniform Data System (UDS) data from the most recent reporting period. Many thanks to the employees of the health center for your steadfast commitment to providing quality primary health care services to our community. On behalf of the Southern Nevada Community Health Center's Governing Board, congratulations for this well-deserved recognition.

IV. **FIRST PUBLIC COMMENT**: A period devoted to comments by the general public about those items appearing on the agenda. Comments will be limited to five (5) minutes per speaker. Please clearly state your name and address and spell your last name for the record. If any member of the Board wishes to extend the length of a presentation, this may be done by the Chair or the Board by majority vote.

Ms. Bellamy provided clear and complete instructions for members of the general public to call in to the meeting to provide public comment, including a telephone number and access code.

Seeing no one, the Chair closed the First Public Comment portion.

V. **ADOPTION OF THE SEPTEMBER 17, 2024 MEETING AGENDA** *(for possible action)*

Chair Melendrez called for questions and there were none.

A motion was made by Member Black, seconded by Member Castro and carried unanimously to approve the September 17, 2024 Meeting Agenda, as presented.

VI. **CONSENT AGENDA**: Items for action to be considered by the Southern Nevada Community Health Center Governing Board which may be enacted by one motion. Any item may be discussed separately per Board Member request before action. Any exceptions to the Consent Agenda must be stated prior to approval.

1. **APPROVE MINUTES – SNCHC GOVERNING BOARD MEETING**: August 20, 2024 *(for possible action)*

2. **Approve Credentialing and Privileging of Provider Sarah Hall, APRN II;** direct staff accordingly or take other action as deemed necessary *(for possible action)*

3. **Approval of the After-Hours Coverage System Policy and Procedure;** *direct staff accordingly or take other action as deemed necessary (for possible action)*

4. **Approval of the Patient Satisfaction Survey System Policy and Procedure;** *direct staff accordingly or take other action as deemed necessary (for possible action)*

   Ms. Bellamy advised the job title on item 2, should be APRN I not APRN II.

   Chair Melendrez called for questions and there were none.

A motion was made by Member Feliz-Barrows, seconded by Member Coca, and carried unanimously to approve the Consent Agenda, as presented.

VII. REPORT / DISCUSSION / ACTION

Recommendations from the September 16, 2024 Finance and Audit Committee Meeting

1. **Receive, Discuss and Accept the July 2024 Year to Date Financial Report;** direct staff accordingly or take other action as deemed necessary *(for possible action)*

Donnie Whitaker, Chief Financial Officer presented the July 2024 Year to date Financial Report, unaudited, as of July 31, 2024 with the following highlights. Ms. Whitaker advised there were recommendations made by the committee and staff that she would mention during the presentation.

Revenue

- General Fund revenue (Charges for Services & Other) was $2.64M compared to a budget of $2.34M, a favorable variance of $300K.
- Special Revenue Funds (Grants) was $687K compared to a budget of $655K, a favorable variance of $32K.
- Total Revenue was $3.31M compared to a budget of $3M, a favorable variance of $331K.

Expenses

- Salary, Tax, and Benefits is $1.16M compared to a budget of $1.14M, an unfavorable variance of $20K.
- Other Operating Expense is $2.83M compared to a budget of $2.02M, an unfavorable variance of $815K.
- Indirect Cost/Cost Allocation is $727K compared to a budget of $639K, an unfavorable variance of $88K.
- Total Expense is $4.72M compared to a budget of $3.80M, an unfavorable variance of $921K.

Net Position: was negative $1.39M compared to a budget of negative $801K, an unfavorable variance of $591K.

Ms. Whitaker further reviewed the following and noted the changes the Finance and Audit Committee recommended.

- Revenue and Expenses by Department (graphical diagram)
- Revenue by Department
- Expenses by Department
- Patient Encounters by Department
  - 48% year over year growth
  - FY2024 Total: 2,157
  - FY2025 Total: 3,200
- Patient Encounters by Clinic

Member Coca thanked Ms. Whitaker for making the changes.

Chair Melendrez called for questions and there were none.

A motion was made by Member Breen, seconded by Member Black, and carried unanimously to accept the July 2024 Year to Date Financial Report, as presented.

Heard out of order.

IX. CEO & STAFF REPORTS *(Information Only)*

Mr. Smith advised of the following upcoming board activities:

- Conflict of Interest/Disclosure
- Committee Assignments
- CY25 Board Meetings Calendar
- Board Officer positions
- Board Retreat
- Strategic Planning Committee

Mr. Smith shared that Chair Melendrez has been an amazing board chair and provided a brief description of the term limits for the officer roles of the chair and vice-chairs. Mr. Smith shared that Chair Melendrez role as chair will expire soon and that he could be nominated to continue, others may express interest or be nominated by someone. Mr. Smith further shared that the Nominations Committee would need to meet and the recommendations from that meeting would be voted on at the October meeting.

Chair Melendrez commented that it has been a great honor to serve as chair of the board and that he would continue to serve as a member whether he was chair or not. Chair Melendrez shared that the board put in place the idea to have members serving in the vice chair roles be prepped to step into the chair role with training, support and mentoring involved by the previous chair.

There was further discussion between Chair Melendrez and Member Feliz-Barrows regarding interest in the chair role. Member Macia-Villa commented that she likes the idea of having the vice chair roles be mentored to potentially serve as chair and believes it would be an amazing opportunity.

Mr. Smith provided an update to the Governing Board Retreat. Mr. Smith thanked Member Black for offering to host the retreat at North Las Vegas City Hall. Mr. Smith shared that there is a big event happening at North Las Vegas City Hall that may make it difficult to have a good retreat. Member Black shared that ordinarily the space would have worked however their police department has their big Halloween Trunk or Treat happening the same day and it would be a logistical nightmare. Mr. Smith further shared that an alternative location would be UNLV's University Gate Way Building. Chair Melendrez commented that it would be at the School of Public Health Gate Way Building, which is across the street from UNLV. Chair Melendrez will confirm the location, as a staff or facility member must be present for after-hours events.

REPORT / DISCUSSION / ACTION

SNCHC Governing Board

2. **Receive, Discuss and Approve the Chief Executive Officer's Report of Accomplishments and Identification of Goals for FY25;** direct staff accordingly or take other action as deemed necessary *(for possible action)*

Randy Smith, Chief Executive Officer presented the Chief Executive Officer's Report of Accomplishments for FY24 and Identification of Goals for FY25. Mr. Smith shared the following highlights from the FY24 accomplishments.

- As of June 30, 2024, 10,335 unique patients served in the health center.
    - *95% year-over-year increase*
- As of June 30, 2024, 24,032 provider visits were conducted.
    - *95% year-over-year increase*
        - Medical: 21,639
        - Behavioral Health: 1,864
        - Pharmacist: 253
        - Dietician: 276
- As of June 30, 2024, 15,977 unique patients served in the pharmacy.
- As of June 30, 2024, 23,479 prescriptions were filled.

Mr. Smith continued to provide additional highlights of the CEO FY24 accomplishments.

Mr. Smith reviewed the Goals and Opportunities for FY24.

Goals and Opportunities for FY24	
Maintained, Met or Made Progress	**Not Started**
• Increase the number of unique patients serviced. • Improve daily operations and clinical performance results. • Optimize and expand services at the Fremont Location. • Enhance integration of Sexual Health Clinic services. • Build the Behavioral Health clinic at the Decatur Location. • Develop Oral Health program at the Fremont Location. • Enhanced Refugee Services. • Maintain HRSA Compliance. • Improve financial stability – Increase the number of Medicaid patients served.	• Obtain Patient Centered Medical Home (PCMH) accreditation.

Chair Melendrez left the meeting at 3:14 p.m.

Mr. Smith shared the Proposed Goals and Opportunities for FY25.

Proposed Goals and Opportunities for FY25
• Pursue Patient Centered Medical Home (PCMH) accreditation. • Increase the number of unique patients serviced by 3%. • Improve daily access to care (visits) by 3%.

- Optimize and expand services at the Fremont location – Sexual Health Clinic/Ryan White /Refugee Health.
- Improve financial stability – Increase the number of Medicaid patients served.
- Enhance integrated Behavioral Health services and optimize new clinic at Decatur.
- Build a dental clinic at Fremont and develop an operational plan.
- Maintain Health Resources and Services Administration (HRSA) Compliance.

Vice Chair Feliz-Barrows called for questions and there were none.

A motion was made by Member Coca, seconded by Member Breen, and carried unanimously to approve the Chief Executive Officer's Report of Accomplishments for FY24 and Identification of Goals for FY25, as presented.

Member Coca commented that we should be proud of what has been done, as those were great accomplishments. Mr. Smith thanked Member Coca for the compliment.

VII. **BOARD REPORTS:** The Southern Nevada District Board of Health members may identify and comment on Health District related issues. Comments made by individual Board members during this portion of the agenda will not be acted upon by the Southern Nevada District Board of Health unless that subject is on the agenda and scheduled for action. *(Information Only)*

Vice Chair Feliz-Barrow called for board reports.

Member Coca shared that Chair Melendrez will be honored in September or October by the School of Public for the work he has done in his role at UNLV.

IX. **CEO & STAFF REPORTS** *(Information Only)*

- CEO Comments

  Mr. Smith advised the board of the HRSA requirements of the Chief Executive Officer annual review, the evaluation process and timeline. Mr. Smith further advised of the evaluation tool which includes four scored questions, each weighted, and two non-scored questions.

- CY23 Clinical Performance Measures

  Mr. Smith provided an overview and update on the CY23 Clinical Performance Measures. Mr. Smith reviewed the year over year comparison for preventative, chronic disease and maternal and childhood health measures.

- CY23 Nevada FQHC Comparison Report

  Mr. Smith provided an update on the CY23 Nevada FQHC Comparison Report.

  Mr. Smith further provided an update on the following:
  - August Access Report (visits only conducted by a licensed independent practitioner)
  - Unduplicated Patients and Visit Counts
  - 2024 Medicaid Visits – Actuals vs. Goal
  - Medicaid Patients Empaneled

- Administrative Updates
  - HRSA Operational Site Visit tentatively scheduled for quarter one of CY25.
  - HRSA New Access Point application due on September 30, 2024.
  - Construction of the new Behavioral Health Clinic at Decatur is anticipated to be complete by September 23, 2024.
  - Architectural plans for the Dental Clinic at Fremont are in review.
  - Medical Director recruitment ongoing.
  - New Family Medicine Doctor will start in October 2024.
  - The annual employee evaluation process is underway.
  - Employee Recognitions:
    - On the Spot Awards
      - 11 employees recognized.
    - Exemplary Service
      - One employee recognized.

There were no further questions or comments.

X. INFORMATIONAL ITEMS

- Community Health Center (FQHC) August 2024 Operations Reports

XI. SECOND PUBLIC COMMENT:

A period devoted to comments by the general public, if any, and discussion of those comments, about matters relevant to the Board's jurisdiction will be held. Comments will be limited to five (5) minutes per speaker. If any member of the Board wishes to extend the length of a presentation, this may be done by the Chair or the Board by majority vote.

Seeing no one, the Vice Chair closed the Second Public Comment period.

XII. ADJOURNMENT

The Vice Chair adjourned the meeting at 3:51 p.m.

Randy Smith
Chief Executive Officer - FQHC

/tab

SOUTHERN NEVADA Community HEALTH CENTER

AT THE SOUTHERN NEVADA HEALTH DISTRICT

SNCHC Governing Board Meeting

October 15, 2024

I. CALL TO ORDER & ROLL CALL

Instructions for public comment are provided to virtual attendees.

SOUTHERN NEVADA Community HEALTH CENTER
AT THE SOUTHERN NEVADA HEALTH DISTRICT

II. PLEDGE OF ALLEGIANCE

III. FIRST PUBLIC COMMENT

A period devoted to comments by the general public about those items appearing on the agenda. Comments will be limited to five (5) minutes per speaker. **Please clearly state and spell your name for the record.** If any member of the Board wishes to extend the length of a presentation, this may be done by the Chair or the Board by majority vote. **There will be two public comment periods.**

IV. ADOPTION OF THE OCTOBER 15, 2024 AGENDA

(for possible action)

Motion to Adopt the October 15, 2024 agenda, as presented.

SOUTHERN NEVADA Community HEALTH CENTER
AT THE SOUTHERN NEVADA HEALTH DISTRICT

V. CONSENT AGENDA:

Items for action to be considered by the Southern Nevada Community Health Center Governing Board which may be enacted by one motion. Any item may be discussed separately per Board Member request before action. Any exceptions to the Consent Agenda must be stated prior to approval.

1. **APPROVE MINUTES – SNCHC GOVERNING BOARD MEETING**: September 17, 2024 *(for possible action)*

2. **Approve Initial Credentialing and Privileging of Provider Michelle Jordan, DO;** direct staff accordingly or take other action as deemed necessary *(for possible action)*

Motion to approve the consent agenda, as presented.

SOUTHERN NEVADA Community HEALTH CENTER
AT THE SOUTHERN NEVADA HEALTH DISTRICT

VI. REPORT / DISCUSSION / ACTION

SOUTHERN NEVADA Community HEALTH CENTER
AT THE SOUTHERN NEVADA HEALTH DISTRICT

Recommendations from the October 14, 2024 Finance and Audit Committee Meeting

1. **Receive, Discuss and Accept the August 2024 Year to Date Financial Report**; direct staff accordingly or take other action as deemed necessary *(for possible action)*

SOUTHERN NEVADA Community HEALTH CENTER
AT THE SOUTHERN NEVADA HEALTH DISTRICT

SOUTHERN NEVADA Community HEALTH CENTER

AT THE SOUTHERN NEVADA HEALTH DISTRICT

Financial Report
Results as of August 31, 2024

(Unaudited)

Summary of Revenue, Expenses and Net Position (August 31, 2024 – Unaudited)

Revenue

- General Fund revenue (Charges for Services & Other) is $5.67M compared to a budget of $4.69M, a favorable variance of $978K.
- Special Revenue Funds (Grants) is $1.49M compared to a budget of $1.31M, a favorable variance of $174K.
- Total Revenue is $7.15M compared to a budget of $6.00M, a favorable variance of $1.15M.

Expenses

- Salary, Tax, and Benefits is $2.26M compared to a budget of $2.29M, a favorable variance of $23K.
- Other Operating Expense is $5.20M compared to a budget of $4.04M, an unfavorable variance of $1.17M.
- Indirect Cost/Cost Allocation is $1.30M compared to a budget of $1.28M, an unfavorable variance of $20K.
- Total Expense is $8.76M compared to a budget of $7.60M, an unfavorable variance of $1.16M.

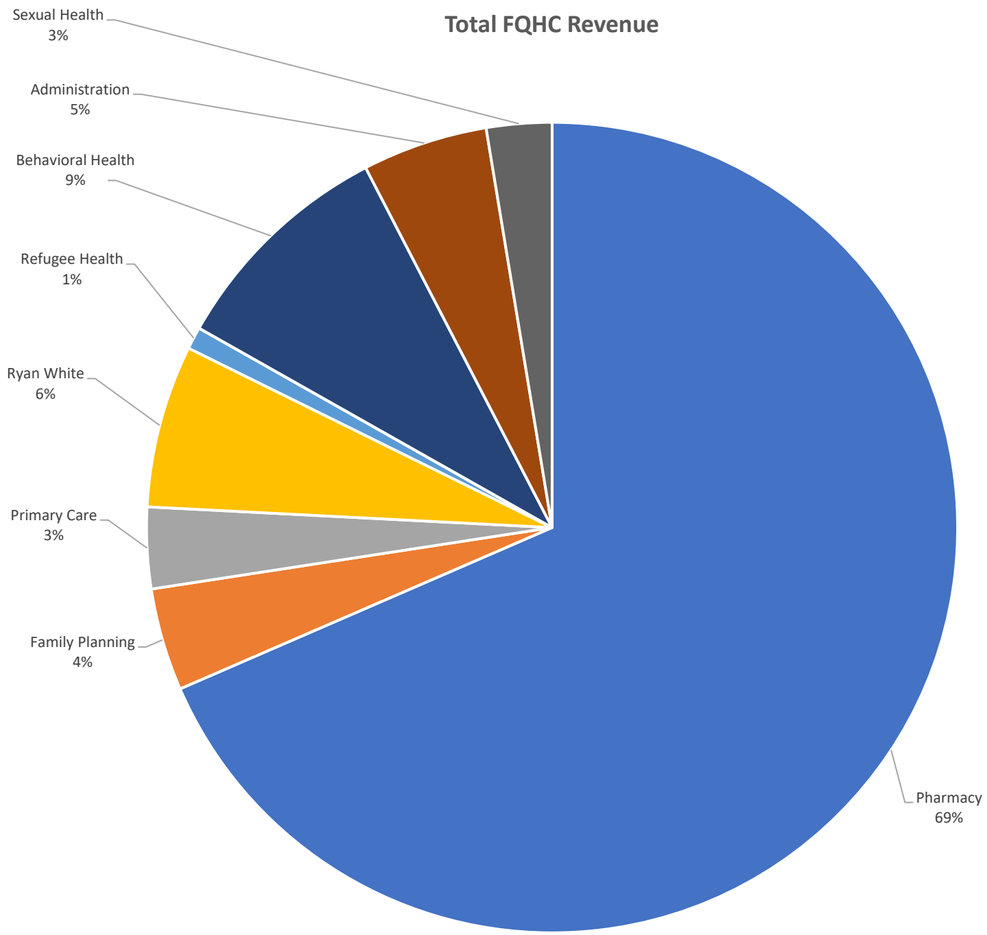
Net Position: is ($1.61M) compared to a budget of ($1.60M), an unfavorable variance of $11K.

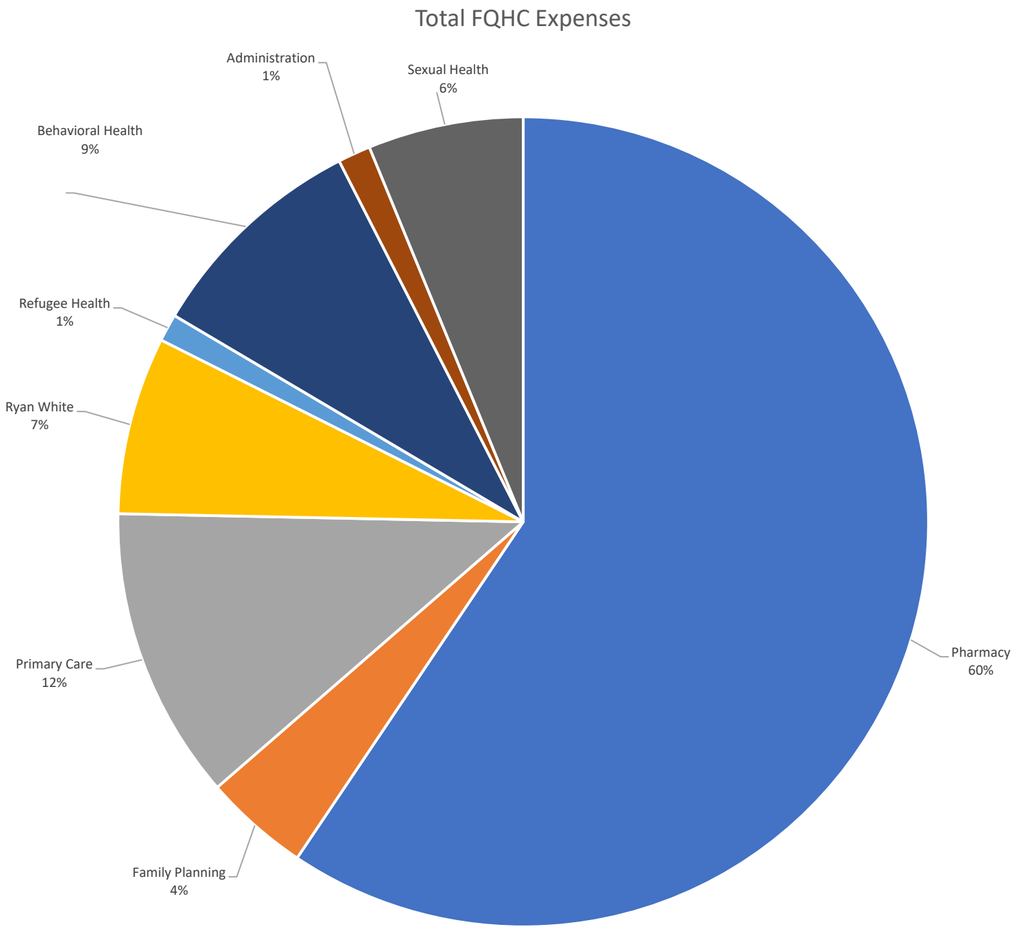
All Funds/Divisions by Type
Budget to Actual

Activity	Budget as of August	Actual as of August	Variance Favorable (Unfavorable)	%	
Charges for Services	4,505,282	5,285,755	780,473	17%	1
Other	184,445	382,110	197,665	107%	2
Federal Revenue	493,197	960,694	467,498	95%	3
Pass-Thru Revenue	606,386	463,716	(142,670)	-24%	
State Revenue	211,902	61,600	(150,302)	-71%	
Total FQHC Revenue	6,001,211	7,153,876	1,152,664	19%	
Salaries	1,568,646	1,558,512	10,133	1%	
Taxes & Fringe Benefits	719,288	705,986	13,301	2%	
Total Salaries & Benefits	2,287,933	2,264,499	23,435	1%	
Supplies	3,620,385	4,404,703	(784,319)	-22%	4
Capital Outlay	152,017	575,602	(423,585)	-279%	5
Contractual	254,048	220,007	34,041	13%	
Travel & Training	11,024	4,472	6,552	59%	
Total Other Operating	4,037,474	5,204,784	(1,167,310)	-29%	
Indirect Costs/Cost Allocations	1,278,042	1,298,081	(20,039)	-2%	
Transfers IN	(117,840)	(82,894)	(34,946)	30%	
Transfers OUT	117,840	82,894	34,946	30%	
Total Transfers	1,278,042	1,298,081	(20,039)	-2%	
Total FQHC Expenses	7,603,449	8,767,364	(1,163,914)	-15%	
Net Position	(1,602,238)	(1,613,488)	(11,250)	1%	

NOTES:
1) PHARMACY PATIENT ENCOUNTERS DRIVING MAJORITY OF GROWTH; PATIENT ENCOUNTERS CONTINUE YEAR-OVER-YEAR GROWTH ACROSS FQHC (+31%).
2) WRAP REVENUE REIMBURSEMENTS ARE CONTINUING TO OUTPACE PROJECTIONS IN FY25.
3) INCLUDES PAYMENT FOR GRANT-FUNDED REIMBURSEMENTS FOR BEHAVIORAL HEALTH CLINIC CAPITAL EXPENSES.
4) PHARMACY PATIENT ENCOUNTERS DRIVING CORRESPONDING INCREASE IN MEDICATION SUPPLIES EXPENSES.
5) CAPITAL EXPENSES ASSOCIATED WITH CONSTRUCTION OF NEW BEHAVIORAL HEALTH CLINIC.

Percentage of Revenues and Expenses by Department





Revenues by Department
Budget to Actuals

Department	Budget as of August	Actual as of August	Variance Favorable (Unfavorable)	%	
Charges for Services, Other, Wrap					
Family Planning	66,440	31,298	(35,142)	-53%	
Pharmacy	4,124,477	4,881,701	757,224	18%	
Oral Health (Dental)	-	-	-	0%	1
Primary Care	84,338	79,579	(4,759)	-6%	
Ryan White	46,084	44,528	(1,556)	-3%	
Refugee Health	9,028	17,323	8,295	92%	
Behavioral Health	45,966	45,683	(283)	-1%	
Administration	183,526	382,110	198,584	108%	2
Sexual Health	129,867	185,663	55,796	43%	
OPERATING REVENUE	**4,689,727**	**5,667,885**	**978,159**	**21%**	
Grants					
Family Planning	353,515	260,168	(93,347)	-26%	
Oral Health (Dental)	182,976	-	(182,976)	-100%	1
Primary Care	168,609	151,544	(17,065)	-10%	
Ryan White	433,307	417,708	(15,599)	-4%	
Refugee Health	37,785	46,008	8,223	22%	
Behavioral Health	135,294	610,583	475,289	351%	3
SPECIAL REVENUE	**1,311,485**	**1,486,010**	**174,526**	**13%**	
TOTAL REVENUE	**6,001,211**	**7,153,896**	**1,152,684**	**19%**	

NOTES:
1) DENTAL CLINIC PLANNED OPENING IN Q4 FY25.
2) WRAP REVENUE REIMBURSEMENTS ARE CONTINUING TO OUTPACE PROJECTIONS IN FY25.
3) INCLUDES PAYMENT FOR GRANT-FUNDED REIMBURSEMENTS FOR BEHAVIORAL HEALTH CLINIC CAPITAL EXPENSES.

Expenses by Department

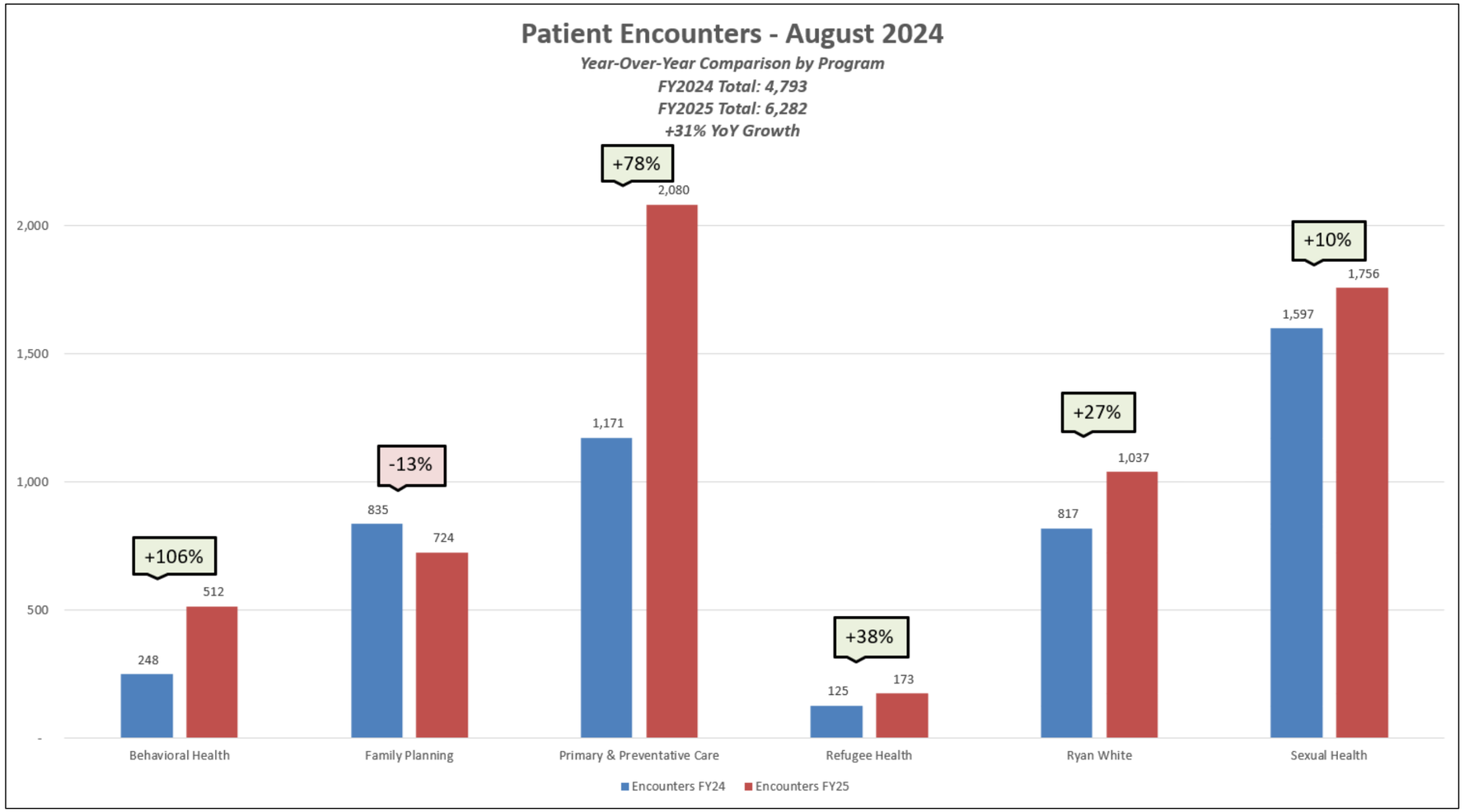
Budget to Actuals

Department	Budget as of August	Actual as of August	Variance Favorable (Unfavorable)	%	
Employment (Salaries, Taxes, Fringe)					
Family Planning	385,306	293,470	91,836	24%	
Pharmacy	91,010	107,727	(16,716)	-18%	
Oral Health (Dental)	18,899	-	18,899	100%	1
Primary Care	765,485	805,116	(39,631)	-5%	
Ryan White	450,957	461,134	(10,177)	-2%	
Refugee Health	30,980	43,981	(13,001)	-42%	
Behavioral Health	83,116	110,573	(27,457)	-33%	
Administration	19,520	23,822	(4,302)	-22%	
Sexual Health	442,661	418,677	23,983	5%	
Total Personnel Costs	2,287,933	2,264,499	23,435	1%	
Other (Supplies, Contractual, Capital, etc.)					
Family Planning	140,410	20,140	120,270	86%	
Pharmacy	3,392,230	4,330,517	(938,288)	-28%	2
Oral Health (Dental)	133,581	-	133,581	100%	1
Primary Care	49,411	68,936	(19,525)	-40%	
Ryan White	63,331	68,452	(5,121)	-8%	
Refugee Health	22,331	37,815	(15,484)	-69%	
Behavioral Health	99,548	561,059	(461,511)	-464%	3
Administration	94,362	73,569	20,792	22%	
Sexual Health	42,271	44,295	(2,025)	-5%	
Total Other Expenses	4,037,474	5,204,784	(1,167,310)	-29%	
Total Operating Expenses	6,325,407	7,469,283	(1,143,876)	-18%	
Indirect Costs/Cost Allocations	1,278,042	1,298,081	(20,039)	-2%	
Transfers IN	(117,840)	(82,894)	(34,946)	30%	
Transfers OUT	117,840	82,894	34,946	30%	
Total Transfers & Allocations	1,278,042	1,298,081	(20,039)	-2%	
TOTAL EXPENSES	7,603,449	8,767,364	(1,163,914)	-15%	

NOTES:

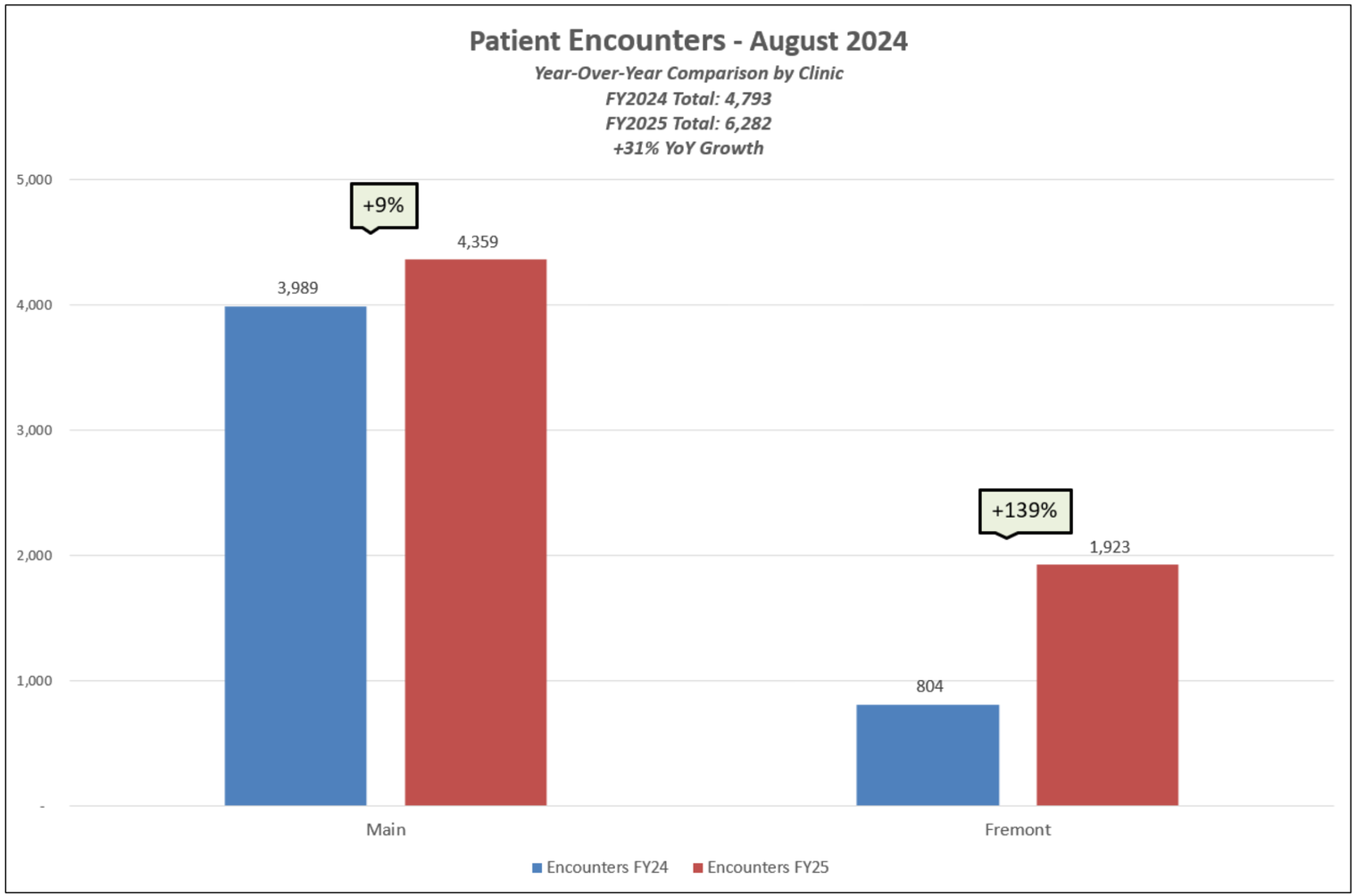
1) DENTAL CLINIC PLANNED OPENING IN Q4 FY25.
2) PHARMACY PATIENT ENCOUNTERS DRIVING CORRESPONDING INCREASE IN MEDICATION SUPPLIES EXPENSES.
3) CAPITAL EXPENSES ASSOCIATED WITH CONSTRUCTION OF NEW BEHAVIORAL HEALTH CLINIC.

Patient Encounters By Department



NOTE 1: PATIENT ENCOUNTERS INCLUDE VISITS PROVIDED BY LICENSED INDEPENDENT PRACTITIONERS (LIPS) AND NURSES. FY24 AND FY25 SEXUAL HEALTH CLINIC ENCOUNTERS DO NOT INCLUDE SELECT NURSE VISITS THAT ARE NOW PROVIDED IN THE PRIMARY AND PREVENTIVE CARE DIVISION.
NOTE 2: ENCOUNTER VOLUME INCREASING DUE TO FILLING AND CREDENTIALLING ALL OPEN POSITIONS COMBINED WITH PROCESS IMPROVEMENT IMPLEMENTATIONS FOLLOWING CONSOLIDATION OF SHC AND RHC UNDER FQHC.

Patient Encounters By Clinic



Financial Report Categorization

Statement Category – Revenue	Elements
Charges for Services	Fees received for medical services provided from patients, insurance companies, Medicare, and Medicaid.
Other	Medicaid MCO reimbursements (the wrap), administrative fees, and miscellaneous income (sale of fixed assets, payments on uncollectible charges, etc.).
Grants	Reimbursements for grant-funded operations via Local, State, Federal, and Pass-Through grants.

Statement Category – Expenses	Elements
Salaries, Taxes, and Benefits	Salaries, overtime, stand-by pay, retirement, health insurance, long-term disability, life insurance, etc.
Travel and Training	Mileage reimbursement, training registrations, hotel, flights, rental cars, and meeting expenses pre-approved, job-specific training and professional development.
Supplies	Medical supplies, medications, vaccines, laboratory supplies, office supplies, building supplies, books and reference materials, etc.
Contractual	Temporary staffing for medical/patient/laboratory services, subrecipient expenses, dues/memberships, insurance premiums, advertising, and other professional services.
Property/Capital Outlay	Fixed assets (i.e. buildings, improvements, equipment, vehicles, computers, etc.)
Indirect/Cost Allocation	Indirect/administrative expenses for grant management and allocated costs for shared services (i.e. Executive leadership, finance, IT, facilities, security, etc.)

Questions?

Motion to accept the August 2024 Year to Date Financial Report, as presented.

Recommendations from the October 9, 2024 Quality, Credentialing & Risk Management Committee Meeting

2. **Receive, Discuss and Accept the Third Quarter Risk Management Report;** direct staff accordingly or take other action as deemed necessary *(for possible action)*

SOUTHERN NEVADA Community HEALTH CENTER
AT THE SOUTHERN NEVADA HEALTH DISTRICT

Q3 Risk Management Report

Calendar Year 2024 Update: January 1, 2024, through September 30, 2024

Q3 and YTD Risk Management Report

SOUTHERN NEVADA Community HEALTH CENTER

CY24 Risk Management Report

CY24 Goals	Baseline	CY24 Activities (What, Who, When)	CY24 Performance
			# of Medication Errors
Goal #1: Reduce medication errors to 0.	CY22 – 7 errors CY23 – 3 errors	• Implementation of the vaccine administration training and competency checklist, which is reviewed one by one during employee evaluation, and updated by the supervisor annually. • Annual vaccine administration training every September organized and facilitated by the Vaccine Coordinator.	Q1: 0 Q2: 0 Q3: 0 Q4: 0 CY24 Result: **0 Med errors** in CY24 compared to 3 Med errors in CY23
			# of Bluebird responses under 2 Minutes
Goal #2: Reduce delayed response time for Dr. Bluebird events by 50% year over year.	CY22 – 25% of bluebird incidents w/response time at or longer than 2 min CY23 – 4% bluebird incidents w/response time at or longer than 2 min	• Clinical staff and Chief Nurse are working to revise the current policy for medical events, that will include training for staff responding to medical events. This is currently in process and should be ready for presentation in Q3. • Inspect and verify the crash carts are labeled and stocked with supplies. • Mapping of AEDs and provide biannual training for use of AEDs when BLS licenses are renewed.	Q1: 3/3 response time under 2 min Q2: 1/1 response time under 2 min Q3: 16/17 response time under 2 min Q4: CY24 Result: 20/21 (95.2%) < 2-minute response compared to 96% < 2-minute response in CY23
			# of Employee Injuries
Goal #3: Reduce the number of employee injuries to 0.	1 employee injury in 2022 2 employee injuries in 2023	• Safety Officer and Security training on Active Shooter and parking lot safety in February of 2024. • Director of Facilities and Security and the Safety Officer will organize a way to monitor safety and security on a regular basis by Q3.	Q1: 0 Q2: 0 Q3: 0 Q4: 0 CY24 Result: **0 Employee injuries** compared to 2 Employee injuries in CY23
			# of Incident Reports Completed
Goal #4: Improve the reporting of actual or potential incidents.	15 total incidents reported in CY22 65 total incidents reported in CY23	• FQHC Administrative Manager to create, implement, and monitor the new Incident Reporting process. • FQHC Administrative Manager to create, implement, and monitor the new incident reporting forms. • FQHC Administrative Manager to keep statistics of types of incidents being reported, severity of incidents, and the number of incidents. • FQHC Administrative Manager to review the findings with the Quarterly Quality, Risk Management, and Credentialing Committee.	2024 2023 Q1: 15 16 Q2: 12 9 Q3: 25 18 Q4: CY24 Result: **52 incident reports submitted through Q3 of 2024** compared to 43 incident reports submitted through Q3 of CY23, a **20.9% increase in the number of incidents reported.**

Q3 and YTD Risk Management Report

SOUTHERN NEVADA Community HEALTH CENTER

CY24 Risk Management Report

			Clinical Obstetric Measures

Goal #5: Implement workflow to track prenatal services and baby birth weights to help mitigate obstetric risks, and ensure appropriate care is received.	CY23 0 prenatal visits/referrals documented
	CY23 0 newborn birth weights documented
		• Verify eCW documentation requirements to capture data for patients by age who received prenatal visits/referrals by trimester of pregnancy
		  ○ UDS Table 6b Sections A & B
		• Verify eCW documentation requirements to capture data for the newborn birthweights (in grams) being documented by race/ethnicity.
		  ○ UDS Table 7a - Birthweight
		• FQHC Operations Managers to develop and implement a workflow and process to
		  ○ document and track prenatal pts by age and
		  ○ document and track prenatal pts by which trimester their pregnancy is in per UDS requirements
		  ○ document whether SNCHC conducted the prenatal visit or provided the patient a referral to another provider for prenatal care per UDS requirements.
		  ▪ Follow up with referred patients to document status of pregnancy, and ensure prenatal, intrapartum, and postpartum care needs are planned.
		• FQHC Operations Managers to develop and implement a workflow and process to document and track newborn birth weights by race, per UDS requirements.
		• Adopt new Pregnancy Intention Screening practices to satisfy new UDS measure.
			**Q1:
			1. 0
			2. 0
			3. 0
			4. 0
			5. 550 / 1325 – 41.51%
			**Q2:
			1. 34
			2. 0
			3. 0
			4. 0
			5. 363 / 897 – 40.5%%
			**Q3:
			1. 10
			2. 0
			3. 0
			4. 0
			5. 589 / 1419 – 41.51%
			**Q4:
			1.
			2.
			3.
			4.
			5.
			**CY24 Results:
			1. 44
			2. 0
			3. 0
			4. 0
			5. 1502 / 3641 – 41.25%

**KEY

1. # of documented eligible pregnant pts by age
2. # of documented Pts listed by Trimester of Pregnancy
3. # of documented Prenatal visits or prenatal referrals
4. # of documented newborn birthweights by race
5. # of Pts screened for pregnancy intention vs. # of Pts eligible for screening

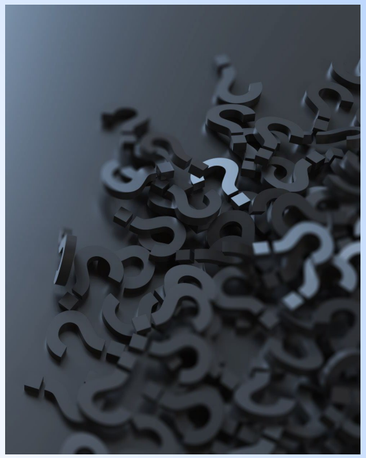
Action being taken on Goals 1-4 reflect the FTCA focus on the reduction of clinical errors

- CY24 Goals 1-4 are on track to show an improvement over CY23
- Steps being taken to improve Goals 1-4:
  - Monthly review with staff regarding:
    - Results
    - Reporting all incidents and close calls

Action being taken on Goal #5

- Goal #5 was added to align with FTCA focuses on clinical safety regarding obstetric care.
- Steps being taken to improve Goal #5:
  - AZARA reporting being tracked monthly
  - eCW/AZARA collaboration underway to discover where structured data is being pulled, so data can be captured when providers are entering the data.
  - Workflows being developed to capture, monitor, and improve results.
  - Pregnancy intention screening is already being captured.

Questions?



Motion to accept the Accept the Third Quarter Risk Management Report, as presented.

SOUTHERN NEVADA Community HEALTH CENTER

AT THE SOUTHERN NEVADA HEALTH DISTRICT

3. **Receive, Discuss and Accept the Third Quarter Risk Management Assessment;** direct staff accordingly or take other action as deemed necessary *(for possible action)*

SOUTHERN NEVADA Community HEALTH CENTER
AT THE SOUTHERN NEVADA HEALTH DISTRICT

Risk Assessment and Mitigation Tool: Infection Prevention and Control (IPC)

Information provided by ECRI is not intended to be viewed as required by ECRI or the Health Resources and Services Administration, nor should these materials be viewed as reflecting the legal standard of care. Further, these materials should not be construed as dictating an exclusive course of treatment or procedure. Practice by providers varies, for reasons including the needs of the individual patient and limitations unique to the institution or type of practice. Best practice recommendations change over time. All organizations should consult with their clinical staff or other experts for specific guidance and with their legal counsel, as circumstances warrant.

- Refer to the “Guidance and Resources” section at the end of the document for pertinent references and resources.

Objective	Yes/No	Comments/Supportive Documentation
A. Leadership and Accountability		--
IPC plans, policies, and procedures include non-clinical and clinical services (e.g., medical, dental, obstetrical, optometry, podiatry, chiropractic services).	NO	-- No Infection Prevention Control (IPC) Policy can be found, so one needs to be developed, including all elements that pertain to this risk assessment. NEED TO DEVELOP AN FQHC POLICY/SOP FOR INFECTION PREVENTION AND CONTROL (IPC).
As a best practice, the organization designates an individual (at least one) who is trained in IPC and who is responsible for overall IPC management and compliance.	NO	-- No IPC Officer has been officially delegated. NEED TO HAVE LEADERSHIP DECIDE WHO SHOULD BE RESPONSIBLE FOR IPC MANAGEMENT AND COMPLIANCE AND ENSURE PROVISION OF TRAINING AN IPC CERTIFICATION.
As a best practice, the person designated as responsible for overall IPC management and compliance obtains a certificate in IPC.	NO	-- No IPC Certification is currently required for a clinical supervisor. NEED TO HAVE LEADERSHIP DECIDE WHO SHOULD BE RESPONSIBLE FOR IPC MANAGEMENT AND COMPLIANCE AND ENSURE PROVISION OF TRAINING AN IPC CERTIFICATION.

Objective	Yes/No	Comments/Supportive Documentation
The organization assesses and provides resources, equipment, and supplies that are appropriate and in sufficient amounts to ensure staff have the tools necessary to adhere to disinfection, sterilization, and IPC policies.	YES	-- SUPPLIES AND EQUIPMENT ARE KEPT IN INVENTORY TO PROPERLY DISINFECT AND STERILIZE ROOMS, EQUIPMENT, AND TOOLS.
The organization incorporates the Centers for Disease Control and Prevention (CDC) and state immunization recommendations for healthcare workers in the IPC plan.	NO	-- There is no IPC policy, making this item non-compliant.
The organization collects, analyzes, tracks, monitors, and reports the IPC plan and outcomes to leadership and the board.	NO	-- No IPC data or reports are being tracked, analyzed, nor presented to leadership. ALTHOUGH RISK ASSESSMENT, INCIDENT DATA, AND PLANS ARE PRESENTED TO LEADERSIHP, THE QUALITY RISK AND CREDENTIALING COMMITTEE OF THE GOVERNING BOARD, AND TO THE GOVERNING BOARD, THERE IS NOT A SPECIFIC INFECTION PREVENTION CONTROL POLICY FOR THE FQHC YET.
The organization provides and maintains documentation for IPC training and competency testing as a requirement upon hiring, annually, and when new tasks or procedures are started in the health center.	YES	-- IPC TRAINING IS CONDUCTED FOR ALL CLINICAL STAFF ANNUALLY FOR HAND HYGIENE, BLOOD BORNE PATHOGENS, AND SAFE INJECTION PRACTICES. TRAINING IS TRACKED AND UPDATED FOR FTCA COMPLIANCE. COMMUNITY HEALTH NURSE MANAGERS OVERSEE COMPETENCIES, WORKFLOWS, AND PRACTICES.
As a best practice, the organization supports safe injection practices with additional training and competency evaluations for staff who administer injectable medications.	YES	-- SAFE INJECTION TRAINING IS PROVIDED ANNUALLY TO ALL CLINICAL STAFF. COMMUNITY HEALTH NURSE MANAGERS OVERSEE COMPETENCIES, WORKFLOWS, AND PRACTICES.

Objective	Yes/No	Comments/Supportive Documentation
The organization arranges for additional training and maintain documentation on competency evaluations for staff assigned to reprocessing medical devices tasks (i.e., high-level disinfection; sterilization of instruments, equipment, and devices).	NO	-- COMPETENCY EVALUATIONS OF STAFF - No evaluation process is established to monitor staff competency.
B. Communication and Documentation		--
The organization has developed communication materials about managing an exposure or breach in IPC (e.g., reporting to state agencies, patient notification, patient testing if indicated).	YES	-- SNCHC IS THE FQHC DIVISION OF THE SOUTHERN NEVADA HEALTH DISTRICT, THE GOVERNING PUBLIC HEALTH AUTHORITY FOR SOUTHERN NEVADA. AS SUCH, INTERNAL PROCESSES HAVE BEEN ESTABLISHED TO COMMUNICATE BREACHES IN INFECTION CONTROL, INCLUDING REPORTING TO PERTINENT AUTHORITIES AND PATIENTS.
The organization retains documentation for routine equipment maintenance, quality test results, and employee trainings.	NO	-- No documentation found the documents routine equipment maintenance, nor quality test results. Third party vendor provides bi-annual inspection, calibration, and repair of all medical equipment, but documentation is not readily available for review. THERE ARE TRACKERS FOR INVENTORY MANAGEMENT, HOWEVER, THERE ARE NOT EQUIPMENT MAINTENANCE, QUALITY TEST RESULT, OR EMPLOYEE TRAINING RECORDS FOR EQUIPMENT.
The organization retains and ensures staff can access manufacturer’s instructions for use of instruments, equipment, devices, and cleaning and disinfection products.	NO	-- There is no current process to retain manufacturer’s instructions for us of instruments, equipment, devices, and cleaning/disinfection products where staff can access them.

Objective	Yes/No	Comments/Supportive Documentation
The organization preserves from each sterilizer the logs/records of sterilization cycles and monitoring measures (mechanical, chemical, and biological) according to CDC, state, and local regulations.	NO	-- The logs for each sterilizer of sterilization cycles seems to be monitored, but it is unclear if logs/records are compliant with CDC, State, and local regulations.
C. Patient Safety, Risk, Quality		--
The organization monitors community transmission levels to decide what infection control interventions need to be implemented.	YES	-- SNCHC IS THE FQHC DIVISION OF THE SOUTHERN NEVADA HEALTH DISTRICT, THE GOVERNING PUBLIC HEALTH AUTHORITY FOR SOUTHERN NEVADA. AS SUCH, INTERNAL PROCESSES HAVE BEEN ESTABLISHED TO COMMUNICATE BREACHES IN INFECTION CONTROL, INCLUDING REPORTING TO PERTINENT AUTHORITIES AND PATIENTS.
The organization performs a risk assessment at least annually to help prioritize resources for areas that pose greater risks to patients and staff and to prevent outbreaks.	NO	-- Annual IPC Risk Assessments have not formally been done before. This is the inaugural IPC Risk Assessment, and it will now be conducted annually as a part of FTCA's quarterly risk assessment requirement. INFECTION PREVENTION AND CONTROL RISK ASSESSMENT WILL BE CONDUCTED ANNUALLY FOR FTCA COMPLIANCE AND INCIDENT PREVENTION.
The organization conducts infection control rounds periodically (e.g., quarterly as a best practice, annually) to ensure procedures have been correctly implemented.	NO	-- IPC rounds are not being conducted with intent to monitor IPC. INFECTION PREVENTION AND CONTROL RISK ASSESSMENT WILL BE CONDUCTED ANNUALLY FOR FTCA & POLICY COMPLIANCE AND INCIDENT PREVENTION.

Objective	Yes/No	Comments/Supportive Documentation
The organization adheres to local, state, and federal requirements for surveillance, disease, and outbreak reporting.	YES	-- SNCHC IS THE FQHC DIVISION OF THE SOUTHERN NEVADA HEALTH DISTRICT, THE GOVERNING PUBLIC HEALTH AUTHORITY FOR SOUTHERN NEVADA. AS SUCH, INTERNAL PROCESSES HAVE BEEN ESTABLISHED TO COMMUNICATE BREACHES IN INFECTION CONTROL, INCLUDING REPORTING TO PERTINENT AUTHORITIES AND PATIENTS.
D. Procedures		--
IPC procedures include, but are not limited to, hand hygiene, choice of personal protective equipment, mask usage, safe injection practices, and sharps handling practices.	YES	-- IPC TRAINING IS CONDUCTED FOR ALL CLINICAL STAFF ANNUALLY FOR HAND HYGIENE, BLOOD BORNE PATHOGENS, AND SAFE INJECTION PRACTICES. TRAINING IS TRACKED AND UPDATED FOR FTCA COMPLIANCE. THERE IS ALSO TRAINING FOR PROPER DONNING, USAGE, AND DOFFING OF PPE.COMMUNITY HEALTH NURSE MANAGERS OVERSEE COMPETENCIES, WORKFLOWS, AND PRACTICES.
The organization utilizes manufacturer's instructions when writing policies for all reusable medical/surgical/dental devices and equipment cleaning, proper solution, and soak/dwell times.	YES	-- ALTHOUGH THESE PRACTICES ARE ALREADY IN PLACE, THIS WILL BE ADDRESSED IN THE IPC POLICY WHEN THE POLICY IS CREATED, THIS WILL BE COMPLIANT.

Objective	Yes/No	Comments/Supportive Documentation
The organization has developed a procedure for checking expiration dates, proper storage, and temperatures for supplies, vaccines, and medications and recording the procedure.	NO	-- There are some practices in place to monitor expiration dates, proper storage, and temperatures for supplies, vaccines, and medications, however, there is not a formal health center policy/procedure that can be identified that sets clear expectations to be followed. ALTHOUGH THESE PRACTICES ARE ALREADY IN PLACE, THIS WILL BE ADDRESSED IN THE IPC POLICY WHEN THE POLICY IS CREATED, THIS WILL BE COMPLIANT.
The organization has developed a system for early detection and management of potentially infectious persons at initial points of the patient encounter.	NO	-- There are some practices in place for early detection and management of potentially infectious persons at initial points of patient encounter, however there is still a need for a formal health center policy/procedure that can be identified that sets clear expectations to be followed. ALTHOUGH THESE PRACTICES ARE ALREADY IN PLACE, THIS WILL BE ADDRESSED IN THE IPC POLICY WHEN THE POLICY IS CREATED, THIS WILL BE COMPLIANT.
The organization has trained staff to initiate standard, airborne, contact, and droplet precautions based on policy guidelines.	NO	-- There are some practices in place for initiation of standard, airborne, contact, and droplet precautions, however there is still a need for a formal health center policy/procedure that can be identified that sets clear expectations to be followed. ALTHOUGH THESE PRACTICES ARE ALREADY IN PLACE, THIS WILL BE ADDRESSED IN THE IPC POLICY WHEN THE POLICY IS CREATED, THIS WILL BE COMPLIANT.

Objective	Yes/No	Comments/Supportive Documentation
The organization enforces CDC safe injection and sharps safety guidelines.	NO	-- There is no IPC policy, making the requirement to use CDC safe injection and sharps safety guidelines non-compliant. ALTHOUGH THESE PRACTICES ARE ALREADY IN PLACE, THIS WILL BE ADDRESSED IN THE IPC POLICY WHEN THE POLICY IS CREATED, THIS WILL BE COMPLIANT.
The organization utilizes the special work practices of one-hand scoop technique and removal of burs before disconnecting in dental procedures.*	N/A	-- DENTAL SERVICES ARE NOT AVAILABLE AT SNCHC YET BUT WILL LIKELY BECOME AVAILABE IN THE NEXT YEAR.
The organization assesses infection prevention skill and technique by observation and simulation as part of the risk management plan.	N/A	-- IPC IS NOT CURRENTLY A GOAL LISTED ON THE RISK MANAGEMENT PLAN, HOWEVER, IT WILL BECOME A PART OF THE IPC POLICY.
E. Emergency Concerns		
The organization acts promptly when exposures or outbreaks of bacteria, viruses, parasites (e.g., measles, mumps, bed bugs) occur.	NO	-- There is an internal process in SNHD to mitigate and manage exposures or outbreaks of bacteria, viruses, parasites, etc., however, there is not a formal health policy/procedure that can be identified that sets clear expectations to be followed. SNCHC IS THE FQHC DIVISION OF THE SOUTHERN NEVADA HEALTH DISTRICT, THE GOVERNING PUBLIC HEALTH AUTHORITY FOR SOUTHERN NEVADA. AS SUCH, INTERNAL PROCESSES HAVE BEEN ESTABLISHED TO COMMUNICATE BREACHES IN INFECTION CONTROL, INCLUDING REPORTING TO PERTINENT AUTHORITIES AND PATIENTS.

* Items marked with a (*) apply only to dental services.

Objective	Yes/No	Comments/Supportive Documentation
The organization follows the bloodborne pathogen and exposure control plan directions to ensure time-sensitive actions are promptly initiated.	NO	-- There is annual bloodborne pathogen training for clinical team members conducted annually, however, there is not a formal health policy/procedure that can be identified that sets clear expectations to be followed.ALTHOUGH THERE IS ANNUAL TRAINING PROVIDED TO THE CLINICAL TEAM REGARDING BLOODBORNE PATHOGEN EXPOSURE AND CONTROL, THERE IS NOT A SPECIFIED PLAN, HOWEVER, IT WILL BECOME A PART OF THE IPC POLICY.
When mechanical, chemical, or biological test results suggest that a sterilizer is not functioning promptly, the organization responds promptly by recalling sterilized devices, removing the sterilizer from service, and conducting repeat testing.	NO	- There are some practices in place that address the response process for when mechanical, chemical, or biological test results suggest that a sterilizer is not functioning promptly, and if the team responds promptly by recalling sterilized devices, removing the sterilizer from service, and conducting repeat testing, however there is still a need for a global formal health center policy/procedure that can be identified that sets clear expectations to be followed. ALTHOUGH THESE PRACTICES ARE ALREADY IN PLACE, THIS WILL BE ADDRESSED IN THE IPC POLICY WHEN THE POLICY IS CREATED, THIS WILL BE COMPLIANT.
F. Sterilization and Disinfection	--	--
The organization ensures that single-use (disposable) devices are not reprocessed and that they are properly disposed of after one use.	YES	-- ALTHOUGH THESE PRACTICES ARE ALREADY IN PLACE, THIS WILL BE ADDRESSED IN THE IPC POLICY. WHEN THE POLICY IS CREATED. Team was observed consistently disposing of single-use disposable devices like gloves, needles, etc.

Objective	Yes/No	Comments/Supportive Documentation
Staff clean and disinfect point-of-care testing devices after every use.	NO	-- ALTHOUGH THESE PRACTICES ARE ALREADY IN PLACE, THIS WILL BE ADDRESSED IN THE IPC POLICY WHEN THE POLICY IS CREATED Autoclave at Decatur is stored and used next to a coffee machine, where people prepare and consume beverages, possibly compromising the sterile environment needed surrounding a piece of equipment designed to sterilize and disinfect.
The organization sterilizes equipment that are classified as critical that penetrate soft tissue or bone (e.g., extraction forceps, scalpel blades, bone chisels, periodontal scalers, surgical scalpels, burs).	NO	-- There are practices in place to sterilize equipment classified as critical that penetrate soft tissue or bone, but there is not a formal health center IPC policy or procedure to govern compliance making this item non-compliant. ALTHOUGH THESE PRACTICES ARE ALREADY IN PLACE, THIS WILL BE ADDRESSED IN THE IPC POLICY WHEN THE POLICY IS CREATED
The organization sterilizes dental instruments that are not intended to penetrate soft tissue or bone (e.g., amalgam condensers, air-water syringes) but that might contact oral tissue and are heat tolerant, although classified as semi-critical. *	N/A	-- DENTAL SERVICES ARE NOT AVAILABLE AT SNCHC YET BUT WILL LIKELY BECOME AVAILABE IN THE NEXT YEAR.
The organization enforces that dental handpieces or intraoral devices are removed for sterilization or have U.S. Food and Drug Administration clearance not to be removed *	N/A	-- DENTAL SERVICES ARE NOT AVAILABLE AT SNCHC YET BUT WILL LIKELY BECOME AVAILABE IN THE NEXT YEAR.

Objective	Yes/No	Comments/Supportive Documentation
The organization performs high-level disinfection for reusable semi-critical equipment that touches either mucous membranes or nonintact skin, even if probe covers have been used (e.g., vaginal probes, speculums, cryosurgical probes, scopes, respiratory tubing).	NO	-- There are practices in place to govern high-level disinfection for reusable semi-critical equipment that touches either mucous membranes or nonintact skin, even if probe covers have been used, but there is not a formal health center IPC policy or procedure to govern compliance making this item non-compliant. ALTHOUGH THESE PRACTICES ARE ALREADY IN PLACE, THIS WILL BE ADDRESSED IN THE IPC POLICY WHEN THE POLICY IS CREATED. OTOSCOPE COVERS, THERMOMETER COVERS, DISPOSABLE SUPPLIES WERE WITNESSED BEING USED ONCE AND DISCARDED.
The organization performs low-level disinfection with a U.S. Environmental Protection Agency (EPA)-registered hospital disinfectant for non-critical patient care surfaces and equipment (e.g., blood pressure cuff, thermometer) that touch intact skin.	NO	-- The team uses a U.S. EPA-registered hospital disinfectant for non-critical patient care surfaces and equipment, however there is not a formal health center IPC policy to govern this practice, so it is non-compliant. Team was witnessed inconsistently disinfecting non-critical patient care surfaces and equipment during triage process despite the use of single use covers. ALTHOUGH THESE PRACTICES ARE ALREADY IN PLACE, THIS WILL BE ADDRESSED IN THE IPC POLICY WHEN THE POLICY IS CREATED
G. Environmental Safety		--
The organization consults with a heating, ventilation, and air conditioning (HVAC) professional to ensure that clinical airflow patterns and air exchanges per hour are sufficient to reduce airborne contaminants, including any viruses and bacteria produced from aerosolized procedures.	YES	-- SNHD HAS ITS OWN FACILITIES TEAM THAT HANDLES HVAC ISSUES AND CONSULTING WITH ANY OUTSIDE ORGANIZATIONS NEEDED TO MANAGE HVAC SYSTEMS. THERE IS ALSO A SECTION OF SNHD'S DECATUR LOCATION THAT HAS ITS OWN CLOSED HVAC SYSTEM FOR EVALUATING AND TREATING PATIENTS WHOSE ILLNESSES COULD BE TRASFERRED THROUGH THE AIR.

Objective	Yes/No	Comments/Supportive Documentation
Aerosol-generating procedures are performed cautiously to reduce spread (e.g., use of airborne infection isolation room, ultrasonic scaler, high-speed dental hand pieces, air/water syringe, nebulizers).	NO	-- ALTHOUGH THESE PRACTICES ARE ALREADY IN PLACE, THIS WILL BE ADDRESSED IN THE IPC POLICY WHEN THE POLICY IS CREATED. THERE IS A SECTION OF SNHD'S DECATUR LOCATION THAT HAS ITS OWN CLOSED HVAC SYSTEM FOR EVALUATING AND TREATING PATIENTS WHOSE ILLNESSES COULD BE TRASFERRED THROUGH THE AIR. However, there is no formal health center IPC policy to govern expectations on how to properly perform or monitor the aerosol-generating procedures.
The organization monitors dental treatment units' water quality to meet EPA standards for drinking, provided by the manufacturer of the unit or waterline treatment product. The organization uses sterile water as a coolant when performing surgery. *	N/A	-- DENTAL SERVICES ARE NOT AVAILABLE AT SNCHC YET BUT WILL LIKELY BECOME AVAILABE IN THE NEXT YEAR.
Staff respond to community boil water notices by following procedures on how to modify care delivery during such notices.	NO	-- ALTHOUGH THESE PRACTICES ARE ALREADY IN PLACE, THIS WILL BE ADDRESSED IN THE IPC POLICY WHEN THE POLICY IS CREATED. There is no formal health center IPC policy to govern expectations on how staff should respond to community boil water notices, or how to modify care delivery during such a notice.
Between patients, staff clean and disinfect or provide barrier protection to noncritical clinical contact surfaces that are touched often with gloved hands, that are likely to become contaminated with blood or body substances, and that are difficult to clean with EPA-registered hospital disinfectants (e.g., exam lamps, curing lights, light handles, dental units).	NO	-- ALTHOUGH THESE PRACTICES ARE ALREADY IN PLACE, THIS WILL BE ADDRESSED IN THE IPC POLICY WHEN THE POLICY IS CREATED. There is no formal health center IPC policy to govern expectations on how staff should clean and disinfect or provide barrier protection to noncritical clinical contact surfaces that are touched often with gloved hands, that are likely to become contaminated with blood or body substances, and that are difficult to clean with EPA-registered hospital disinfectants in between patients.

Objective	Yes/No	Comments/Supportive Documentation
Staff clean surfaces with EPA-registered products (e.g., floors, tabletops) on a regular basis, when spills occur, and when surfaces are visibly soiled.	NO	-- ALTHOUGH THESE PRACTICES ARE ALREADY IN PLACE, THIS WILL BE ADDRESSED IN THE IPC POLICY WHEN THE POLICY IS CREATED. There is no formal health center IPC policy to govern expectations on how staff should clean surfaces with EPA-registered products (e.g., floors, tabletops) on a regular basis, when spills occur, and when surfaces are visibly soiled.
Staff dispose of waste (e.g., regular, biohazard, sharps) properly following current state and federal regulations.	NO	-- ALTHOUGH THESE PRACTICES ARE ALREADY IN PLACE, THIS WILL BE ADDRESSED IN THE IPC POLICY WHEN THE POLICY IS CREATED. There is no formal health center IPC policy to govern expectations on how staff should dispose of waste (e.g., regular, biohazard, sharps) properly following current state and federal regulations.
H. Equipment and Technology Safety		--
The health center makes certain medical devices and instruments supplied by or on loan from vendors, contracted providers, mobile dental vans, or portable dental equipment meet or exceed infection control and equipment management requirements outlined in health center ICP policies and procedures.	NO	-- ALTHOUGH THESE PRACTICES ARE ALREADY IN PLACE, THIS WILL BE ADDRESSED IN THE IPC POLICY WHEN THE POLICY IS CREATED. There is no formal health center IPC policy to govern how the health center staff should monitor that medical devices and instruments meet or exceed infection control and equipment management requirements outlined in health center ICP policies and procedures.

Objective	Yes/No	Comments/Supportive Documentation
The health center has a preventive maintenance plan that includes routine and annual inspection, calibration, updates, and repair to ensure proper function.	NO	-- SNCHC USES A MEDICAL EQUIPMENT PREVENTIVE MAINTENANCE VENDOR TO INSPECT, CALIBRATE, UPDATE, AND REPAIR ALL MEDICAL EQUIPMENT AT ALL SITES, BUT DOES NTO HAVE A PREVENTIVE MAINTENANCE PLAN. THIS WILL BE ADDRESSED IN THE IPC POLICY WHEN IT IS CREATED. There is no formal health center IPC policy to govern how the health center staff should have a preventive maintenance plan that includes routine and annual inspection, calibration, updates, and repair to ensure proper function.

Guidance and Resources

Note: Guidance and resources are provided as supplemental information. Consultants are expected to follow the checklist when conducting the assessment and refer to this section when additional clarification or resources/references are needed.

General

Resource Collection: Infection Control: https://www.ecri.org/components/HRSA/Pages/ResourceCollection_InfectionControl.aspx

Resource Collection: COVID-19 Response: https://www.ecri.org/components/HRSA/Pages/ResourceCollection_COVID19Response.aspx

Fundamental Elements of Standard Precautions – 6-part series eLearning course: https://learning.ecri.org/clinicalriskmanagementprogram/content/fundamental-elements-standard-precautions-6-credit-series

CDC. 2007 Guideline for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings: https://www.cdc.gov/infectioncontrol/pdf/guidelines/isolation-guidelines-H.pdf

CDC. Guide to Infection Prevention for Outpatient Settings: Minimum Expectations for Safe Care: https://www.cdc.gov/infectioncontrol/pdf/outpatient/guide.pdf

Occupational Safety and Health Administration (OSHA). Bloodborne Pathogens and Needlestick Prevention: https://www.osha.gov/bloodborne-pathogens

CDC. Approach to an infection control breach with potential risk of bloodborne pathogen transmission: https://www.cdc.gov/hai/pdfs/bbp/fig1_ApporachToAnInfectionControlBreach.pdf

CDC. Interim Infection Prevention and Control Recommendations for Healthcare Personnel During the Coronavirus Disease 2019 (COVID-19) Pandemic: https://www.cdc.gov/coronavirus/2019-ncov/hcp/infection-control-recommendations.html

CDC. Cleaning & Disinfecting Environmental Surfaces: https://www.cdc.gov/oralhealth/infectioncontrol/faqs/cleaning-disinfecting-environmental-surfaces.html

Joint Commission. Demystifying the Sterilization Process: https://www.jointcommission.org/-/media/tjc/documents/accred-and-cert/ahc/Demystifying_the_Sterilization_Process.pdf

CDC. Steps for Evaluating an Infection Control Breach: https://www.cdc.gov/hai/outbreaks/steps_for_eval_ic_breach.html

Chiropractic

Chiropractic Economics. Hand Hygiene Matters for DCs Too: https://www.chiroeco.com/chiropractic-hand-hygiene/

Dental

Resource Collection: Dental: https://www.ecri.org/components/HRSA/Pages/ResourceCollection_Dental.aspx

CDC. Infection Prevention Checklist for Dental Settings: Basic Expectations for Safe Care (see p. 11–18): https://www.cdc.gov/oralhealth/infectioncontrol/pdf/safe-care-checklist-a.pdf

CDC. Guidelines for Infection Control in Dental Health-Care Settings — 2003: https://www.cdc.gov/mmwr/PDF/rr/rr5217.pdf

CDC. Dental Unit Water Quality: https://www.cdc.gov/oralhealth/infectioncontrol/faqs/dental-unit-water-quality.html

CDC. Outbreaks of Nontuberculous *Mycobacteria* Infections Highlight Importance of Maintaining and Monitoring Dental Waterlines: https://emergency.cdc.gov/han/2022/han00478.asp

Optometry

Indian Journal of Ophthalmology. Chemical disinfectants in ophthalmic practice: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7942131/

Joint Commission. Disinfection of tonometers and other ophthalmology devices: https://www.jointcommission.org/-/media/tjc/documents/resources/hai/quick_safety_disinfection_of_tonometers_final.pdf?db=web&hash=B3EF5D36D17DCD2D7BCFE9CC6B368604&hash=B3EF5D36D17DCD2D7BCFE9CC6B368604

Podiatry

Journal of the American Podiatric Medical Association. Infection Prevention and Control in the Podiatric Medical Setting: http://www.ndhealth.gov/disease/hai/Docs/Wise%20Infection%20Prevention%20and%20Control%20in%20the%20Podiatric%20Setting%20JAPMA%20201....pdf

CDC. Guide to Infection Prevention for Outpatient Podiatry Settings: https://www.cdc.gov/infectioncontrol/pdf/Podiatry-Guide_508.pdf

2024 Infection Prevention and Control - (IPC) Risk Assessment and Mitigation Tool

Findings/areas of highest risk identified:

A. Leadership and Accountability
   1. No Infection Prevention Control (IPC) Policy can be found, so one needs to be developed, including all elements outlined in the IPC Policy Draft attached.
   2. No IPC Officer has been officially delegated.
   3. No IPC Certification is currently required for a clinical supervisor.
   4. There is no IPC policy, making the requirement to use CDC and State immunization recommendations in the policy non-compliant.
   5. No IPC data or reports are being tracked, analyzed, nor presented to leadership.
   6. No evaluation process is established to monitor staff competency.

B. Communication and Documentation
   1. No documentation found the documents routine equipment maintenance, nor quality test results.
      i. Third party vendor provides bi-annual inspection, calibration, and repair of all medical equipment, but documentation is not readily available for review.
   2. There is no current process to retain manufacturer's instructions for us of instruments, equipment, devices, and cleaning/disinfection products where staff can access them.
   3. The logs for each sterilizer of sterilization cycles seems to be monitored, but it is unclear if logs/records are compliant with CDC, State, and local regulations.

C. Patient Safety, Risk, Quality
   1. Annual IPC Risk Assessments have not formally been done before. This is the inaugural IPC Risk Assessment, and it will now be conducted annually as a part of FTCA's quarterly risk assessment requirement.
   2. IPC rounds are not being conducted with intent to monitor IPC.

D. Procedures
   1. There are some practices in place to monitor expiration dates, proper storage, and temperatures for supplies, vaccines, and medications, however, there is not a formal health center policy/procedure that can be identified that sets clear expectations to be followed.
   2. There are some practices in place for early detection and management of potentially infectious persons at initial points of patient encounter, however there is still a need for a formal health center policy/procedure that can be identified that sets clear expectations to be followed.
   3. There are some practices in place for initiation of standard, airborne, contact, and droplet precautions, however there is still a need for a formal health center policy/procedure that can be identified that sets clear expectations to be followed.
   4. There is no IPC policy, making the requirement to use CDC safe injection and sharps safety guidelines non-compliant.

E. Emergency Concerns
   1. There is an internal process in SNHD to mitigate and manage exposures or outbreaks of bacteria, viruses, parasites, etc., however, there is not a formal health policy/procedure that can be identified that sets clear expectations to be followed.
   2. There is annual bloodborne pathogen training for clinical team members conducted annually, however, there is not a formal health policy/procedure that can be identified that sets clear expectations to be followed.

3. There are some practices in place that address the response process for when mechanical, chemical, or biological test results suggest that a sterilizer is not functioning promptly, and if the team responds promptly by recalling sterilized devices, removing the sterilizer from service, and conducting repeat testing, however there is still a need for a global formal health center policy/procedure that can be identified that sets clear expectations to be followed.

F. Sterilization and Disinfection
   1. The autoclave at Decatur is placed next to a coffee machine where people make and consume beverages. Consider moving either the coffee machine or the autoclave to preserve a sterile environment around the autoclave
   2. There are practices in place to sterilize equipment classified as critical that penetrate soft tissue or bone, but there is not a formal health center IPC policy or procedure to govern compliance making this item non-compliant.
   3. There are practices in place to govern high-level disinfection for reusable semi-critical equipment that touches either mucous membranes or nonintact skin, even if probe covers have been used, but there is not a formal health center IPC policy or procedure to govern compliance making this item non-compliant.
   4. The team uses a U.S. EPA-registered hospital disinfectant for non-critical patient care surfaces and equipment, however there is not a formal health center IPC policy to govern this practice, so it is non-compliant.
      i. Team was witnessed inconsistently disinfecting non-critical patient care surfaces and equipment during triage process despite the use of single use covers.

G. Environmental Safety
   1. There is no formal health center IPC policy to govern expectations on how to properly perform or monitor aerosol-generating procedures.
   2. There is no formal health center IPC policy to govern expectations on how staff should respond to community boil water notices, or how to modify care delivery during such a notice.
   3. There is no formal health center IPC policy to govern expectations on how staff should staff clean and disinfect or provide barrier protection to noncritical clinical contact surfaces that are touched often with gloved hands, that are likely to become contaminated with blood or body substances, and that are difficult to clean with EPA-registered hospital disinfectants in between patients.
   4. There is no formal health center IPC policy to govern expectations on how staff should clean surfaces with EPA-registered products (e.g., floors, tabletops) on a regular basis, when spills occur, and when surfaces are visibly soiled.
   5. There is no formal health center IPC policy to govern expectations on how staff should dispose of waste (e.g., regular, biohazard, sharps) properly following current state and federal regulations.

H. Equipment and Technology Safety
   1. There is no formal health center IPC policy to govern how the health center staff should monitor that medical devices and instruments meet or exceed infection control and equipment management requirements outlined in health center ICP policies and procedures.
   2. There is no formal health center IPC policy to govern how the health center staff should have a preventive maintenance plan that includes routine and annual inspection, calibration, updates, and repair to ensure proper function.

2024 Infection Prevention and Control - (IPC) Risk Assessment and Mitigation Tool

Action Plan:

CY24 Goals	CY24 Activities (What, Who, When)	CY24 Performance
		3 & 6 Month Follow Up
Goal #1: Create an Infection Prevention Control Policy that addresses all components required to resolve the deficiencies identified in the HRSA Risk Assessment and Mitigation Tool: Infection Prevention and Control (IPC).	• IPC Committee to be formed including, at a minimum, the FQHC CEO, FQHC Risk Manager, QMC, Operations Managers, and Medical Director/IPC Officer • IPC Committee will collaborate on the creation, training, and implementation of an IPC Policy by May 31, 2025. • An IPC Policy Draft has been crafted and attached, in correlation with the IPC Risk Assessment and Mitigation Tool to ensure all findings are addressed and mitigated.	December 2024 – March 2025 – June 2025 –
		3 & 6 Month Follow Up
Goal #2: Name a new IPC Officer and a backup IPC Officer	• FQHC CEO to determine who will serve as the FQHC IPC Officer. • FQHC CEO and IPC Officer will determine who will be the backup/Assistant IPC Officer. • An IPC Certification program/training will be identified and both the IPC Officer and the Assistant IPC Officer will be certified.	December 2024 – March 2025 – June 2025 –
		3 & 6 Month Follow Up

Goal #3: IPC daily procedures to be developed, documented, trained, and implemented with measurable metrics and a process for ongoing IPC monitoring and quality control.	• IPC Committee will determine metrics to be measured and provide quarterly reports to the FQHC Leadership team.
	• IPC Committee will oversee the development, documentation, training, and implementation of
	  ○ day-to-day sanitation, sterilization, and disinfection procedures and practices,
	  ○ day-to-day rounding process to monitor and maintain daily IPC procedures and practices,
	  ○ equipment usage, safety, sterilization, preventive maintenance, and
	  ○ equipment manual adherence, use, and availability
		December 2024 –
		March 2025 –
		June 2025 –

An IPC Policy needs to be developed and approved by the SNCHC Board that must include clinical and non-clinical procedures and practices and incorporate Centers for Disease Control and Prevention (CDC) and state immunization recommendations guidelines. The following components are recommended to coincide with the annual IPC Risk Assessment:

1. Leadership and Accountability
    a. Have an IPC Policy
    b. Medical Director or similar role should be named as IPC Officer, so there is someone on staff who is trained in IPC and who is responsible for overall IPC management and compliance
        a. Consider naming an Assistant IPC Officer for succession planning
    c. Consider requiring the IPC Officer and Asst. IPC Officer needing a certificate in IPC
    d. SNCHC assess and provides resources, equipment and supplies that are appropriate and in sufficient amounts to ensure staff have the tools necessary to adhere to disinfection, sterilization, and IPC policies
    e. IPC Officer creates and manages an IPC Plan that includes clinical and non-clinical procedures and practices and incorporates Centers for Disease Control and Prevention (CDC) and state immunization recommendations guidelines
    f. The IPC Officer oversees the collection, analysis, tracking, monitoring, and reporting of the IPC plan and outcomes to leadership and the Quality, Risk Management, & Credentialing (QRMC) Committee and Governing Board as directed by the FQHC CEO.
        a. Data should be monitored and tracked in coordination with the FQHC Risk Manager
    g. SNCHC provides and maintains documentation for IPC training and competency testing as a requirement upon hiring, annually, and when new tasks or procedures are started in the health center
        a. Training program should also define what the competency evaluation process is
        b. HR Assistant and/or FQHC Administrative Secretary keep updated training records
    h. SNCHC supports safe injection practices with additional training and competency evaluations for staff who administer injectable medications
        a. Training program should also define what the competency evaluation process is
    i. SNCHC arranges for additional training and maintain documentation on competency evaluations for staff assigned to reprocessing medical devices tasks (i.e., high-level disinfection, sterilization of instruments, equipment, and devices)
2. Communication/Documentation
    a. SNCHC has developed communication materials about managing an exposure breach in IPC
        a. e.g., reporting to state agencies, patient notification, patient testing if indicated
    b. Documentation retention for equipment maintenance, quality test results, and trainings.
    c. Staff access to manufacturer's instructions for instruments, equipment, devices and cleaning and disinfection products.
    d. Logs/records from each sterilizer (in accordance with CDC, State, and local regulations) that includes:
        a. sterilization cycles &
        b. monitoring measures (mechanical, chemical, and biological)
3. Patient Safety, Risk, Quality
    a. Monitoring of community transmission levels to decide what infection control interventions need to be implemented

b. Risk Manager conducts an annual IPC Risk Assessment & coordinates findings with IPC Officer, Leadership, QRMC Committee and Governing Board, as appropriate and required by FTCA compliance regulations
c. IPC Officer conducts quarterly infection control rounds to monitor compliance, progress, and corrections
    a. Assessment of infection prevention skill and technique by observation and simulation
d. Adheres to local, state, and federal requirements for surveillance, disease, and outbreak reporting

4. Procedures
    a. IPC procedures include, but are not limited to,
        a. hand hygiene,
        b. choice of personal protective equipment,
        c. mask usage,
        d. safe injection practices, and
        e. sharps handling practices
    b. Each IPC procedure should include the following components where applicable:
        a. Utilizing manufacturer's instructions when writing policies for
            i. all reusable medical/surgical/dental devices and equipment
            ii. cleaning, proper solution, and
            iii. soak/dwell times.
        b. Checking and recording expiration dates, proper storage, and temperatures for
            i. supplies,
            ii. vaccines,
            iii. medications
        c. A system for early detection and management of potentially infectious persons at initial points of the patient encounter
        d. Trained staff to initiate standard, airborne, contact, and droplet precautions based on policy guidelines
        e. Enforcement of CDC safe injection and sharps safety guidelines.
        f. Utilization of the special work practices of: (Dental Only)
            i. one-hand scoop technique and
            ii. removal of burs before disconnecting in dental procedures
        g. Assessment of infection prevention skill and technique by observation and simulation
5. Emergency Concerns
    a. SNCHC acts promptly when exposures or outbreaks of bacteria, viruses, parasites (e.g., measles, mumps, bed bugs) occur
    b. SNCHC follows the bloodborne pathogen and exposure control plan directions to ensure time-sensitive actions are promptly initiated
    c. When mechanical, chemical, or biological test results suggest that a sterilizer is not functioning promptly, SNCHC responds promptly by recalling sterilized devices, removing the sterilizer from service, and conducting repeat testing
6. Sterilization and Disinfection
    a. SNCHC ensures that single-use (disposable) devices are not reprocessed and that they are properly disposed of after one use.
    b. Staff clean and disinfect point-of-care testing devices after every use

c. SNCHC sterilizes equipment that are classified as critical that penetrate soft tissue or bone (e.g., extraction forceps, scalpel blades, bone chisels, periodontal scalers, surgical scalpels, burs)
d. SNCHC sterilizes dental instruments that are not intended to penetrate soft tissue or bone (e.g., amalgam condensers, air-water syringes) but that might contact oral tissue and are heat tolerant, although classified as semi-critical*
e. The organization enforces that dental handpieces or intraoral devices are removed for sterilization or have U.S. Food and Drug Administration clearance not to be removed *
f. SNCHC performs high-level disinfection for reusable semi-critical equipment that touches either mucous membranes or nonintact skin, even if probe covers have been used (e.g., vaginal probes, speculums, cryosurgical probes, scopes, respiratory tubing)
g. SNCHC performs low-level disinfection with a U.S. Environmental Protection Agency (EPA)-registered hospital disinfectant for non-critical patient care surfaces and equipment (e.g., blood pressure cuff, thermometer) that touch intact skin

7. Environmental Safety
    a. SNCHC consults with a heating, ventilation, and air conditioning (HVAC) professionals to ensure that clinical airflow patterns and air exchanges per hour are sufficient to reduce airborne contaminants, including any viruses and bacteria produced from aerosolized procedures
    b. Aerosol-generating procedures are performed cautiously to reduce spread (e.g., use of airborne infection isolation room, ultrasonic scaler, high-speed dental hand pieces, air/water syringe, nebulizers)
    c. SNCHC monitors dental treatment units' water quality to meet EPA standards for drinking, provided by the manufacturer of the unit or waterline treatment product. The organization uses sterile water as a coolant when performing surgery *
    d. Staff respond to community boil water notices by following procedures on how to modify care delivery during such notices
    e. Between patients, staff clean and disinfect or provide barrier protection to noncritical clinical contact surfaces that are touched often with gloved hands, that are likely to become contaminated with blood or body substances, and that are difficult to clean with EPA-registered hospital disinfectants (e.g., exam lamps, curing lights, light handles, dental units)
    f. Staff clean surfaces with EPA-registered products (e.g., floors, tabletops) on a regular basis, when spills occur, and when surfaces are visibly soiled
    g. Staff dispose of waste (e.g., regular, biohazard, sharps) properly following current state and federal regulations.
8. Equipment and Technology Safety
    a. SNCHC makes certain medical devices and instruments supplied by or on loan from vendors, contracted providers, mobile dental vans, or portable dental equipment meet or exceed infection control and equipment management requirements outlined in health center ICP policies and procedures
    b. SNCHC has a preventive maintenance plan that includes routine and annual inspection, calibration, updates, and repair to ensure proper function

Q3 Risk Assessment

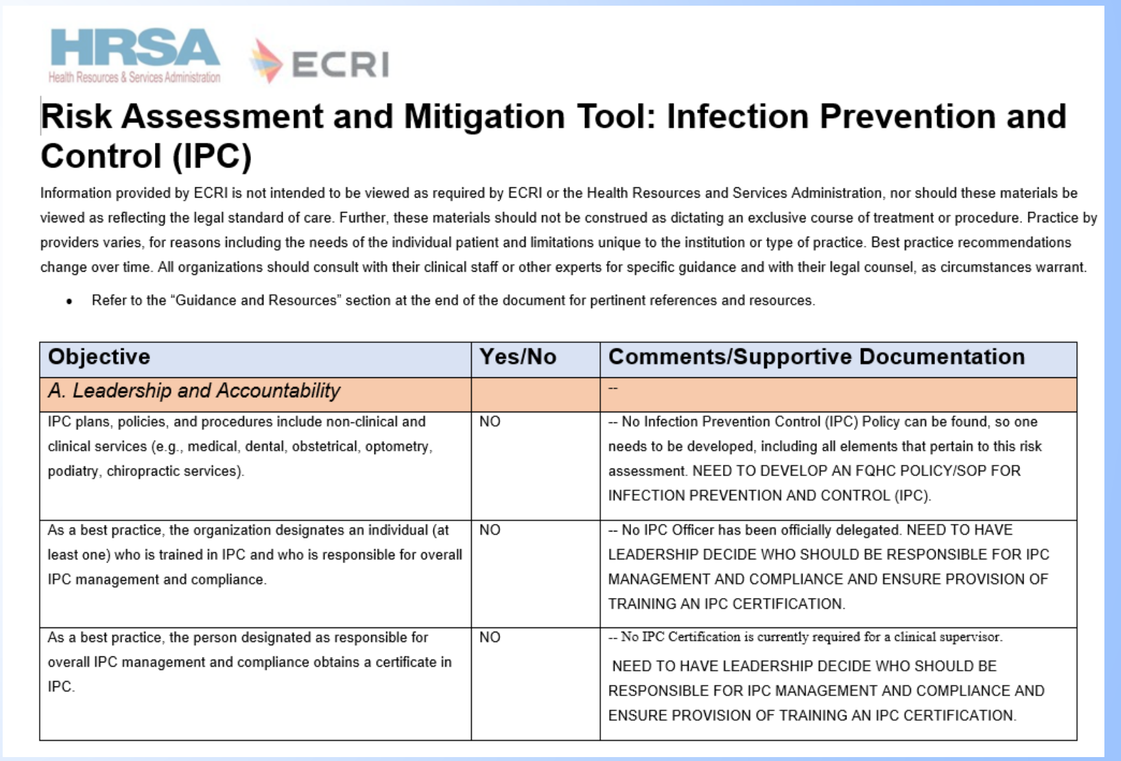
Infection Prevention and Control

Quarterly Risk Assessments Are Required by the Health Resources and Services Administration (HRSA)for annual Federal Tort Claims Act (FTCA) Redeeming

- HRSA requires four quarterly risk assessments be performed each year.
  - All four quarterly risk assessments are submitted as part of the annual FTCA redeeming application.
  - Findings and action plans are created for each quarterly risk assessment are also uploaded as part of the annual FTCA redeeming application.
- Action plans are internally tracked to monitor compliance and improvement.
- FTCA compliance will be part of the upcoming on-site visit in February.
- Four quarterly risk assessment templates were chosen to align with FTCA redeeming components regarding risk mitigation of patient/team safety, HIPAA compliance, infection control, and obstetric clinical safety.

The Q3 Risk Assessment is the Risk Assessment and Mitigation Tool: Infection Prevention and Control (IPC)

This tool is provided by the Emergency Care Research Institute (ECRI), which is the organization recommended by HRSA for FTCA & Risk Management training and support. The IPC Risk Assessment will be performed annually to help prevent and mitigate potential malpractice liabilities that could result from poor infection prevention and control.



HRSA Health Resources & Services Administration ECRI

Risk Assessment and Mitigation Tool: Infection Prevention and Control (IPC)

Information provided by ECRI is not intended to be viewed as required by ECRI or the Health Resources and Services Administration, nor should these materials be viewed as reflecting the legal standard of care. Further, these materials should not be construed as dictating an exclusive course of treatment or procedure. Practice by providers varies, for reasons including the needs of the individual patient and limitations unique to the institution or type of practice. Best practice recommendations change over time. All organizations should consult with their clinical staff or other experts for specific guidance and with their legal counsel, as circumstances warrant.

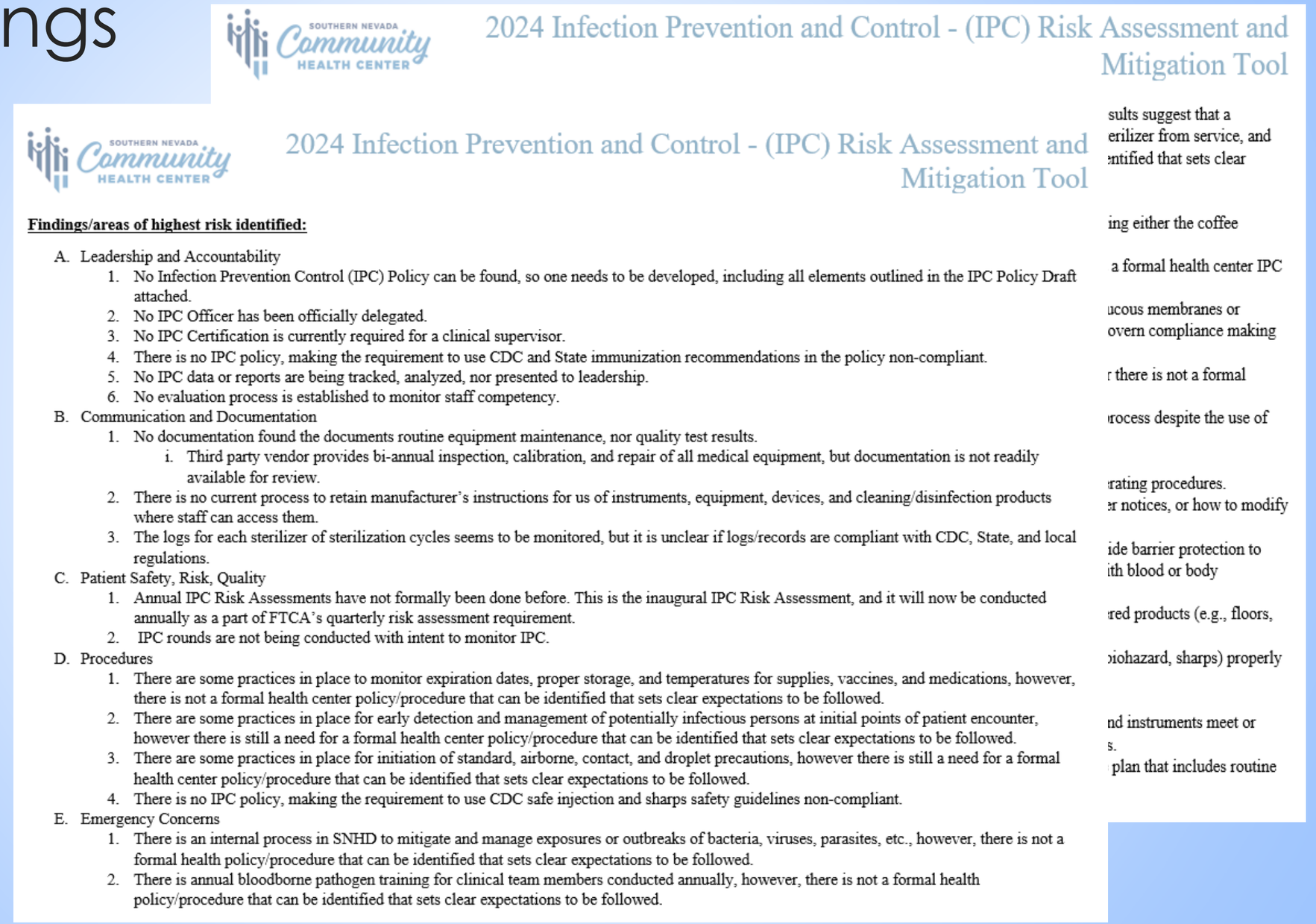
- Refer to the "Guidance and Resources" section at the end of the document for pertinent references and resources.

Objective	Yes/No	Comments/Supportive Documentation
A. Leadership and Accountability		--
IPC plans, policies, and procedures include non-clinical and clinical services (e.g., medical, dental, obstetrical, optometry, podiatry, chiropractic services).	NO	-- No Infection Prevention Control (IPC) Policy can be found, so one needs to be developed, including all elements that pertain to this risk assessment. NEED TO DEVELOP AN FQHC POLICY/SOP FOR INFECTION PREVENTION AND CONTROL (IPC).
As a best practice, the organization designates an individual (at least one) who is trained in IPC and who is responsible for overall IPC management and compliance.	NO	-- No IPC Officer has been officially delegated. NEED TO HAVE LEADERSHIP DECIDE WHO SHOULD BE RESPONSIBLE FOR IPC MANAGEMENT AND COMPLIANCE AND ENSURE PROVISION OF TRAINING AN IPC CERTIFICATION.
As a best practice, the person designated as responsible for overall IPC management and compliance obtains a certificate in IPC.	NO	-- No IPC Certification is currently required for a clinical supervisor. NEED TO HAVE LEADERSHIP DECIDE WHO SHOULD BE RESPONSIBLE FOR IPC MANAGEMENT AND COMPLIANCE AND ENSURE PROVISION OF TRAINING AN IPC CERTIFICATION.

IPC Risk Assessment Occurred on September 30, 2024

- 8 categories were inspected:
  - Leadership and Accountability
  - Communication and Documentation
  - Patient Safety, Risk, Quality
  - Procedures
  - Emergency Concerns
  - Sterilization and Disinfection
  - Environmental Safety, and
  - Equipment and Technology Safety

Findings



2024 Infection Prevention and Control - (IPC) Risk Assessment and Mitigation Tool

2024 Infection Prevention and Control - (IPC) Risk Assessment and Mitigation Tool

Findings/areas of highest risk identified:

A. Leadership and Accountability
   1. No Infection Prevention Control (IPC) Policy can be found, so one needs to be developed, including all elements outlined in the IPC Policy Draft attached.
   2. No IPC Officer has been officially delegated.
   3. No IPC Certification is currently required for a clinical supervisor.
   4. There is no IPC policy, making the requirement to use CDC and State immunization recommendations in the policy non-compliant.
   5. No IPC data or reports are being tracked, analyzed, nor presented to leadership.
   6. No evaluation process is established to monitor staff competency.

B. Communication and Documentation
   1. No documentation found the documents routine equipment maintenance, nor quality test results.
      i. Third party vendor provides bi-annual inspection, calibration, and repair of all medical equipment, but documentation is not readily available for review.
   2. There is no current process to retain manufacturer's instructions for us of instruments, equipment, devices, and cleaning/disinfection products where staff can access them.
   3. The logs for each sterilizer of sterilization cycles seems to be monitored, but it is unclear if logs/records are compliant with CDC, State, and local regulations.

C. Patient Safety, Risk, Quality
   1. Annual IPC Risk Assessments have not formally been done before. This is the inaugural IPC Risk Assessment, and it will now be conducted annually as a part of FTCA's quarterly risk assessment requirement.
   2. IPC rounds are not being conducted with intent to monitor IPC.

D. Procedures
   1. There are some practices in place to monitor expiration dates, proper storage, and temperatures for supplies, vaccines, and medications, however, there is not a formal health center policy/procedure that can be identified that sets clear expectations to be followed.
   2. There are some practices in place for early detection and management of potentially infectious persons at initial points of patient encounter, however there is still a need for a formal health center policy/procedure that can be identified that sets clear expectations to be followed.
   3. There are some practices in place for initiation of standard, airborne, contact, and droplet precautions, however there is still a need for a formal health center policy/procedure that can be identified that sets clear expectations to be followed.
   4. There is no IPC policy, making the requirement to use CDC safe injection and sharps safety guidelines non-compliant.

E. Emergency Concerns
   1. There is an internal process in SNHD to mitigate and manage exposures or outbreaks of bacteria, viruses, parasites, etc., however, there is not a formal health policy/procedure that can be identified that sets clear expectations to be followed.
   2. There is annual bloodborne pathogen training for clinical team members conducted annually, however, there is not a formal health policy/procedure that can be identified that sets clear expectations to be followed.

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Action Plan – Three Goals that will address and correct all findings:

SOUTHERN NEVADA Community HEALTH CENTER

2024 Infection Prevention and Control - (IPC) Risk Assessment and Mitigation Tool

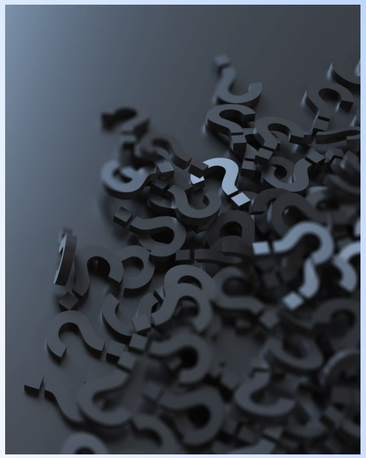
Action Plan:

CY24 Goals	CY24 Activities (What, Who, When)	CY24 Performance
		3 & 6 Month Follow Up
Goal #1: Create an Infection Prevention Control Policy that addresses all components required to resolve the deficiencies identified in the HRSA Risk Assessment and Mitigation Tool: Infection Prevention and Control (IPC).	• IPC Committee to be formed including, at a minimum, the FQHC CEO, FQHC Risk Manager, QMC, Operations Managers, and Medical Director/IPC Officer • IPC Committee will collaborate on the creation, training, and implementation of an IPC Policy by May 31, 2025. • An IPC Policy Draft has been crafted and attached, in correlation with the IPC Risk Assessment and Mitigation Tool to ensure all findings are addressed and mitigated.	December 2024 – March 2025 – June 2025 –
		3 & 6 Month Follow Up
Goal #2: Name a new IPC Officer and a backup IPC Officer	• FQHC CEO to determine who will serve as the FQHC IPC Officer. • FQHC CEO and IPC Officer will determine who will be the backup/Assistant IPC Officer. • An IPC Certification program/training will be identified and both the IPC Officer and the Assistant IPC Officer will be certified.	December 2024 – March 2025 – June 2025 –
		3 & 6 Month Follow Up
Goal #3: IPC daily procedures to be developed, documented, trained, and implemented with measurable metrics and a process for ongoing IPC monitoring and quality control.	• IPC Committee will determine metrics to be measured and provide quarterly reports to the FQHC Leadership team. • IPC Committee will oversee the development, documentation, training, and implementation of o day-to-day sanitation, sterilization, and disinfection procedures and practices, o day-to-day rounding process to monitor and maintain daily IPC procedures and practices, o equipment usage, safety, sterilization, preventive maintenance, and o equipment manual adherence, use, and availability	December 2024 – March 2025 – June 2025 –

IPC Policy Coming Soon

- Based on the contents of the IPC Risk Assessment, a new policy draft has been created that covers all components of the IPC Risk Assessment for further development.
- Once a final draft is completed by SNCHC Leadership, it will be presented to the SNCHC QRMC Committee and SNCHC's Governing Board for review and approval.

Questions?



Motion to accept the Accept the Third Quarter Risk Management Assessment, as presented.

SOUTHERN NEVADA Community HEALTH CENTER

AT THE SOUTHERN NEVADA HEALTH DISTRICT

Recommendations from the October 9, 2024 Executive Director Annual Review Committee Meeting

4. Receive, Discuss and Approve the FY24 Summary of Accomplishments and FY25 Goals for the Chief Executive Officer; direct staff accordingly or take other action as deemed necessary *(for possible action)*

SOUTHERN NEVADA Community HEALTH CENTER
AT THE SOUTHERN NEVADA HEALTH DISTRICT

High-Level Summary of FY24 Accomplishments and FY25 Goals

Randy Smith, Chief Executive Officer - FQHC

Administration

- Awarded a new three-year Health Center grant – continued designation as a FQHC
- Selected and hired a new Health Center – CEO
- Received FTCA deeming coverage
- Established a health center business office
  - Developed a Risk Management program and assigned a Risk Manager role
- Created new site manager positions to oversee daily operations
- Updated the electronic health record and migrated to cloud-based hosting
- Implemented population health system software

Operations

- 95% year-over-year growth in the number of patients served
- 95% year-over-year growth in the number of visits provided
- Transitioned the sexual health clinic into the FQHC
- Moved refugee health clinic to Fremont and transition operations into the FQHC
- Added sexual health and Ryan White services to Fremont
- Onboarded a new Behavioral Health Manager
- Onboarded new mid-level medical provides and behavioral health providers

Finance

- 30% year-over-year increase in total revenue
- 12% year-over-year increase in sliding fee adjustments provided
- Increased empaneled Medicaid members from 286 to 1,146
- Implemented standing revenue cycle meeting

Proposed Goals/Opportunities for FY25

Pursue Patient Centered Medical Home (PCMH) accreditation

Increase the number of unique patients served by 3%

Improve daily access to care (visits) by 3%

Optimize and expand services at the Fremont location – SHC/RW/RH

Improve financial stability – Increase the number of Medicaid patients served by 5%

Enhance integrated Behavioral Health services and optimize new clinic at Decatur

Build a dental clinic at Fremont and develop an operational plan

Maintain HRSA Compliance

SOUTHERN NEVADA Community HEALTH CENTER

Questions?

Motion to approve the FY24 Summary of Accomplishments and FY25 Goals for the Chief Executive Officer, as presented.

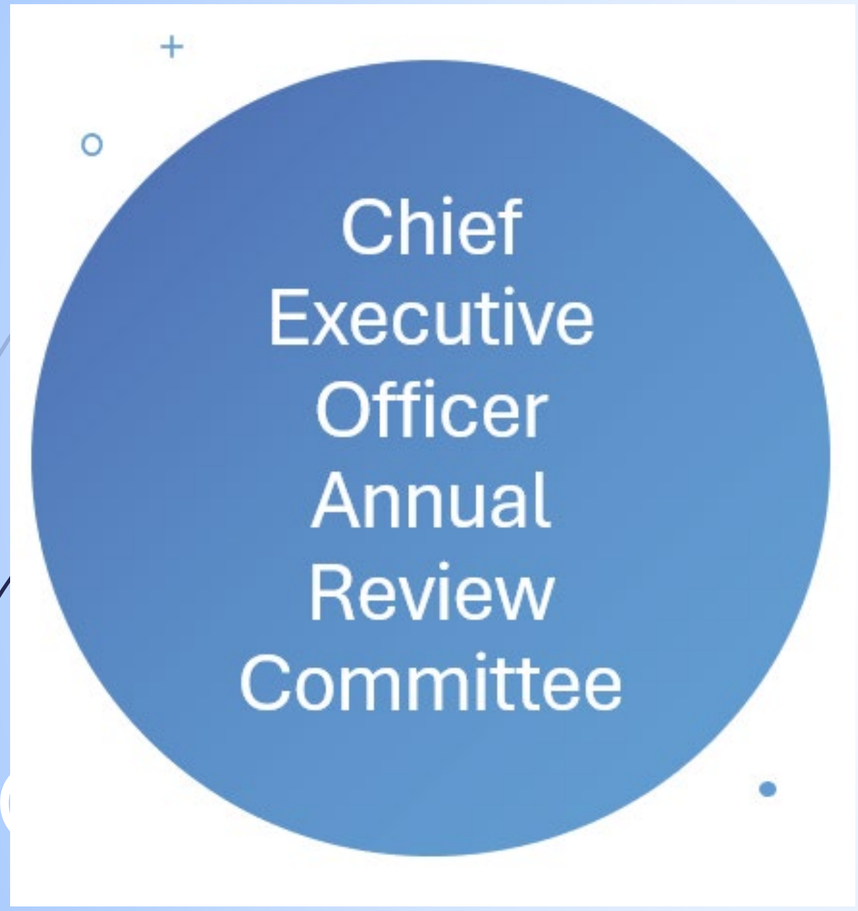
5. **Receive, Discuss and Approve the FY24 Evaluation Results of the Chief Executive Officer;** direct staff accordingly or take other action as deemed necessary *(for possible action)*

SOUTHERN NEVADA Community HEALTH CENTER

AT THE SOUTHERN NEVADA HEALTH DISTRICT

SNCHC Governing Board/SNHD Internal Staff Survey Results for Randy Smith, Chief Executive Officer

October 15, 2024



- HRSA required activity.
- The health center Governing Board is responsible for assessing the achievement of project objectives.
- The Governing Board is responsible for evaluating the performance of the Chief Executive Officer (CEO) of the Southern Nevada Community Health Center.
- The Executive Director Annual Review Committee will evaluate performance and provide feedback and support to the Governing Board and the CEO as a part of the CEO's Annual Evaluation process.

Evaluation Tool

- **Five (5) Scored Questions - Scoring Guide**
  - 1 – Poor
  - 2 – Needs Improvement
  - 3 – Fair
  - 4 – Good
  - 5 – Outstanding

- **Two (2) Non-Scored Narrative Questions**
  - General Strengths
  - Areas for Growth

- **Weight of Each Question**
  - Question 1 – Weighted 15% of overall score
  - Question 2 – Weighted 40% of overall score
  - Question 3 – Weighted 15% of overall score
  - Question 4 – Weighted 15% of overall score
  - Question 5 – Weighted 15% of overall score

- **Survey scores were compiled from participating Governing Board Members, but comments were provided by a mixture of Governing Board Members and SNHD Staff.**

# of Evals Requested:

- **11**

# of Evals Received:

- **7**

Q1. The CEO consistently demonstrates equitable and fair treatment of SNCHC employees, contractors, and volunteers.

- Divides and assigns work effectively, delegating appropriate levels of freedom and authority.
- Recruits and retains a diverse staff.
- Encourages staff development and education.
- Maintains a climate which attracts, keeps, and motivates a diverse staff of top-quality people

Average Score

(Weighted at 15%)

4.85

Q1. Mr. Smith consistently demonstrates equitable and fair treatment of SNCHC employees, contractors, and volunteers.

1 - Strongly Disagree	0
2 - Disagree	0
3 - Unsure	0
4 - Agree	1
5 - Strongly Agree	6

Comments:

- Mr. Smith is fair and consistent
- Mr. Randy Smith strives to create an environment where staff have equal opportunity to succeed such as supporting staff to go to school to become an RN or MA. He initiated employee engagement committee where staff have a seat in the table to discuss what activities they would like to have, improvements they want to see.
- Randy carefully considers the facts, data, and feedback from the team before making decisions that affect others. Weighing the perceptions and experiences of everyone affected always plays into his decision-making.
- When events unfold and plans are made, one of Randy's first considerations is the effect it may have on staff and working relationships.

Q2. The CEO consistently provides thorough administrative leadership and oversite of SNCHC's compliance with HRSA program requirements.

- Establishes and makes use of an effective management team.
- Maintains appropriate balance between administration and programs.
- Ensures that job descriptions are developed, and that regular performance evaluations are held and documented.
- Ensures compliance with personnel policies and state and federal regulations on workplaces and employment.
- Ensures that employees are licensed and credentialed as required.
- Ensures that policies and procedures are in place.

Average Score

(Weighted at 40%)

4.71

Q2. Mr. Smith consistently provides thorough administrative leadership and oversite of SNCHC’s compliance with HRSA program requirements.

1 - Strongly Disagree	0
2 - Disagree	0
3 - Unsure	0
4 - Agree	2
5 - Strongly Agree	5

Comments:

- Under Mister Smith's leadership, a second clinic opened, programs were initiated. Refugee program was added, saw an increase in the number of patients served, more insurance contracts in place, we got our FTCA approved. We maintain compliance with HRSA program requirements.
- Randy has the experience necessary to anticipate what the organization may need in the future to remain compliant. He is constantly preparing the team and considering steps that need to be taken now, and consulting with HRSA experts and project officers when there are questions without obvious answers.
- Randy has thorough knowledge of FQHC requirements and is acutely aware of areas that need attention.

Q3. The CEO ensures that the SNCHC has a viable long-range strategy to achieve its mission and utilizes data to measure progress towards achieving programmatic, clinical, and financial goals:

- Providing Leadership in Program development and org plans with BOD.
- Meets or exceeds program goals in quantity and quality.
- Evaluates how well goals and objectives have been met.
- Demonstrates quality of analysis and judgment in program planning, implementation, and evaluation.
- Shows creativity, and initiative in developing new programs.
- Maintains and utilizes a working knowledge of significant developments and trends in the field (such as healthcare legislation, public health concerns, health disparities, other disease and healthcare issues in communities served).

Average Score

(Weighted at 15%)

5

Q3. Mr. Smith ensures that the SNCHC has a viable long-range strategy to achieve its mission and utilizes data to measure progress towards achieving programmatic, clinical, and financial goals.

1 - Strongly Disagree	0
2 - Disagree	0
3 - Unsure	0
4 - Agree	0
5 - Strongly Agree	7

Comments:

- Under Mr. Smith's leadership, Key performance indicators were established, monthly leadership meeting utilizing data to measure progress were initiated, Revenue and Monthly financial standings are monitored. He conducts regular operations meeting to discuss programmatic and clinical goals.
- Strategic goals, planning, and review occur monthly to ensure the trajectory of the organization is still aligned with SNCHC/SNHD mission, vision, and values.
- Randy has a good understanding of the key drivers for success of CHC and has implemented changes that have made substantial progress toward our goals.

Q4. The CEO appropriately utilizes financial and utilization data to ensure SNCHC is maximizing budgetary and human resources to achieve health center goals.

- Assures adequate control and accounting of all funds, including developing and maintaining sound financial practices.
- Works with the staff, Finance Committee, and the board in preparing a budget; sees that the organization operates within budget guidelines.
- Maintains official records and documents, and ensures compliance with federal, state, and local regulations and reporting requirements (such as annual information returns, payroll withholding and reporting, etc.).
- Executes legal documents appropriately.
- Assures that funds are disbursed in accordance with contract requirements and donor designations.

Average Score

(Weighted at 15%)

4.85

Q4. Mr. Smith appropriately utilizes financial and utilization data to ensure SNCHC is maximizing budgetary and human resources to achieve health center goals.

1 - Strongly Disagree	0
2 - Disagree	0
3 - Unsure	0
4 - Agree	1
5 - Strongly Agree	6

Comments:

- Mr. Smith created a business team to ensure the health center's financial wellness, grant and general fund spending are tracked including lab expenses. He regularly reviews the health center organizational chart to ensure we are adequately staffed , so we can achieve health center goals
- Randy works very closely with the rest of the Business Office to monitor, adjust, and oversee the financial performance and planning of the FQHC.
- Resource utilization is key metric that is regularly reviewed and discussed with the management team. We focus on improvements in efficiency and productivity resulting in year over year improvements

Q5. The CEO properly represents SNCHC in the community and fosters the establishment of new community partners and develops existing partnerships.

- Serves as an effective spokesperson for the agency; represents the programs and point of view of the organization to the agencies, organizations and the general public.
- Establishes sound working relationships and cooperative arrangements with community groups and organizations.
- Welcomes and pursues opportunities to share organizational objectives and perspectives in local, regional, and national forums as strategically appropriate.

Average Score

(Weighted at 15%)

4.57

Q5. Mr. Smith properly represents SNCHC in the community and fosters the establishment of new community partners and develops existing partnerships.

1 - Strongly Disagree	0
2 - Disagree	0
3 - Unsure	0
4 - Agree	3
5 - Strongly Agree	4

Comments:

- Randy collaborates well internally and externally with leaders and professionals. Randy represents the organizational mission, vision, and values in all he does and says, and is a true brand ambassador.
- Randy has made it a priority to reach out to community partners and other FQHCs to offer help and insights. This includes his involvement in the Nevada Primary Care Association and the inclusion of the management team.
- I do believe Mr. Smith could be stronger in this area.

Two Open Ended Questions/Comments

- **General Strengthens**
  - Mr. Smith is an asset to the SNCHC. He has exhibited strong leadership skills as well as a clear vision of how to make the clinic even better.
  - Mr. Smith's dedication and passion of the SNCHC is demonstrated when presenting to the board. He is extremely knowledge, always prepared, and demonstrates team ownership of the success and challenges of growing a successful FQHC.
- **Areas for Growth**
  - Mr. Smith could be stronger in properly representing SNCHC in the community and fostering the establishment of new community partners and developing existing partnerships.

General Comments

- Mr. Smith demonstrates effectively the goals for the health center.
- Mr. Smith is a strong leader with a good heart and great intentions. Our achievements and growth demonstrate his hard work and support for his staff.
- It is an honor to have Randy as a leader and mentor. I have learned and continue to learn a lot by observing his leadership and continue to develop more skills under his tutelage.
- Randy has created a supportive and collaborative environment that has enabled the management team to do its best work and move the CHC forward. He prioritizes inclusion and stability allowing working relationships to develop and thrive.
- I believe Mr. Smith is an asset to the SNCHC. He has exhibited strong leadership skills as well as a clear vision of how to make the clinic even better.

2024 Chief Executive Officer Annual Review Overall Weighted Score:

4.78

Scoring Guide

- 1 – Poor
- 2 – Needs Improvement
- 3 – Fair
- 4 – Good
- 5 - Outstanding

SOUTHERN NEVADA Community HEALTH CENTER

Questions?

Motion to approve the FY24 Evaluation Results of the Chief Executive Officer, as presented.

SOUTHERN NEVADA Community HEALTH CENTER

AT THE SOUTHERN NEVADA HEALTH DISTRICT

SNCHC Governing Board

6. **Receive, Discuss and Approve Governing Board Chair, 1st Vice Chair and 2nd Vice Chair Officer Appointments;** direct staff accordingly or take other action as deemed necessary *(for possible action)*

Chair, 1st Vice Chair and 2nd Vice Chair Officer Appointments

SUMMARY OF OFFICER INTEREST		
Chair	**First Vice Chair**	**Second Vice Chair**
Donna Feliz-Barrows	Jasmine Coca	Sara Hunt

Motion to approve the Governing Board Chair, 1st Vice Chair and 2nd Vice Chair Officer Appointments, as presented.

7. **Review, Discuss and Approve Committee Memberships;** direct staff accordingly or take other action as deemed necessary *(for possible action)*

Committee Assignments

GOVERNING BOARD COMMITTEE MEMBERS - FY2024					
Executive Committee	**Executive Director Annual Review Committee**	**Finance and Audit Committee**	**Quality, Credentialing & Risk Management Committee**	**Nominations Committee**	**Strategic Planning Committee**
Jose Melendrez	Luz Castro	Donna Feliz-Barrows	Scott Black	Luz Castro	Scott Black
Donna Feliz-Barrows	Donna Feliz-Barrows	Jasmine Coca	Jose Melendrez	Donna Feliz-Barrows	Luz Castro
Brian Knudsen	Jose Melendrez	Sara Hunt	Erin Breen	Erin Breen	Jose Melendrez
		Blanca Macias-Villa			Blanca Macias-Villa
		Marie Dukes			

SUMMARY OF COMMITTEE INTEREST FORMS - FY2025					
Executive Committee	**Executive Director Annual Review Committee**	**Finance and Audit Committee**	**Quality, Credentialing & Risk Management Committee**	**Nominations Committee**	**Strategic Planning Committee**
Donna Feliz-Barrows	Scott Black	Marie Dukes	Sara Hunt	Sara Hunt	Scott Black
Brian Knudsen	Donna Feliz-Barrows	Ashley Brown		Donna Feliz-Barrows	Jasmine Coca
Jasmine Coca		Jasmine Coca			Blanca Macias-Villa
		Blanca Macias-Villa			

Motion to Approve the Committee Assignments for FY25 Calendar.

8. **Review, Discuss and Approve the 2025 Governing Board Meeting Schedule**; direct staff accordingly or take other action as deemed necessary *(for possible action)*

SOUTHERN NEVADA Community HEALTH CENTER
AT THE SOUTHERN NEVADA HEALTH DISTRICT

PROPOSED 2025 CHC Governing Board Meeting Schedule

All Governing Board meetings are proposed to occur on the third Tuesday of each month at 2:30 p.m. with the following exception:

→ December – Second Tuesday in December (December 9, 2024), at 2:00 p.m., in order to not coincide with Christmas holiday plans.

DATE	TIME
January 21, 2025	2:30 p.m.
February 18, 2025	2:30 p.m.
March 18, 2025	2:30 p.m.
April 15, 2025	2:30 p.m.
May 20, 2025	2:30 p.m.
June 17, 2025	2:30 p.m.
July 15, 2025	2:30 p.m.
August 19, 2025	2:30 p.m.
September 16, 2025	2:30 p.m.
October 21, 2025	2:30 p.m.
November 18, 2025	2:30 p.m.
*December 9, 2025	2:00 p.m.

2025 Governing Board Meeting Schedule

All Governing Board meetings are proposed to occur on the third Tuesday of each month at 2:30 p.m. with the following exception:

- December – Second Tuesday in December (December 9, 2025), at 2:00 p.m., in order to not coincide with Christmas holiday plans.

DATE	TIME
January 21, 2025	2:30 p.m.
February 18, 2025	2:30 p.m.
March 18, 2025	2:30 p.m.
April 15, 2025	2:30 p.m.
May 20, 2025	2:30 p.m.
June 17, 2025	2:30 p.m.
July 15, 2025	2:30 p.m.
August 19, 2025	2:30 p.m.
September 16, 2025	2:30 p.m.
October 21, 2025	2:30 p.m.
November 18, 2025	2:30 p.m.
***December 9, 2025**	2:00 p.m.

Motion to approve the Approve the 2025 Governing Board Meeting Schedule, as presented.

SOUTHERN NEVADA Community HEALTH CENTER
AT THE SOUTHERN NEVADA HEALTH DISTRICT

VII. BOARD REPORTS

The Southern Nevada Community Health Center Governing Board members may identify and comment on Health Center related issues or ask a question for clarification. Comments made by individual Board members during this portion of the agenda will not be acted upon by the Southern Nevada Community Health Center Governing Board unless that subject is on the agenda and scheduled for action.
(*Information Only*)

VIII. CEO COMMENTS & STAFF REPORTS

RANDY SMITH, CHIEF EXECUTIVE OFFICER - FQHC

SOUTHERN NEVADA Community HEALTH CENTER
AT THE SOUTHERN NEVADA HEALTH DISTRICT

Governing Board Retreat

Scheduled: October 30, 5-8 p.m.

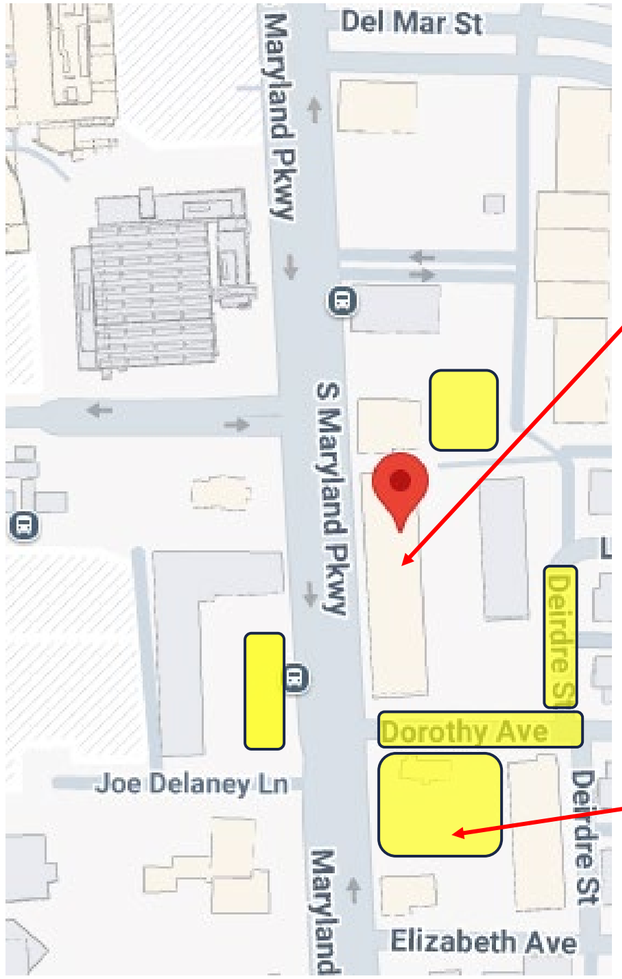
Location:
UNLV, University Gateway Bldg.
4700 S. Maryland Pkwy.
Las Vegas, NV 89119

Room: GTW 268 & 268

- Food will be provided.

Note: Main entry doors lock at 5 p.m. Someone will be there until 5:15 p.m. to let board members in.

Parking



UNLV, University Gateway Bldg.
4700 S. Maryland Pkwy.
Las Vegas, NV 89119

The University Gateway Building is located near the northeast corner of Maryland Parkway and Dorothy Avenue.

Take elevator to second floor, room GTW 268 & 269

Parking Available – yellow shaded areas

Street Parking

- Dorothy Ave.
- Deirdre St.

Starbucks parking lot

Additional parking in retail center parking lots

Short Term Retail Parking Garage

Agenda

4:45 – 5:00 p.m.	Board Members Arrives
5:00 – 5:40 p.m.	Eat and Network
5:40 – 6:00 p.m.	Steven Messinger, Policy Director, Nevada Primary Care Association • Legislative Policies - Impact on Health Centers
6:00 – 6:45 p.m.	Health Center History and Governance (pages 7-13) • OSV Jeopardy Game • SNHD and SNCHC History and Org Charts • Videos from Clinic
6:45 – 7:15 p.m.	Community Partners and SNHD Strategic Plan
7:15 – 7:45 p.m.	Program Review
7:45 – 8:00 p.m.	Questions & Answers/Closing

IX. INFORMATIONAL ITEMS

Community Health Center (FQHC) September 2024 Operations Report

SOUTHERN NEVADA Community HEALTH CENTER
AT THE SOUTHERN NEVADA HEALTH DISTRICT

MEMORANDUM

Date: **October 15, 2024**

To: Southern Nevada Community Health Center Governing Board

From: Randy Smith, Chief Executive Officer, FQHC RS

Fermin Leguen, MD, MPH, District Health Officer FL

Subject: Community Health Center FQHC Operations Officer Report – September 2024

Division Information/Highlights: The Southern Nevada Community Health Center, a division of the Southern Nevada Health District, mission is to serve residents of Clark County from underserved communities with appropriate and comprehensive outpatient health and wellness services, emphasizing prevention and education in a culturally respectful environment regardless of the patient's ability to pay.

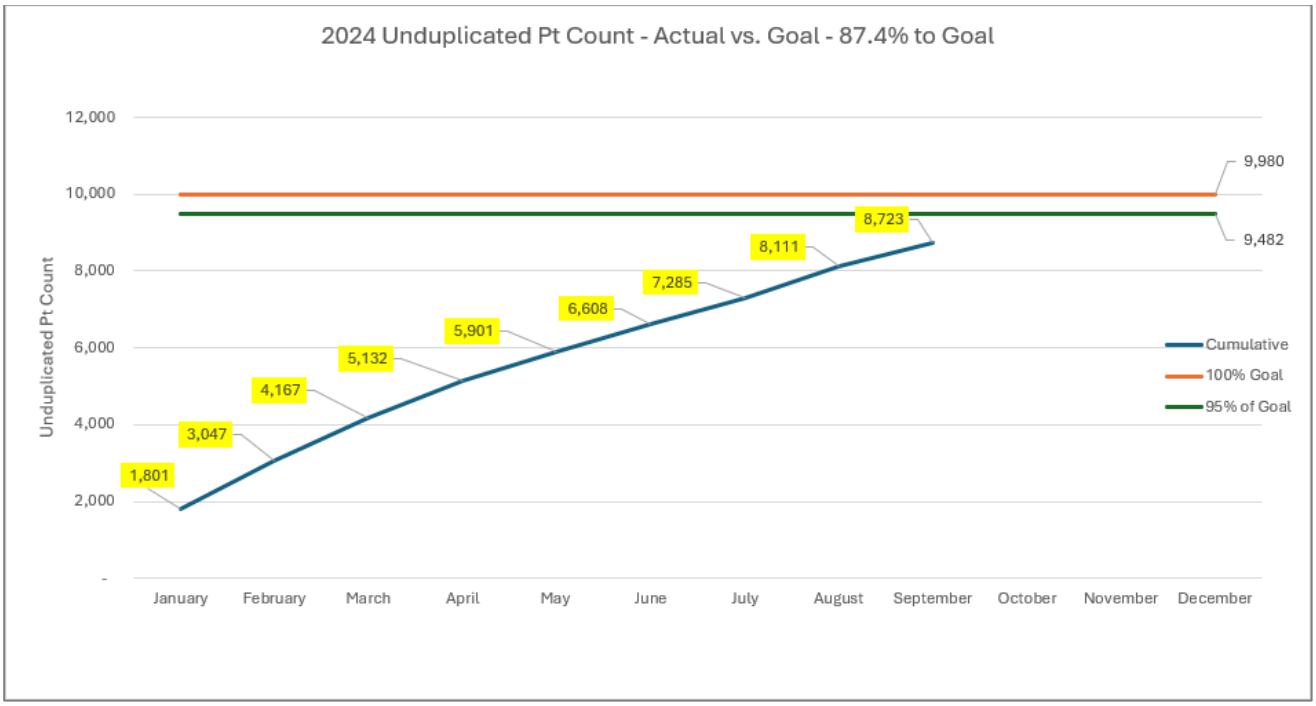
September Highlights

Administrative

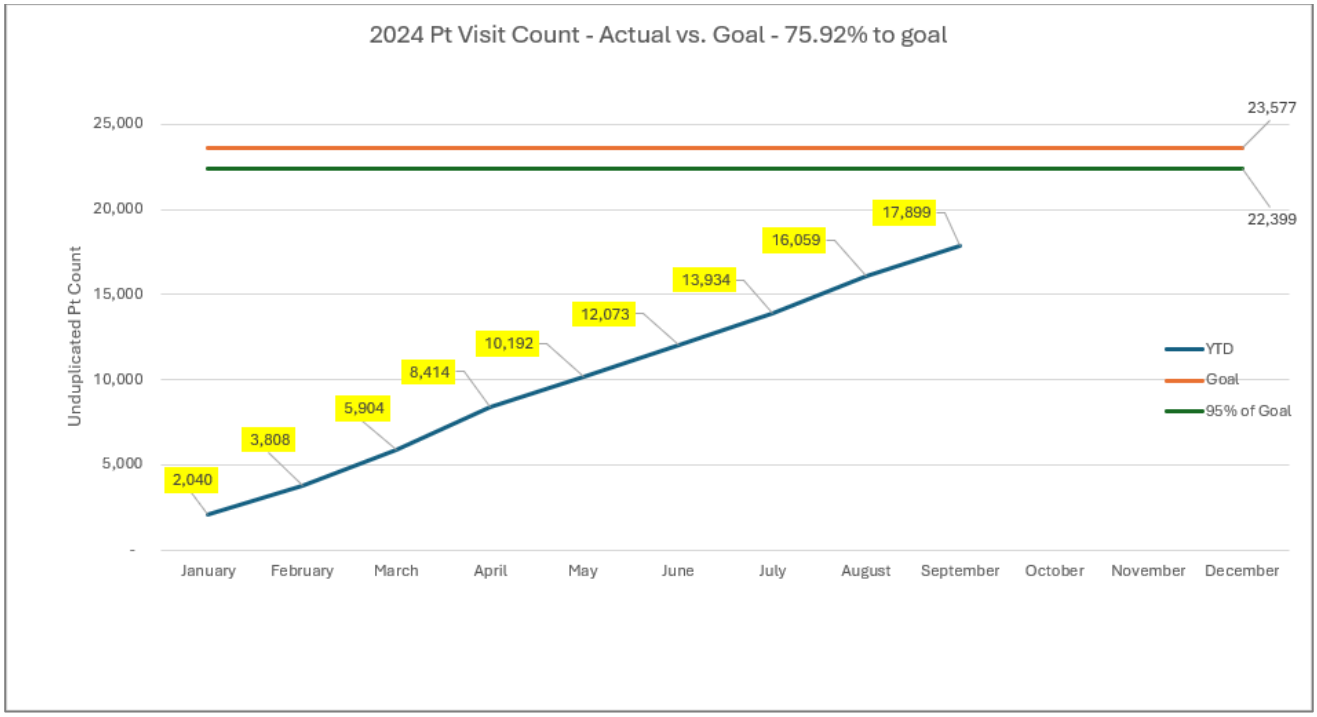
- New Access Point application submitted
- Ryan White Part A and EHE renewal grants due on 10/30/24
- Ryan White site visit: 11/6/24
- HRSA Operational Site Visit (OSV): 2/25/25 – 2/27
- HRSA Title X site visit: 9/2025
- Medical Director recruitment ongoing:
  - Two candidates scheduled for final interviews
- Employee Engagement Plan Update:
  - New onboarding process implemented
- Employee Annual Evaluations are being completed in October
- Behavioral Health Clinic at Decatur buildout complete. Furniture and IT installation to occur in October.
- Permits for the Oral Health Clinic at Fremont received. Development of the bid package for construction in process.

Access

Unduplicated Patients through September of 2024 = 87.4% to annual goal of 9,980 unduplicated patients:



Patient Visits through September of 2024 – 75.92% to goal of 23,577 patient visits:



Provider Visits by Program and Site – September 2024

Facility	Program	SEPT '25	SEPT '24	SEPT YoY %	FY25 YTD	FY24 YTD	FY YTD YoY%
Decatur	Family Health	524	368	30%	1,674	1,086	35%
Fremont	Family Health	349	189	46%	1,011	508	50%
Total	Family Health	873	557	36%	2,685	1,594	41%
Decatur	Family Planning	155	115	26%	446	410	8%
Fremont	Family Planning	118	47	60%	351	311	11%
Total	Family Planning	273	162	41%	797	721	10%
Decatur	Sexual Health	535	519	3%	1,614	1,650	-2%
Fremont	Sexual Health	126			357		
ASEC	Sexual Health		130		113	383	
Total	Sexual Health	661	649	2%	2,084	2,033	2%
Decatur	Behavioral Health	97	106	-9%	351	365	-4%
Fremont	Behavioral Health	92			354		
Total	Behavioral Health	189	106	44%	705	365	48%
Decatur	Ryan White	213	245	-15%	710	698	2%
Fremont	Ryan White	19			63		
Total	Ryan White	232	245	-6%	773	698	10%
FQHC Total		2,228	1,719	23%	7,044	5,411	23%

Pharmacy Services

	Sep-23	Sep-24		FY24	FY25		% Change YOY
Pharmacy Services	1,251	1,378	↑	3,922	4,184	↑	6.7%
Client Encounters (Pharmacy)	1,739	2,219	↑	5,441	6,789	↑	24.8%
Prescriptions Filled	29	49	↑	96	151	↑	57.3%
Client Clinic Encounters (Pharmacist)	17	41	↑	53	96	↑	81.1%
Financial Assistance Provided	7	9	↑	8	35	↑	337.5%

A. Dispensed 2,219 prescriptions for 1,378 clients.
B. The pharmacist completed 49 client clinic encounters.
C. Assisted 41 clients to obtain medication financial assistance.
D. Assisted 9 clients with insurance approvals.

Family Planning Services

A. The Family Planning program increased access to care by 41% in September 2024 compared to September 2023. Fiscal year to date, the program has provided 10% more patient encounters compared this time last year. The program continues to experience a high number of no-shows resulting in waste and limiting access to care. To overcome this, the team has commenced a process improvement project to address scheduling procedures and clinic workflows with a goal of increasing access to reproductive and sexual health services. The results of quality improvement initiative will be shared in January 2025.

HIV / Ryan White Care Program Services

A. The Ryan White program received 60 referrals between September 1st and September 30th. There were three (3) pediatric clients referred to the Medical Case Management program in September and the program received two (2) referrals for pregnant women living with HIV during this time.

B. There were 670 total service encounters in the month of September provided by the Ryan White program (Linkage Coordinator, Eligibility Workers, Care Coordinators, Nurse Case Managers, Community Health Workers, and Health Educator). There were 338 unduplicated clients served under these programs in September.

C. The Ryan White ambulatory clinic had a total of 435 visits in the month of September: 18 initial provider visits, 191 established provider visits including 10 tele-visits (established clients). There were 29 nurse visits and 197 lab visits. There were 46 Ryan White services provided under Behavioral Health by the Licensed Clinical Social Worker and the Psychiatric APRN during the month of September and 41 unduplicated clients served. There were 14 Ryan White clients seen by the Registered Dietitian under Medical Nutrition services in September.

D. The Ryan White clinic continues to implement the Rapid StART project, which has a goal of rapid treatment initiation for newly diagnosed patients with HIV. The program continues to receive referrals and accommodate clients on a walk-in basis. There were 9 patients seen under the Rapid StART program in September.

FQHC-Sexual Health Clinic (SHC)

A. The FQHC-Sexual Health Clinic (SHC) clinic provided 1,378 unique services to 932 unduplicated patients for the month of September. There were 12 unduplicated patients seen at the All-Saints Episcopal Church (ASEC) Outreach Clinic. All-Saints Episcopal Church transition all services to SNHD FQHC-SHC. There are currently more than 100 patients receiving injectable treatment for HIV prevention (PrEP).

B. The FQHC-SHC continues to collaborate with UMC on referrals for evaluation and treatment of neurosyphilis. The SHC is collaborating with the PPC- Sexual Health and Outreach Prevention Programs (SHOPP) with the Gilead FOCUS grant to expand express testing services for asymptomatic patients and provide linkage to care for patients needing STI, Hepatitis C or HIV treatment services.

C. The FQHC-SHC staff continues to see patients for Mpox evaluation and referral for vaccine.

D. The FQHC-SHC staff attended Overdose Response w/ Naloxone training.

Refugee Health Program (RHP)

Services provided in the Refugee Health Program for the month of September 2024

Client required medical follow-up for Communicable Diseases	-
Referrals for TB issues	18
Referrals for Chronic Hep B	2
Referrals for STD	4
Pediatric Refugee Exams	25
Clients encounter by program (adults)	53
Refugee Health screening for August 2024	53
Total for FY24-25	182

Eligibility and Insurance Enrollment Assistance

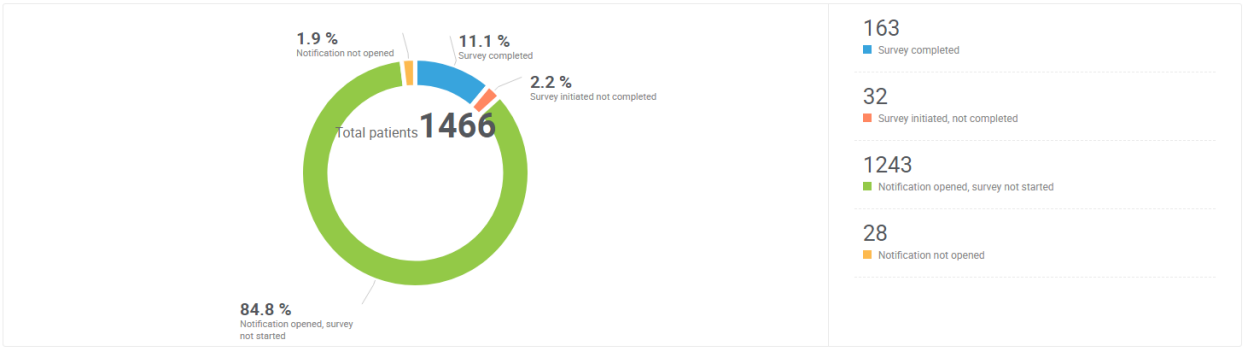
Except for the Ryan White program, eligibility assistance is now coordinated through our partnerships with the Social Services Department and Three Square. Both organizations are onsite at either the Decatur or Fremont health center and are available to provide patients with education, resources, and support accessing insurance options and publicly funded programs.

Patient Satisfaction: See attached survey results.

SNCHC continues to receive generally favorable responses from survey participants when asked about ease of scheduling an appointment, wait time to see their provider, care received from providers and staff, understanding of health care instructions following their visit, hours of operation, and recommendation of the Health Center to friends and family.

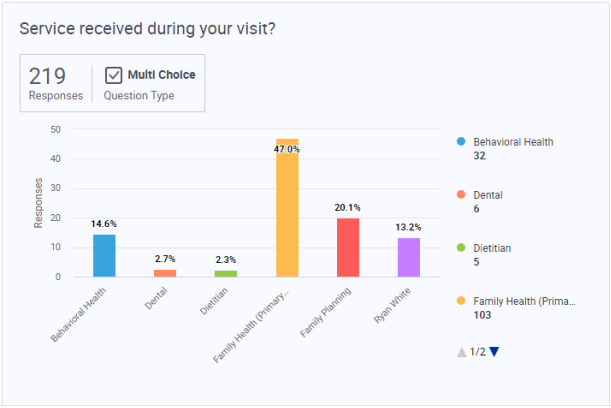
Southern Nevada Community Health Center
Patient Satisfaction Survey – September 2024

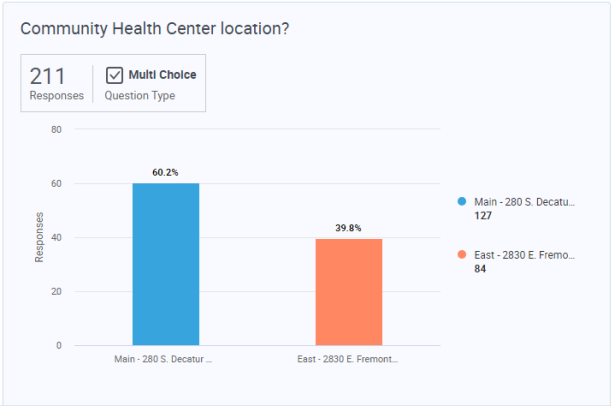
Overview



Gender

Service and Location

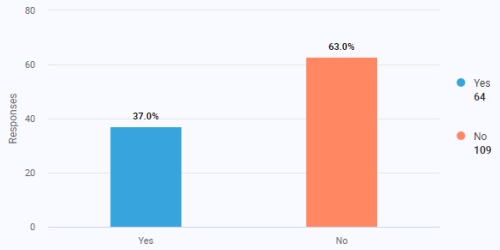




Provider, Staff, and Facility

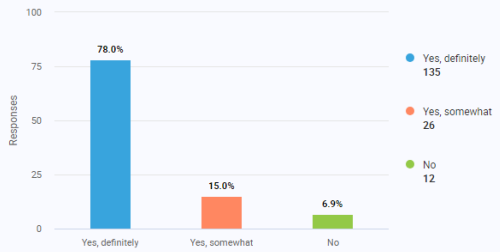
Was your most recent visit for an illness, injury or condition that needed care right away?

173 Responses | Multi Choice Question Type



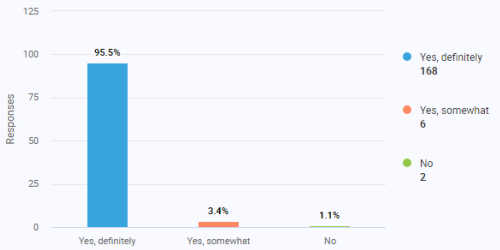
Was the recent visit as soon as you needed?

173 Responses | Multi Choice Question Type



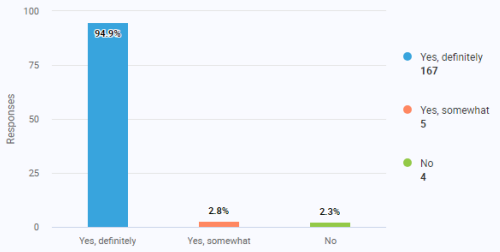
During your most recent visit, did this provider explain things in a way that was easy to understand?

176 Responses | Multi Choice Question Type



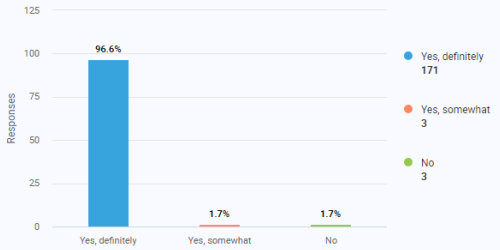
During your most recent visit, did this provider listen carefully to you?

176 Responses | Multi Choice Question Type



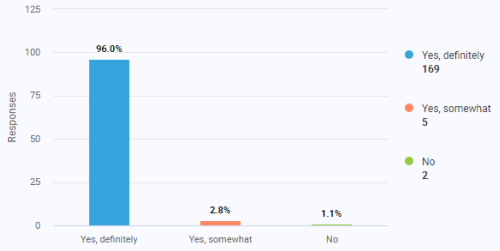
During your most recent visit, did this provider show respect for what you had to say?

177 Responses | Multi Choice Question Type



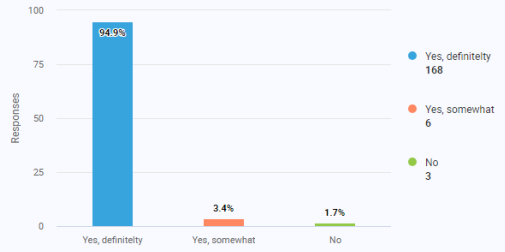
During your most recent visit, did this provider spend enough time with you?

176 Responses | Multi Choice Question Type



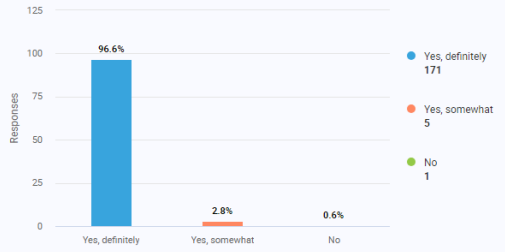
Thinking about your most recent visit, were the staff as helpful as you thought they should be?

177 Responses | Multi Choice Question Type



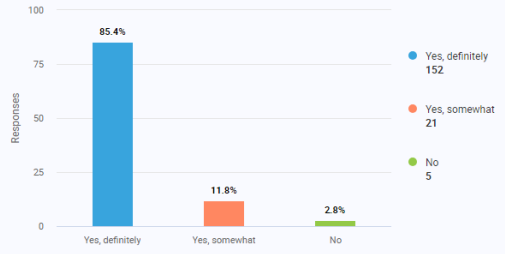
Thinking about your most recent visit, did the staff treat you with courtesy and respect?

177 Responses | Multi Choice Question Type



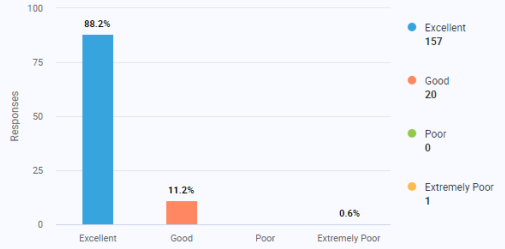
Thinking about your recent visit, was it easy to schedule an appointment?

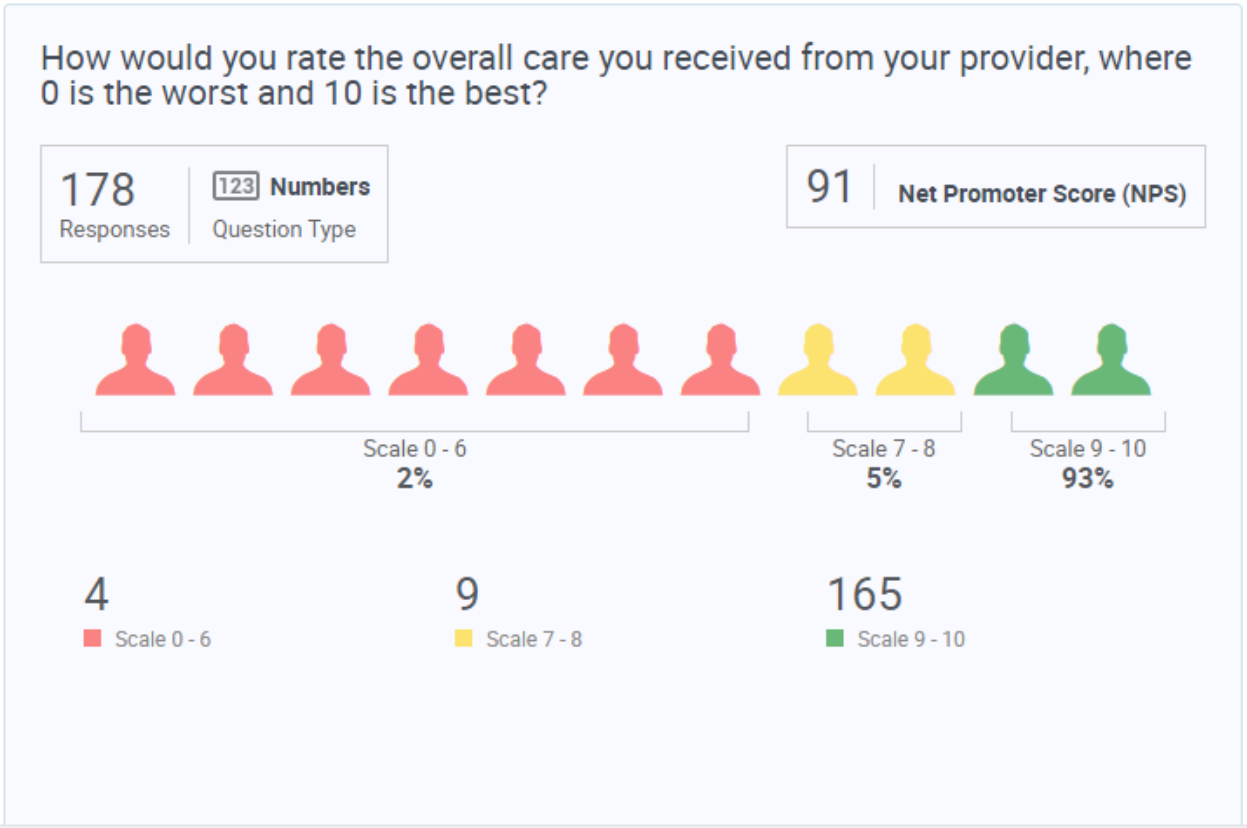
178 Responses | Multi Choice Question Type



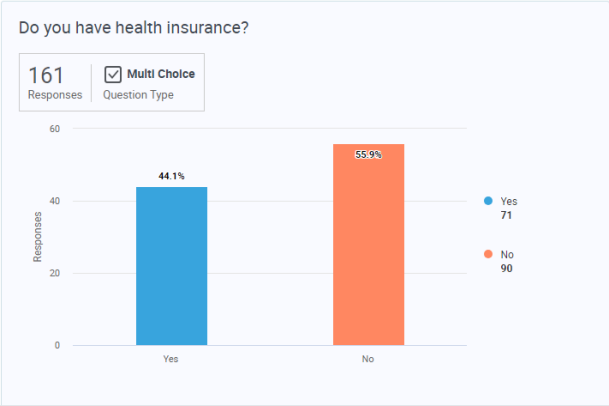
Thinking about the facility, how was the overall cleanliness and appearance?

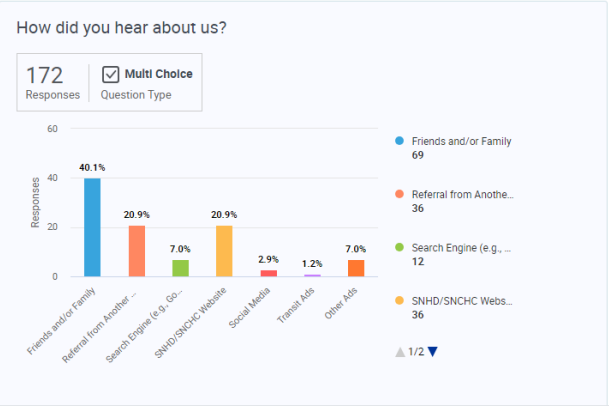
178 Responses | Multi Choice Question Type





General Information





X. SECOND PUBLIC COMMENT

A period devoted to comments by the general public, if any, and discussion of those comments, about matters relevant to the Board's jurisdiction will be held. Comments will be limited to five (5) minutes per speaker. **Please clearly state and spell your name for the record.** If any member of the Board wishes to extend the length of a presentation, this may be done by the Chair or the Board by majority vote.

SOUTHERN NEVADA Community HEALTH CENTER

AT THE SOUTHERN NEVADA HEALTH DISTRICT

XI. ADJOURNMENT

THANK YOU.