# MINUTES

**SOUTHERN NEVADA COMMUNITY HEALTH CENTER GOVERNING BOARD MEETING**
**February 17, 2026 – 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 Rooms A and B**

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| **MEMBERS PRESENT:** | Jasmine Coca, First Vice Chair<br>Sara Hunt, Second Vice Chair<br>Erin Breen<br>Ashley Brown<br>Blanca Macias-Villa<br>David Neldberg<br>Fr Rafael Pereira |
| **ABSENT:** | Rebeca Aceves<br>Donna Feliz-Barrows, Chair<br>Jose L. Melendrez |
| **ALSO PRESENT** | Cage Grogan |
| **LEGAL COUNSEL:** | Edward Wynder, Associate General Counsel |
| **CHIEF EXECUTIVE OFFICER:** | Randy Smith |
| **STAFF:** | Emily Anelli, Chelle Alfaro, Tawana Bellamy, Donna Buss, Robin Carter, Andria Cordovez Mulet, David Kahananui, Cassius Lockett, Luann Province, Yin Jie Qin, Stephanie Romano, Felicia Sgovio, Greg Tordjmanm, Renee Trujillo, Donnie (DJ) Whitaker |

## I. CALL TO ORDER and ROLL CALL

The Southern Nevada Community Health Center (SNCHC) Governing Board Meeting was called to order at 2:34 p.m. Ms. Tawana Bellamy, Senior Administrative Specialist, administered the roll call and confirmed a quorum.

## II. PLEDGE OF ALLEGIANCE

## III. RECOGNITION

1. **Southern Nevada Health District – Employee of the Month - February 2026**
   - Stephanie Romano

The Governing Board recognized Ms. Romano as Southern Nevada Health District's Employee of the Month for February 2026. Ms. Bellamy read an excerpt from her nomination, highlighting her exceptional dedication and patient-centered care. On behalf of the SNCHC Governing Board, the Vice Chair extended congratulations to Ms. Romano.

**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.

Seeing no public comment was presented online or in person, the Vice Chair closed the First Public Comment period.

**V.** **ADOPTION OF THE FEBRUARY 17, 2026 MEETING AGENDA** *(for possible action)*

The Vice Chair called for questions or comments on the agenda. There were none.

*A motion was made by Father Rafael, seconded by Member Neldberg, and carried unanimously to approve the February 17, 2026 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**: January 20, 2026 *(for possible action)*

2. **Approve Re-Credentialing and Renewal of Privileges for Provider;** direct staff accordingly or take other action as deemed necessary *(for possible action)*
   - Tabitha Johnson, Behavioral Health Manager, LMFT, LCADC

The Vice Chair inquired if there were any items on the Consent Agenda that board members wanted to remove for further discussion. There were no requests.

*A motion was made by Father Rafael, seconded by Member Neldberg, and carried unanimously to approve the Consent Agenda, as presented.*

**VII.** **REPORT / DISCUSSION / ACTION**

1. **Receive, Discuss and Accept the Single Audit Report as of June 30, 2025, from FORVIS MAZARS LLP;** direct staff accordingly or take other action as deemed necessary *(for possible action)*

   Donnie (DJ) Whitaker, Chief Financial Officer, presented the Singel Audit Report as of June 30, 2025, from FORVIS MAZARS LLP. Ms. Whitaker reported that the final document contains no changes from the draft presented in December by Mr. Josh Findlay. Ms. Whitaker noted that

issuance of the Office of Management and Budget (OMB) Compliance Supplement enabled final completion of the report.

Ms. Whitaker stated that the Single Audit received an unmodified, clean opinion with no findings. The finalized Single Audit Report, along with the previously accepted and signed Financial Statement Audit Report, was included in the meeting packet. Ms. Whitaker further noted that the Board of Health (BOH) formally accepted the Single Audit Report on January 22, 2026 and that the report has been published on SNHD's website together with the financial audit.
Total federal expenditures reported in the Schedule of Expenditures of Federal Awards (SEFA) amounted to $45.4 million. All required auditor communications were addressed during Mr. Findlay's November presentation to the BOH, therefore, no additional communications were required. The financial statement audit also received an unmodified opinion, with no reportable findings related to internal control or compliance.

Ms. Whitaker reviewed the four major federal programs that were reviewed for compliance. Ms. Whitaker further confirmed that all information presented is consistent with what was shared at the December meeting.

The Vice Chair called for further questions and there were none.

*A motion was made by Father Rafael, seconded by Member Neldberg, and carried unanimously to accept the Single Audit Report as of June 30, 2025, from FORVIS MAZARS LLP, as presented.*

2. **Discuss and Accept the December 2025 Year to Date Financial Report;** direct staff accordingly or take other action as deemed necessary *(for possible action)*

Donnie (DJ) Whitaker, Chief Financial Officer, presented the December 2025 Year to Date Financial Report as of December 31, 2025, with the following key highlights:

**Revenue**

- General Fund revenue (Charges for Services & Other) is $18.64M compared to a budget of $19.53M, an unfavorable variance of $897K.
- Special Revenue Funds (Grants) are $2.39M compared to a budget of $3.82M, an unfavorable variance of $1.42M.
- Total Revenue is $21.03M compared to a budget of 23.35M, an unfavorable variance of $2.32M.

**Expenses**

- Salary, Tax, and Benefits is $7.12M compared to a budget of $8.30M, a favorable variance of $1.18M.
- Other Operating Expense is $14.65M compared to a budget of $15.54M, a favorable variance of $887K.
- Indirect Cost/Cost Allocation is $5.32M compared to a budget of $6.43M, a favorable variance of $1.11M.
- Total Expense is $27.09M compared to a budget of $30.27M, a favorable variance of $3.18M.

**Net Position:** is ($6.06M) compared to a budget of ($6.92M), a favorable variance of negative $854K.

Ms. Whitaker further advised of the following:

- Percentage of Revenues and Expenses - by Department
- Revenues by Department - Budget to Actuals
- Expenses by Department - Budget to Actuals
- Patient Encounters - By Department
  - FY2025 – 18,274
  - FY2026 – 21,118
  - 16% year-over-year growth
- Month-to-Month Comparisons - Year-to-Date revenues and expenses by department and by type.

The Vice Chair called for further questions and there were none.

*A motion was made by Father Rafael, seconded by Member Neldberg, and carried unanimously to accept the December 2025 Year to Date Financial Report, as presented.*

3. **Receive, Discuss and Approve Finance & Audit Committee Assignment;** direct staff accordingly or take other action as deemed necessary *(for possible action)*

Randy Smith, Chief Executive Officer, FQHC presented the recommendation to appoint Father Rafael Pereira to the Finance and Audit Committee. Mr. Smith noted that Father Rafael is a Certified Public Accountant, has expressed interest in serving on the committee, and has previously served in this capacity. Although the Board members are familiar with Father Rafael, this recommendation is formally brought forward for Board approval.

The Vice Chair called for further questions from the board and there were none.

*A motion was made by Member Neldberg, seconded by Member Breen, and carried unanimously to approve the Finance & Audit Committee Assignment, as presented.*

4. **Receive, Discuss and Approve Updates to CHCA-028 Credentialing and Privileging Policy**; direct staff accordingly or take other action as deemed necessary *(for possible action)*

Mr. Smith presented the proposed updates to the CHCA-028 Credentialing and Privileging Policy. Mr. Smith noted that approximately one year ago, during preparation for the operational site visit, the team identified updated HRSA compliance guidelines. These guidelines allow the Health Center to manage credentialing and privileging internally without requiring Board approval for each individual provider action.

Mr. Smith said that earlier in the meeting, a provider item appeared on the consent agenda. Under the updated policy, such items would no longer require Board approval, streamlining meeting agendas while ensuring that all HRSA required elements continue to be completed. The Health Center is not the only SNHD division with licensed providers. We took the opportunity to create a cross-divisional policy ensuring consistency in credentialing and

privileging processes across both the Health Center and the Primary, Preventative, and Public Health divisions.

Mr. Smith explained that the policy refresh included:

- Expanding the policy from Health Center–only to district-wide applicability
- Clarifying terminology and acronyms (e.g., "LIP – Licensed Independent Practitioner")
- Clearly delineating requirements for each provider category.
- Updating related forms and approval workflows.
- Establishing the Chief Medical Officer/Medical Director, as responsible for document review and coordination with Human Resources.

Mr. Smith reported significant growth in Human Resources' capacity to support credentialing functions, especially since becoming an FTCA organization. The updated policy will help maintain regulatory compliance, streamline Board agendas, and support consistent provider oversight.

Mr. Smith advised the policy will continue to require Board review and approval on a three-year cycle as part of our standard operational site visit preparation.

Vice Chair Coca requested clarification on the removal of Board approval from routine credentialing procedures. Mr. Smith confirmed that while the Board will still review and approve the overarching policy every three years, it will no longer be required to approve individual provider credentialing actions, such as those previously included on consent agendas.

The Vice Chair called for further questions and there were no additional questions or concerns were raised by Board members.

**VIII.** **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)*

There were no reports from board members.

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

- CEO Comments

**Federal Health Center Program Funding**

Mr. Smith reported that Congress approved ongoing funding for the Health Center Program, including a $340 million increase, representing the largest funding expansion for the program in the past decade. This increase reflects national recognition of the growing demand for community health services and the critical role Federally Qualified Health Centers (FQHCs) play in underserved communities. HRSA is in the process of determining how this increase will be distributed. Potential allocation methods include:

- New Access Point (NAP) awards

- Increases to existing Health Center base grants.
- Other programmatic adjustments to support capacity and access

Mr. Smith noted that staff received informal notification earlier that morning that HRSA is actively working through distribution options, though no timeline has been provided.

Vice Chair Coca asked about when do you expect HRSA to issue guidance on how the $340 million funding increase will be used. Mr. Smith explained that HRSA has acknowledged the urgency and is currently developing the guidance, but no definitive date has been given. He added that many Health Centers nationwide are hopeful for base grant increases, as base funding has remained flat for several years.

Mr. Smith further explained that a previously closed NAP opportunity could potentially be reopened, as many organizations have recent applications on file. Historically, when HRSA issues base grant adjustments, the formula often considers patient volume and uninsured populations, both of which could position the Health Center favorably.

**Title X Family Planning Funding**
Mr. Smith provided an update on Title X funding, noting that the Health District's current grant expires March 31, 2026. Title X supports the Health Center's family planning and reproductive health services and represents approximately $1.4 million in annual funding. Due to the absence of updated federal guidance for the new funding cycle, the team:

- Submitted the required non-competing continuation application using the most recent guidance from the previous year.
- Ensured the submission is accessible to the assigned federal project officer.
- Continued to coordinate with both the project officer and the Nevada Primary Care Association, the other Nevada Title X recipient.

Mr. Smith emphasized concerns related to the timing, as national discussions indicate federal leaders are considering program changes that may affect eligibility, reporting requirements, and the scope of services covered. To prepare for possible funding delays or reductions, the Health District implemented a hiring freeze earlier in the fiscal year, intentionally leaving certain Title X-supported roles unfilled to create operational and financial flexibility.

Vice Chair Coca inquired about what is the worst-case scenario if Title X funding does not come through, and what would the plan be. Mr. Smith stated that the organization's priority would be to avoid staff layoffs and maintain continuity of essential services. Leadership would work collaboratively with Dr. Lockett, Finance, and HR to determine internal adjustments. While the patient demand is high—illustrated by current clinic volumes—operations would need to be evaluated to sustain services without that funding.

Vice Chair Coca further inquired about has the health canter been in this situation before, waiting this close to the deadline. Mr. Smith explained that in past years, award notices occasionally arrived after the start of the new grant period; however, those delays occurred during relatively stable federal cycles. The current environment involves significant federal restructuring of the program, making this year's delay more impactful and uncertain.

**Federal Reporting Compliance**
Mr. Smith reported that several major annual reporting requirements have been completed:

- Family Planning Annual Report (FPAR)
  - Submitted ahead of schedule to avoid potential delays related to federal administrative interruptions.
  - Prepared in collaboration with the Business Office and Informatics teams.

- Uniform Data System (UDS) Report – Calendar Year 2025
  - Submitted last week.
  - HRSA will conduct a first-level review before issuing requests for clarification or adjustments.
  - Staff will present summary findings—including demographic trends and service utilization patterns—to the Board later in the spring.

Mr. Smith advised that these reports are essential compliance requirements that influence federal oversight, funding, and operational performance monitoring.

**Operational Site Visit (OSV) Badge Recognition**
Mr. Smith shared that HRSA awarded the Health Center an Operational Site Visit Badge, recognizing excellence in compliance, readiness, and program execution. This is the first time the Health Center has received this recognition since his tenure began.

Mr. Smith highlighted that:
- The badge reflects sustained adherence to HRSA's stringent operational and governance standards.
- The Health Center received strong feedback during the OSV conducted last year, with any minor findings promptly corrected.

Mr. Smith expressed appreciation for the dedicated work of Mr. Kahananui in the Business Office, who supported operational, compliance, and financial reporting functions and Tawana Bellamy, whose work significantly contributed to preparation and documentation.

Vice Chair Coca asked if the OSV badge is displayed on the Health Center website. Mr. Smith shared that it has not been posted but will be added. Mr. Smith further shared he plans to wait until additional performance badges tied to the UDS review are released so they can be displayed together.

- Medicaid Dashboard Update Report

David Kahananui, FQHC Administrative Manager, presented the Medicaid Dashboard Update Report. Mr. Kahananui reported that Medicaid remains the organization's strongest payer due to the PPS rate. Given the organization's payer mix and its role in serving uninsured and vulnerable populations, sustained growth in Medicaid volume is necessary for financial stability.

Mr. Kahananui advised that as part of the 2025 strategic plan, the Board approved a goal to increase Medicaid visits and unduplicated Medicaid patients by 5% by year-end. The organization achieved a 3.68% increase in Medicaid visits and a 6.79% increase in unduplicated Medicaid patients for 2025.

Mr. Kahananui advised that on January 1, CareSource joined the Nevada Medicaid managed care market. Although existing Managed Care Organizations (MCOs) were required to transfer members to CareSource during the redistribution process, the health center's empanelment increased. Empaneled Medicaid patients rose from 920 in January 2025 to 2,295 by year-end, representing 149% growth. Following the January 2026 redistribution, empanelment increased an additional 11% to 2,538 patients.

Mr. Kahananui further advised that a review of January 2026 performance showed continued growth. The organization saw 443 unduplicated Medicaid patients, an 80.1% increase compared to January 2025 (246 patients). This places the organization at 13.97% of its new annual goal. Total visits for the month increased from 352 in January 2025 to 770 in January 2026, a 118.8% year-over-year increase. Of these, 600 were billable provider visits.

Mr. Kahananui advised that multi-year comparisons indicate that the organization has reached its highest Medicaid empanelment level to date and is on pace to exceed previous years in both visits and unduplicated patient counts.

Mr. Kahananui further advised that the year-over-year January visit-type comparison showed increases across nearly all categories, with the exception of nursing visits, which decreased by 72.39%. Operational feedback indicates that many of these encounters were appropriately converted to provider visits.

Vice Chair Coca inquired about how nurse visits are converted into provider visits. Mr. Kahananui explained that when a nurse identifies a condition needing a provider's evaluation, the patient is added to the provider's schedule before leaving the clinic. This improves care quality and ensures appropriate billing. Mr. Kahananui noted that workflow improvements by the Operations Team have increased clinic efficiency and patient capacity. Providers are seeing significantly more patients per day compared to the previous year.

Mr. Smith added that regular coordination with Medicaid MCOs has strengthened relationships, improved issue resolution, and supported empanelment growth. New workflows under Dr. Carter's leadership help identify care gaps and bring patients back for follow-up, with average visits per patient currently at 1.3.

Mr. Smith noted that patient experience played a significant role in visit frequency, stating that when patients feel welcomed, heard, and supported, they are more likely to return for necessary follow-up care. Mr. Smith emphasized that while the organization is seeing meaningful growth in actual patients served, there remains a substantial difference between the number of patients empaneled and those who actively seek care—an expected trend within primary care settings.

Mr. Smith shared that the team continues outreach efforts, including welcoming new patients through letters and other communications. Mr. Smith expressed confidence that the current rate of growth is healthy, sustainable, and reflective of a well-functioning system.

- Pharmacy Update

Todd Bleak, Pharmacy Manager, provided a detailed update on the activities and recent developments within the Pharmacy Finance Work Group. The work group was formed last

year, and is focused on pharmacy-related financial operations, including revenue and expenses.

**HRSA 340B Rebate Pilot Program**

Dr. Bleak explained that, over the past two years, several pharmaceutical manufacturers have sought to transition the 340B program from an upfront discount model to a rebate structure. In response, HRSA objected to these proposed changes and instead announced its own limited 340B rebate pilot. The pilot was scheduled to begin on January 1, 2026, with the announcement released in October 2025, providing covered entities minimal time to prepare for the operational and financial impacts.

Dr. Bleak further noted that, shortly before the implementation date, a hospital group challenged HRSA's authority in federal court. On December 29, 2025, the district court issued a temporary injunction, halting HRSA's program pending further review. HRSA subsequently filed an appeal, which was denied, after which HRSA withdrew its appeal.

Dr. Bleak advised that nothing has changed for the pharmacy. Medications are still discounted at their regular 340B discounted price. Although there is a halt on the rebate pilot, it is not the end of it. After HRSA withdrew their appeal, they started an administrative process. Initially, what the court found is that HRSA did not consider the administrative impacts of this change on covered entities or consider alternatives. Dr. Bleak explained that covered entities have opposed a rebate model as it is a major disruption in cash flow and it is an administrative cost for covered entities. It is not as simple as purchasing the medication, and automatically getting the rebate back, it requires the covered entity to submit claims for the medications to be reviewed and approved by the manufacturer then they issue the rebate. This will require the covered entity to establish the necessary infrastructure to support the process. Through the end of December, the Pharmacy-Finance Work Group had been preparing for the rebate pilot, including making internal changes in how rebates would be recognized and planning for the significantly higher upfront medication costs that would be required under the new model.

Vice Chair Coca inquired about who assists the pharmacy with submitting rebate claims and how long it takes to receive the rebate. Dr. Bleak explained that the pharmacy maintains all claim information and submits it through a portal with assistance from the IT department, uploading the claims data on a weekly basis. Under HRSA's initial structure, once manufacturers received the data, they were required to process it and return the information to the covered entity within ten days. Dr. Bleak further noted that Finance will eventually need to determine how to handle cost allocation, particularly since upfront medication costs could increase to 200% or more of what is currently paid, significantly affecting associated cost allocations. Another unresolved issue is how the rebate should be recorded—whether as revenue or as a reduction in cost. This has not yet been determined. Implementing the rebate model would require substantial changes in how Finance tracks medication expenses.

Member Father Rafael inquired about whether the rebate would ultimately be recorded as revenue or as a reduction in cost, and whether a report was available as of January showing current activity, expenditures, submitted rebate claims, and anticipated outcomes. Dr. Bleak advised that no claims have been submitted because the program remains on hold. Member Father Rafael commented that, in the worst-case scenario, the organization should not expect a rebate at this time, but once the program is approved, a rebate could be anticipated. Dr. Bleak agreed and noted that internal procedures would need to change

because rebates are not currently received for medication purchases. Dr. Bleak further shared that sufficient medication has already been purchased to carry the Health District through the remainder of the fiscal year; therefore, any financial accounting changes would not occur until the next fiscal year, with the new purchase-and-rebate process beginning in fiscal year 2027.

Member Father Rafael also asked about the average rebate percentage the organization might expect to receive. Dr. Bleak explained that the rebate pilot program applies to only ten medications, meaning the impact in the first year would be relatively small. For the Health District, the primary burden is administrative, both the setup and the associated costs. Dr. Bleak added that the broader concern is that this is only the first year, and additional medications will be added overtime. If manufacturers influence the process, the entire 340B program could eventually transition to a rebate-based model.

Vice Chair Coca inquired about who would submit and track the rebates. Dr. Bleak shared that it would be him with the assistance of the Information Technology department, which is currently manageable right now. If it grows, then we would have to plan for additional resources. Dr. Bleak shared the group will continue to monitor this and update the board as things progress.

**Gilead Patient Assistance Program**

Dr. Bleak explained that the Gilead Patient Assistance Program provides free medications for eligible uninsured patients, which for the Health Center are HIV medications. Dr. Bleak further described how the pharmacy's process had worked up until now: the pharmacy would purchase and dispense the medication, and Gilead would reimburse the Health District for those medications, similar to any other insurance claim. In May/June of last year, Gilead announced that community and outside pharmacies would no longer be permitted to participate in the program, and that the program would end in December 2025.

Dr. Bleak also reviewed the volume, revenue, and gross margin associated with these medications. Based on projections for the next six months, the pharmacy anticipated approximately a $2 million loss in revenue. However, the team was able to offset part of this loss by enrolling new patients into the program and ensuring that any potentially insurable patients were connected to insurance. Additionally, an overall increase in pharmacy volume reduced the projected loss from $2.5 million to the current estimate of $1.5 million.

Dr. Bleak further reviewed the following:

- Pharmacy Prescription Volume
- Pharmacy Revenue/Margin Trend
- Prescription Volume by Payer

| Location | Commercial | Medicare | Medicaid | Cash |
|---|---|---|---|---|
| United States | 51% | 28% | 16% | 5% |
| SNCHC Pharmacies | 28%* | 1% | 19% | 52% |
| | *4% Gilead AA | | | |

*Most of the health center's margin is in the commercial tier.

In response to Member Father Rafael's inquiry regarding the significant difference between national figures and the Health Center's data, Dr. Bleak explained that the variation reflects the Health Center's payer mix and the population it serves. Dr. Bleak added that future

improvements will depend on continuing to increase volume, strengthening the payer mix, and exploring additional services that can generate prescription-related revenue.

The Vice Chair called for further questions. There were none.

*Member Breen left the meeting at 3:28 p.m.*

- Clinical Quality Performance Measures: CY25 Quarter 4 Update

Felicia Sgovio, FQHC Quality Management Coordinator provided an update on Clinical Quality Performance Measures: CY25 Quarter 4.

Ms. Sgovio shared the following highlights:

- Tobacco Use: Screening & Cessation
  - Successfully mapped the tobacco assessment under "social history > -smoking"
  - 20% increase; CY 2025 71.4%
- Early Entry Intro Prenatal Care & Birthweight Measures
  - Manual Tracking
  - Continuing to work on challenges with mapping EDC/EDD data
- HIV & Pregnant Patients
  - Manual Tracking
  - ICD codes starting with "O98.7___" have been added to the value set in Azara.

Ms. Sgovio further provided an overview of the following:

- Year by Year Comparison Increases:
  - Childhood Immunization Status: 18.8% increase
  - HIV Linkage to Care: 0.5% increase
  - IVD Use of Aspirin or Another Antiplatelet: 2.1% increase
  - Tobacco use screening and cessation: 14.8% increase
  - Patients
    - BMI, Screening depression f/u, HIV Screening (approx. 2000 more patients)
    - Tobacco screening and cessation (approx. 1700)
- 2025 Quality Measure Focus
  - Surpassed quality measure targets for all focus measures.

Ms. Sgovio shared that the Quality Improvement Workgroup discussed that conducting a deep dive into the line list of patient-level data has been working well. She noted that Azara mapping related to structured clinical data remains an area of opportunity, and that data validation will continue to be a monthly focus.

Further, Ms. Sgovio shared that a new patient satisfaction survey was implemented on January 1, 2026, which includes questions that will satisfy criteria for the Patient Centered Medical Home recognition process. Ms. Sgovio presented the number of surveys completed by month and a comparison of 2024 to 2025. Ms. Sgovio also shared the fourth-quarter survey results from October through December 2025, noting that the net promoter score was 88, reflecting how patients rated the overall care they received from their provider.

Ms. Sgovio presented the Top Three Most Commonly Identified Strengths reported by patients:

- Friendly and caring staff.
- Excellent service.
- Helpful and compassionate providers.

Ms. Sgovio also presented the Top Three Most Commonly Identified Opportunities for Improvement:

- Difficulty obtaining timely appointments or experiencing long wait times.
- Issues with medication refills or communication regarding prescriptions.
- Challenges scheduling follow-up appointments or obtaining referrals.

The Vice Chair called for questions and there were none.

**X. INFORMATIONAL ITEMS**

- Community Health Center (FQHC) Monthly Report – January 2026

**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 Chair closed the Second Public Comment period.

**XII. ADJOURNMENT**

The meeting was adjourned at 4:00 p.m.

Randy Smith
Chief Executive Officer - FQHC

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