

MINUTES

SOUTHERN NEVADA COMMUNITY HEALTH CENTER GOVERNING BOARD MEETING

March 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

MEMBERS PRESENT:

Donna Feliz-Barrows, Chair
Jasmine Coca, First Vice Chair
Sara Hunt, Second Vice Chair
Rebeca Aceves
Erin Breen
Jose L. Melendrez
David Neldberg
Fr Rafael Pereira

ABSENT:

Ashley Brown
Blanca Macias-Villa

ALSO PRESENT

LEGAL COUNSEL:

Edward Wynder, Associate General Counsel

CHIEF EXECUTIVE OFFICER:

Randy Smith

STAFF:

Emily Anelli, Chelle Alfaro, Tawana Bellamy, Todd Bleak, Donna Buss, Robin Carter, Andria Cordovez Mulet, Claudette, Fajardo, David Kahananui, Annie Lin, Cassius Lockett, Luann Province, Renee Trujillo, Merylyn Yegon, 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 - March 2026

- Claudette Fajardo

The Governing Board recognized Ms. Fajardo, a Medical Assistant, as Southern Nevada Health District's Employee of the Month for March 2026. Ms. Bellamy read an excerpt from her nomination, highlighting her exceptional work ethic and consistent application of SNHD's CARES values. On behalf of the SNCHC Governing Board, the Chair extended congratulations to Ms. Fajardo.

- 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 two (2) 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 Chair closed the First Public Comment period.

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

The Chair requested approval of the agenda with one modification: removal of the Behavioral Health Program Update under the CEO Comments.

A motion was made by Father Rafael, seconded by Member Breen, and carried unanimously to approve the March 17, 2026 meeting agenda as amended.

- 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:** February 17, 2026 *(for possible action)*

- 2. Approval of CHCA-039 Insulin and Epinephrine Fee Structure Policy;** direct staff accordingly or take other action as deemed necessary *(for possible action)*

The Chair asked whether any Board member wished to remove items from the Consent Agenda. There were none.

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

- VII. REPORT / DISCUSSION / ACTION**

Recommendations from the March 16, 2026 Finance and Audit Committee Meeting

- 1. Receive, Discuss and Accept the January 2026 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 January 2026 Year to Date Financial Report as of January 31, 2026, with the following key highlights:

Revenue

- General Fund revenue (Charges for Services & Other) is \$21.64M compared to a budget of \$22.79M, an unfavorable variance of \$1.15M.
- Special Revenue Funds (Grants) is \$2.71M compared to a budget of \$4.45M, an unfavorable variance of \$1.74M.
- Total Revenue is \$24.34M compared to a budget of \$27.24M, an unfavorable variance of \$2.90M.

Expenses

- Salary, Tax, and Benefits is \$8.27M compared to a budget of \$9.68M, a favorable variance of \$1.41M.
- Other Operating Expense is \$17.27M compared to a budget of \$18.13M, a favorable variance of \$860K.
- Indirect Cost/Cost Allocation is \$6.21M compared to a budget of \$7.51M, a favorable variance of \$1.30M.
- Total Expense is \$31.75M compared to a budget of \$35.31M, a favorable variance of \$3.56M.

Net Position: is (\$7.41M) compared to a budget of (\$8.07M), a favorable variance of \$660K.

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 and Site
 - FY2025 – 21,356
 - FY2026 – 24,592
 - 15% year-over-year growth

Father Rafael commented on the financial report, noting that approximately 90% of the organization's revenue is generated by the pharmacy while only about 5% of salary expenses are attributed to pharmacy operations. He highlighted this significant imbalance as a positive indicator of efficiency and expressed appreciation for the clarity the financial reports provide. Father Rafael stated that, given the pharmacy's strong revenue contribution, any future decisions to increase staffing in the pharmacy department would be supported, as it continues to be a major source of revenue.

Mr. Smith added that while the pharmacy has been highly successful in generating revenue, it also represents a financial vulnerability, as a substantial portion of pharmacy revenue is derived from a limited class of medications. He referenced recent changes related to Gilead, which have already impacted or put certain pharmacy revenues at risk. Mr. Smith emphasized the importance of diversifying revenue streams to reduce reliance on pharmacy income alone. Mr. Smith further noted that the pharmacy's financial performance is closely tied to patient encounters, reinforcing the connection between service volume and revenue generation. He acknowledged the pharmacy's leadership in contributing to the organization's financial stability and stated that these issues, including 340B considerations, are being closely monitored. He added that a future presentation by Dr. Bleak may further address these topics.

The Chair called for further questions and there were none.

A motion was made by Member Melendrez, seconded by Father Rafael, and carried unanimously to accept the January 2026 Year to Date Financial Report, as presented.

2. Receive, Discuss and Approve the Augmentation to the Southern Nevada Community Health Center FY2026 Budget; direct staff accordingly or take other action as deemed necessary (*for possible action*)

Ms. Whitaker presented the Southern Nevada Community Health Center FY2026 Budget, as follows:

Staffing:

- Staffing for FY26 is projected to be 119.5 FTEs compared to FY26 adopted budget of 126.5 FTEs.

Revenue:

- General Fund revenue is projected at \$38.5M in FY26, a decrease of \$600K from the FY26 adopted budget.
- Special Revenue Fund (Grants) projected at \$5.1M in FY26, a decrease of \$2.6M from FY26 adopted budget.

Expense:

- FQHC combined expenditures for FY26 augmented budget is \$58.4M compared to \$61.3M from FY26 adopted budget.

Father Rafael reported that the Finance and Audit Committee met and discussed the format of financial statements presented to the Governing Board. He requested that future financial reports include side-by-side columns for comparisons of the adopted budget versus the augmented budget, allowing board members to clearly see line-item variances and areas of adjustment.

While acknowledging that the graphs and pie charts are informative and visually helpful, Father Rafael emphasized that regular financial statements are necessary for detailed financial analysis. Father Rafael further noted that having both narrative notes and visual summaries is valuable, however, the inclusion of traditional financial statements is essential to fully understand which areas were augmented and the specific financial impacts.

The Chair called for further questions and there were none.

A motion was made by Father Rafael, seconded by Member Breen, and carried unanimously to Approve the Augmentation to the Southern Nevada Community Health Center FY2026 Budget, as presented.

3. Receive, Discuss and Approve the New Finance Reports; direct staff accordingly or take other action as deemed necessary (*for possible action*)

Ms. Whitaker, along with Donna Buss, Revenue Cycle Manager, presented the New Finance Reports, as follows:

Ms. Whitaker presented the new financial report with support from Donna Buss, Revenue Cycle Manager. Ms. Whitaker reviewed the history of the revenue cycle function, noting that medical billing was brought in-house in FY 2022, transitioning from third-party billing vendors. Prior to this change, PPS Wrap qualifying encounters were not consistently submitted, and denials, rejections, and accounts receivable were not systematically resolved.

Ms. Whitaker shared that since the transition, the Health Center has finalized its Nevada Medicaid PPS rate, enabling receipt of Wrap payments designed to cover gaps when Medicaid Managed Care reimbursement is below the PPS rate. Cumulative WRAP payments received to date total approximately \$3.9 million. Beginning January 1, 2026, Medicaid implemented “shadow billing,” allowing PPS reimbursement to be incorporated at the point of payment rather than through supplemental submissions. Ms. Whitaker reported ongoing monitoring and coordination to address implementation challenges.

Ms. Whitaker reviewed accounts receivable (AR) aging trends, noting improvement in receivables shifting from over 180 days to the 0–30 day category. AR greater than 180 days decreased from 64% in FY 2022 to approximately 23% in FY 2026 year-to-date, indicating improved revenue cycle performance. The billing team continues to actively manage denials, resubmit claims, work with payers and clearinghouses, and identify claim trends. A previously identified payer configuration issue that temporarily removed the Health Center’s FQHC designation has been corrected, allowing for claim reprocessing.

Ms. Whitaker also reported that the Health Center has implemented monthly revenue cycle meetings, patient billing statements for balances not collected at time of service, and a 12-month write-off policy for uncollected balances.

Mr. Smith asked for clarification regarding the accounts receivable (AR) aging report, requesting an explanation of what the aging categories represent. Ms. Donna Buss clarified that claims categorized as greater than 180 days represent claims that are more than 180 days past the date of service. These claims may be delayed due to denials or payer-specific issues but have been submitted timely and are actively being worked, appealed, and reprocessed to capture all eligible revenue. Ms. Buss confirmed that 0–30 day balances are considered favorable, while balances exceeding 180 days indicate higher risk.

Father Rafael emphasized the importance of distinguishing between reported revenue and collected revenue, noting that uncollected revenue ultimately results in write-offs at year end. He requested additional insight into the percentage of revenue derived from cash/self-pay versus insured sources to better assess collection risk.

Mr. Smith stated that payer mix reporting would be a useful addition, noting that although the patient population is approximately 58% uninsured, this group represents a comparatively small portion of actual revenue collected. He explained that insured payers, including Medicaid with WRAP payments, contribute a significantly larger share of revenue.

Father Rafael stated that the Finance and Audit Committee had discussed the need for additional revenue breakdowns to better analyze denial trends, payer performance, and uncollected amounts. He reiterated that the decision to bring billing in-house was intended to improve collections and reduce denials and requested future reporting to identify whether

specific providers or payers contribute disproportionately to non-collection. He also requested year-end reporting on total write-offs to clearly identify revenue losses.

Member Hunt asked whether legislation from the prior legislative session requiring insurance companies to process claims within a defined timeframe had passed. Ms. Buss responded that while she was unsure whether specific legislation passed, most payers follow standard 60–90 day claim processing timelines. She also noted that a temporary payer system configuration issue had increased denials, requiring extensive claim reprocessing that is still underway.

Mr. Smith advised that at the committee meeting, the Chair and Father Rafael discussed what materials get presented to the committee versus the board. Mr. Smith shared the following objectives:

- Enhancing monthly financial reports, including AR aging and future payer mix reports; and
- Streamlining Governing Board presentations to focus on high-level summaries rather than duplicating committee-level detail.

Mr. Smith further advised that it was proposed that future Governing Board financial presentations focus on the summary page and utilization reports, while full financial packets would continue to be distributed to board members for review. Board members would retain the ability to raise questions during meetings as needed.

The Chair expressed support for this approach, stating that detailed financial analysis should occur at the committee level, with the Governing Board receiving a higher-level overview unless specific issues warrant deeper discussion. Member Erin Breen expressed agreement with the proposed approach and affirmed confidence in the Finance Committee’s role in detailed financial oversight.

The Chair called for further questions and there were none.

A motion was made by Father Rafael, seconded by Member Coca, and carried unanimously to Approve the New Finance Reports, as presented.

SNCHC Governing Board

4. Receive, Discuss and Approve the Fourth Quarter Risk Assessment; direct staff accordingly or take other action as deemed necessary *(for possible action)*

David Kahananui, FQHC Administrative Manager, presented the Fourth Quarter Risk Assessment for 2025, covering the compliance period October–December 2025. Mr. Kahananui advised that the assessment was conducted in compliance with Federal Tort Claims Act (FTCA) requirements, which mandate completion of a risk assessment each quarter, including two high-risk assessments annually.

The fourth quarter risk assessment utilized the ECRI Clinical Risk Management Program Self-Assessment Questionnaire for Bloodborne Pathogens, a designated high-risk area for the Health Center. The assessment was conducted on October 27, 2025, by the Medical Director in consultation with the Operations Manager.

Mr. Kahananui advised that a total of 120 criteria were evaluated. Of these, 111 criteria were found compliant, resulting in an overall compliance score of approximately 92%. The remaining nine criteria were identified as either needing improvement or non-compliant, and an action plan was developed to address the findings.

Mr. Kahananui reported that the organizational goal is to maintain 75% or fewer open action items at any evaluation point, acknowledging that percentages fluctuate as new assessments are completed and corrective actions are implemented. A summary of findings and the corresponding action plan for Q4 were presented to the Board.

The Chair called for further questions and there were none.

A motion was made by Member Melendrez, seconded by Member Coca, and carried unanimously to Approve the Fourth Quarter Risk Assessment, as presented.

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

Mr. Kahananui presented the Fourth Quarter 2025 Risk Management Report, covering compliance activities and outcomes for the period October 1–December 31, 2025, in accordance with Federal Tort Claims Act (FTCA) requirements. Mr. Kahananui reviewed the report's color-coding framework, noting that red indicates non-compliance, orange indicates approaching compliance, and green indicates compliance. FTCA mandates that quarterly risk assessments, quarterly risk management reports, and the annual risk management report be presented to the Governing Board for review and approval.

Mr. Kahananui further reported the fourth quarter risk assessment was completed on October 27, 2025, meeting FTCA requirements. The assessment utilized the Clinical Risk Management Program Self-Assessment Questionnaire for Bloodborne Pathogens and was conducted by the Medical Director, Dr. Robin Carter, in consultation with the Operations Manager. At the conclusion of the quarter, 33% of action items from prior risk assessments remained open. Under incident reporting and peer review, Mr. Kahananui reported:

- 19 incidents reported in fourth quarter
- 0 Sentinel events
- 4 high-risk incidents
- 6 incidents requiring root cause analysis and follow-up.
- 96% average score for provider peer review audits

Regarding required annual training, Mr. Kahananui reported that:

- 100% of clinical staff completed all five FTCA-required annual trainings by the end of fourth quarter 2025
- The Risk Manager completed two FTCA-required risk trainings during the year, maintaining compliance.

For risk and patient safety activities, the following outcomes were noted:

- 97% patient satisfaction score.
- No grievances filed.
- No pharmacy packaging or labeling errors.

- No HIPAA breaches.
- 97% of provider referrals were ordered and processed.
- 56% of eligible patients received pregnancy intention screening.
- Five pregnant patients were referred to contracted OB providers.
 - Manual tracking processes were implemented for pregnancy-related metrics.
- No newborn birth weight or race data was reported during the quarter.
- 100% credentialing compliance for licensed clinical providers.
- No claims were filed during the fourth quarter.

Father Rafael requested clarification regarding red (non-compliant) patient safety metrics, specifically related to pregnancy intention screening. Mr. Kahananui explained that challenges primarily involve data capture and reporting limitations, not lack of screening activity. Mr. Kahananui noted improvement from prior years, with performance more than doubling since 2024, and stated that screening often occurs but is not consistently reflected in reporting systems. Ongoing outreach and data validation efforts are in place, though many patients decline to provide follow-up information. Mr. Kahananui further reported that overall data quality for 2025 showed significant improvement and was the most accurate to date.

The Chair called for further questions and there were none.

A motion was made by Member Breen, seconded by Father Rafael, and carried unanimously to Approve the Fourth Quarter Risk Management Report, as presented.

6. Receive, Discuss and Approve the CY25 Annual Risk Management Report; direct staff accordingly or take other action as deemed necessary *(for possible action)*

Mr. Kahananui presented the Calendar Year 2025 Annual Risk Management Report, noting that the report is comprehensive and covers all four quarters of 2025. The report is approximately 40 pages in length, and board members received the document in advance. The presentation focused on key metrics and dashboard highlights.

Mr. Kahananui reminded the board that the same color-coding system applies throughout the report, noting that red indicates non-compliance, orange indicates approaching compliance, and green indicates compliance and reviewed FTCA requirements, which mandates one risk assessment per quarter, and at least two annual assessments focused on areas of high risk.

Risk Assessments

- Four required quarterly risk assessments were completed in 2025.
- Three assessments were conducted in designated high-risk areas.
- At year end, 22% of action items from risk assessment action plans remained open.

Incident Reporting and Peer Review

- 87 incidents were reported in 2025, compared to 70 incidents in the prior year.

Mr. Kahananui emphasized that the increase reflects improved awareness and reporting, not necessarily increased risk.

- 12 incidents were categorized as high-risk severity.
- 20 incidents required root cause analysis and follow-up.

- Provider peer review audits achieved an average score of 96%, exceeding the benchmark of 80%.
- Definitions of low, medium, high, and Sentinel events were included for reference.

Required Annual Training Compliance

- All five FTCA-required annual trainings were completed by 100% of clinical staff by the end of 2025.
- Previously identified gaps from 2024 were corrected and reported to FTCA.
- The Risk Manager completed all FTCA-required risk trainings, resulting in 100% compliance.

Patient Risk and Safety Measures

- Average patient satisfaction: 98% (benchmark: 90%)
- Three grievances filed in 2025; all were resolved promptly, generally within two weeks.
- No pharmacy packaging or labeling errors
- No HIPAA breaches; a previously reported Q3 issue was later determined not to be an actual breach.
- 97% of referrals ordered were processed and sent.
- 47.8% of eligible patients received pregnancy intention screening.
- 17 pregnant patients were referred to contracted OB providers.
 - Manual tracking continues for pregnancy-related measures due to lack of electronic reporting.
- One patient provided newborn birth weight/race data.
- 100% credentialing compliance for licensed independent practitioners and licensed clinical staff.
- No claims were filed during 2025.

Member Melendrez commented great work on the report.

The Chair called for further questions and there were none.

A motion was made by Member Melendrez, seconded by Father Rafael, and carried unanimously to Approve the CY25 Annual Risk Management Report, as presented.

7. Review and Discuss the FTCA Redeeming Process and Approve Submittal of the CY27 FTCA Redeeming Application; direct staff accordingly or take other action as deemed necessary *(for possible action)*

Mr. Kahananui presented the FTCA redeeming application process and provided an overview of the Calendar Year 2027 FTCA Redeeming Application for board approval. Mr. Kahananui explained that FTCA coverage provides medical malpractice protection for the Health Center and its eligible covered individuals, including licensed independent practitioners, other licensed clinical practitioners, and clinical staff registered with HRSA.

Mr. Kahananui noted that the FTCA redeeming application is due June 26, 2026, for coverage effective in calendar year 2027. He explained that Health Centers must meet specific deeming and redeeming criteria annually to maintain coverage and that the organization was initially

deemed in 2023 for 2024 coverage. Redeeming applications are submitted each June and are based on prior-year performance and current policy compliance.

Mr. Kahananui reviewed the four required components of the FTCA redeeming application:

1. Quarterly risk assessments
2. Incident reporting, provider reviews, and training
3. Risk and patient safety activities
4. Claims management

Mr. Kahananui reported that the Health Center continues to perform well across all required areas. He also noted that FTCA regulations require the Health Center to display a public notice on its website indicating its federal Public Health Service deemed status for purposes of medical malpractice coverage.

During discussion, the Chair requested clarification regarding whether formal board approval was required, as the agenda item title referenced review and discussion. Mr. Wynder confirmed that Governing Board approval was appropriate and necessary prior to submittal.

The Chair called for further questions and there were none.

A motion was made by Father Rafael, seconded by Member Breen, and carried unanimously to Approve Submittal of the CY27 FTCA Redeeming Application, as presented.

- 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
- ~~Behavioral Health Program Update~~ – This item was removed from the agenda.

Mr. Smith shared positive news regarding Title X funding. The Health Center was notified that the non-competing continuation application for Year Five of the existing five-year Title X agreement was opened. The funding amount is flat compared to the prior funding cycle, which Mr. Smith described as very favorable news following extended uncertainty. Staff have been notified, and Mr. Smith expressed appreciation to David Kahananui, Ryan, and their teams for proactive preparation. Mr. Smith noted the application has a short turnaround, with a submission deadline later that week, and confirmed there were no concerns about meeting the deadline.

Mr. Smith next reported that the Uniform Data System (UDS) report has been submitted and has completed its final round of review. Mr. Smith stated that, barring any exceptional issues, the report is considered complete and received positive feedback from reviewers. He noted that this reporting cycle was the strongest to date. Mr. Smith contrasted this with the prior year, when Calendar Year 2024 data had been excluded due to data quality concerns, which

prevented the Health Center from receiving recognition badges. He expressed confidence that the organization has cleared that hurdle. Once the final report is received, additional data—such as patient origin and benchmarking analyses will be presented to the board to support strategic planning.

Mr. Smith then addressed Governing Board composition. He reported that the board is currently in compliance with HRSA requirements and organizational bylaws regarding both member count and composition. However, Mr. Smith noted that the board traditionally operates with 11 members and currently has one vacancy. He expressed interest in filling the vacancy and discussed the value of recruiting a community board member with a clinical or quality-focused background, such as a practicing clinician, healthcare practitioner, or quality improvement professional. Board members were encouraged to suggest potential candidates from the community and to notify Mr. Smith or Ms. Bellamy for follow-up.

Finally, Mr. Smith discussed plans to organize a Governing Board retreat. He acknowledged prior conversations and noted that end-of-year scheduling is challenging. To move planning forward, Ms. Bellamy will distribute a survey to board members to assess availability (full-day or partial-day options) and desired retreat content. Mr. Smith stated that he anticipates sharing preliminary information at the next meeting and identifying a retreat date for further planning.

Father Rafael asked when the previous board retreat occurred. Mr. Smith responded that it took place in October of the prior year.

Father Rafael also asked about changes to financial reporting and committee meetings. Mr. Smith confirmed the intent of the Finance Committee is to meet monthly prior to Governing Board meetings, with flexibility if quorum cannot be achieved. Mr. Smith emphasized the goal of strengthening committee work to allow the full Board to focus on higher-level discussion and strategic topics.

The Chair called for questions and there were none.

X. INFORMATIONAL ITEMS

- Community Health Center (FQHC) Monthly Report – February 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 two (2) 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 3:40 p.m.

Randy Smith
Chief Executive Officer - FQHC

/tab

AGENDA

SOUTHERN NEVADA COMMUNITY HEALTH CENTER

GOVERNING BOARD MEETING

March 17, 2026 – 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 and B

NOTICE

Microsoft Teams:

<https://events.teams.microsoft.com/event/d927d7f9-72b2-41e5-b462-d90c4d88184f@1f318e99-9fb1-41b3-8c10-d0cab0e9f859>

To call into the meeting, dial (702) 907-7151 and enter Phone Conference ID: 932 055 745#

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.
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I. CALL TO ORDER & ROLL CALL

II. PLEDGE OF ALLEGIANCE

III. RECOGNITION

1. Southern Nevada Health District – Employee of the Month – March 2026

- Claudette Fajardo

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 two (2) 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 meeting controls at the top of the screen and select the Raise Hand icon. When called upon, select the Microphone icon to unmute yourself.
- **By telephone:** Call 702-907-7151 and when prompted to provide the Meeting ID, enter 932 055 745#. Press *5 to raise your hand. When called upon, press *6 on your phone keypad to unmute yourself.
- **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.

V. ADOPTION OF MARCH 17, 2026 AGENDA *(for possible action)*

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:** February 17, 2026 *(for possible action)*
2. **Approval of CHCA-039 Insulin and Epinephrine Fee Structure Policy;** direct staff accordingly or take other action as deemed necessary *(for possible action)*

VII. REPORT / DISCUSSION / ACTION

Recommendations from the March 16, 2026 Finance and Audit Committee Meeting

1. **Receive, Discuss and Accept the January 2026 Year to Date Financial Report;** direct staff accordingly or take other action as deemed necessary *(for possible action)*
2. **Receive, Discuss and Approve the Augmentation to the Southern Nevada Community Health Center FY2026 Budget;** direct staff accordingly or take other action as deemed necessary *(for possible action)*
3. **Receive, Discuss and Approve the New Finance Reports;** direct staff accordingly or take other action as deemed necessary *(for possible action)*

SNCHC Governing Board

4. **Receive, Discuss and Approve the Fourth Quarter Risk Assessment;** direct staff accordingly or take other action as deemed necessary *(for possible action)*
5. **Receive, Discuss and Approve the Fourth Quarter Risk Management Report;** direct staff accordingly or take other action as deemed necessary *(for possible action)*
6. **Receive, Discuss and Approve the CY25 Annual Risk Management Report;** direct staff accordingly or take other action as deemed necessary *(for possible action)*
7. **Review and Discuss the FTCA Redeeming Process and Approve Submittal of the CY27 FTCA Redeeming Application;** direct staff accordingly or take other action as deemed necessary *(for possible action)*

VIII. 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)***

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

- CEO Comments
- Behavioral Health Program Update

X. INFORMATIONAL ITEMS

- Community Health Center (FQHC) February 2026 Monthly Report

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 two (2) 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.**

XII. 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.



AT THE SOUTHERN NEVADA HEALTH DISTRICT

MINUTES

SOUTHERN NEVADA COMMUNITY HEALTH CENTER GOVERNING BOARD MEETING

February 17, 2026 – 2:30 p.m.

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Red Rock Trail Rooms A and B

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Jasmine Coca, First Vice Chair
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Erin Breen
Ashley Brown
Blanca Macias-Villa
David Neldberg
Fr Rafael Pereira

ABSENT:

Rebeca Aceves
Donna Feliz-Barrows, Chair
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 Single 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 center 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 Into 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

/tab

SOUTHERN NEVADA COMMUNITY HEALTH CENTER DISTRICT-WIDE POLICY

DIVISION:	FQHC	NUMBER(s):	CHCA-039
PROGRAM:	Pharmacy	VERSION:	1.01
TITLE:	Insulin and Epinephrine Fee Structure	PAGE:	1 of 3
		EFFECTIVE DATE: Click or tap here to enter text.	
DESCRIPTION:	Fee structure for insulin and epinephrine for patients of the FQHC.	ORIGINATION DATE: October 21, 2025	
APPROVED BY: CHIEF EXECUTIVE OFFICER - FQHC		REPLACES: Version 1.00	
Randy Smith, MPA _____		Date _____	

I. PURPOSE

To ensure SNCHC fee structure is compliant with Executive Order 14273 and associated HRSA grant requirements for Federally Qualified Health Centers (FQHC).

II. SCOPE

This policy applies to all workforce members involved in the delivery of Southern Nevada Community Health Center services.

III. POLICY

SNHD Pharmacy and any FQHC-associated contract pharmacies are required to make insulin and injectable epinephrine available to individuals with low incomes at fees specified in the FQHC grant.

IV. PROCEDURE

A. Low Income Individuals

1. Definition: Individual living in a household with income level at or below 200 percent of the Federal Poverty Guidelines (see 42 CFR 51c.303(f))
2. The insulin/epinephrine fee schedule applies to low-income individuals with the following.
 - a. No health care insurance: Not covered by a federal, state, or commercial insurance plan that includes coverage of outpatient prescription medications.
 - b. High unmet deductible: Insured individuals that have a high-deductible health plan as defined by the Internal Revenue Service (IRS) with deductibles that meet or exceed the annual minimums published by the IRS that have not been satisfied at the time of service.
 - c. High cost-sharing requirement: Individuals covered by health insurance plans with deductible, copayment, and coinsurance requirements that exceed an individual's ability to pay for insulin/epinephrine and prevent access to treatment.

B. Fee Structure

1. The fee schedule applies to insulin/epinephrine purchased by the SNCHC under 340B Drug Pricing Program.
2. Fees for insulin/epinephrine are calculated as the medication acquisition cost plus an administrative dispensing fee. ($\$ACQ + DF = Price$)
3. The maximum dispensing fee is equivalent to the ~~current Nevada Medicaid dispensing fee paid to participating pharmacies average cost to dispense a prescription at SNCHC pharmacies, adjusted annually.~~
4. SNCHC may apply a dispensing fee lower than Nevada Medicaid rate
5. The SNCHC Sliding Fee Scale (SFS) for medications does not apply to insulin/epinephrine. All qualifying individuals are charged a flat fee as specified in B.2.
6. SNCHC regularly reviews insulin/epinephrine costs and adjusts the fee schedule accordingly.

ACRONYMS/DEFINITIONS

Not Applicable.

REFERENCES

Not Applicable.

DIRECT RELATED INQUIRIES TO

Pharmacy Service Manager

ATTACHMENTS-FORMS-TEMPLATES

Not Applicable.

HISTORY TABLE

Table 1: History

Version No.	Effective Date	Change Made
Version 1		1. Updated Procedure in Section B – Fee Structure, #3. 2. Formatted to current template
Version 0	10/21/2025	First issuance



SOUTHERN NEVADA
Community
HEALTH CENTER

AT THE SOUTHERN NEVADA HEALTH DISTRICT

Financial Report
Results as of January 31, 2026

(Unaudited)

Summary of Revenue, Expenses and Net Position (January 31, 2026 – Unaudited)

Revenue

- General Fund revenue (Charges for Services & Other) is \$21.64M compared to a budget of \$22.79M, an unfavorable variance of \$1.15M.
- Special Revenue Funds (Grants) is \$2.71M compared to a budget of \$4.45M, an unfavorable variance of \$1.74M.
- Total Revenue is \$24.34M compared to a budget of \$27.24M, an unfavorable variance of \$2.90M.

Expenses

- Salary, Tax, and Benefits is \$8.27M compared to a budget of \$9.68M, a favorable variance of \$1.41M.
- Other Operating Expense is \$17.27M compared to a budget of \$18.13M, a favorable variance of \$860K.
- Indirect Cost/Cost Allocation is \$6.21M compared to a budget of \$7.51M, a favorable variance of \$1.30M.
- Total Expense is \$31.75M compared to a budget of \$35.31M, a favorable variance of \$3.56M.

Net Position: is (\$7.41M) compared to a budget of (\$8.07M), a favorable variance of \$660K.

All Funds/Divisions by Type

Budget to Actual

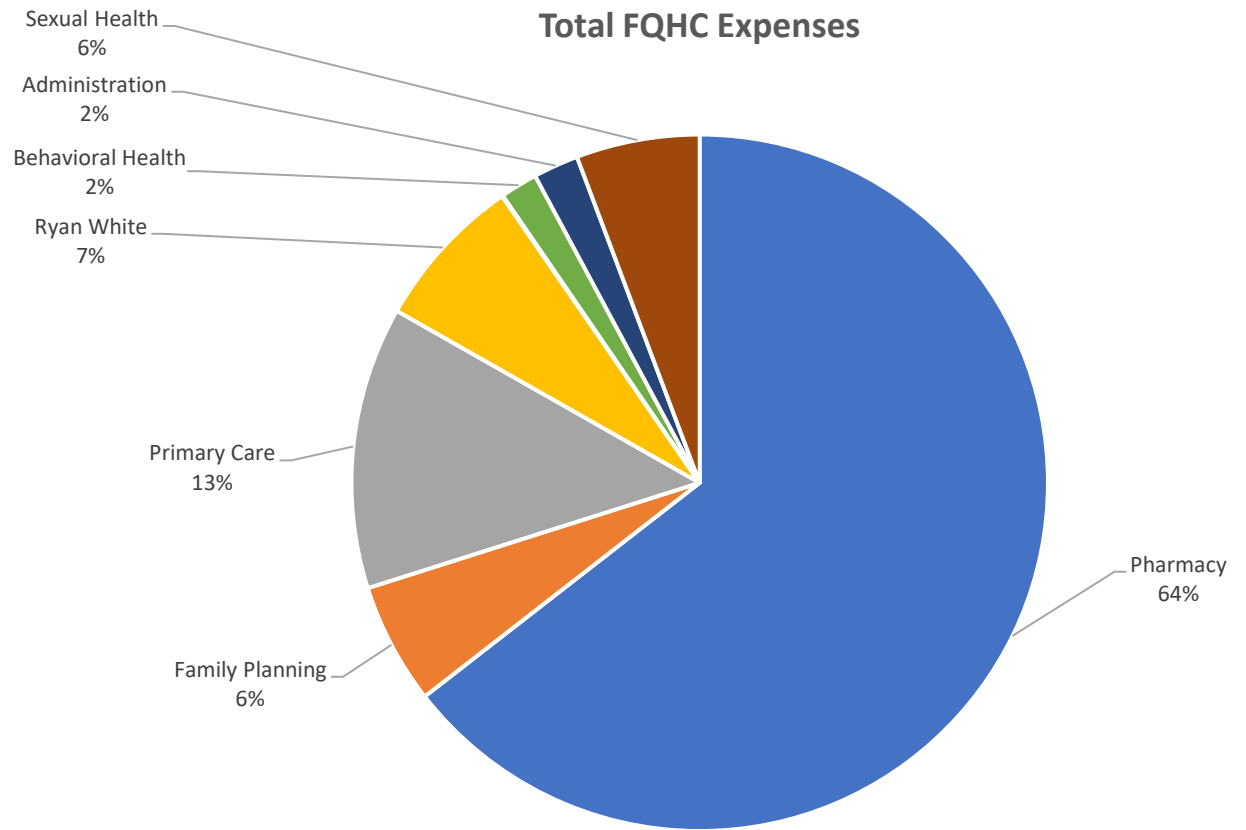
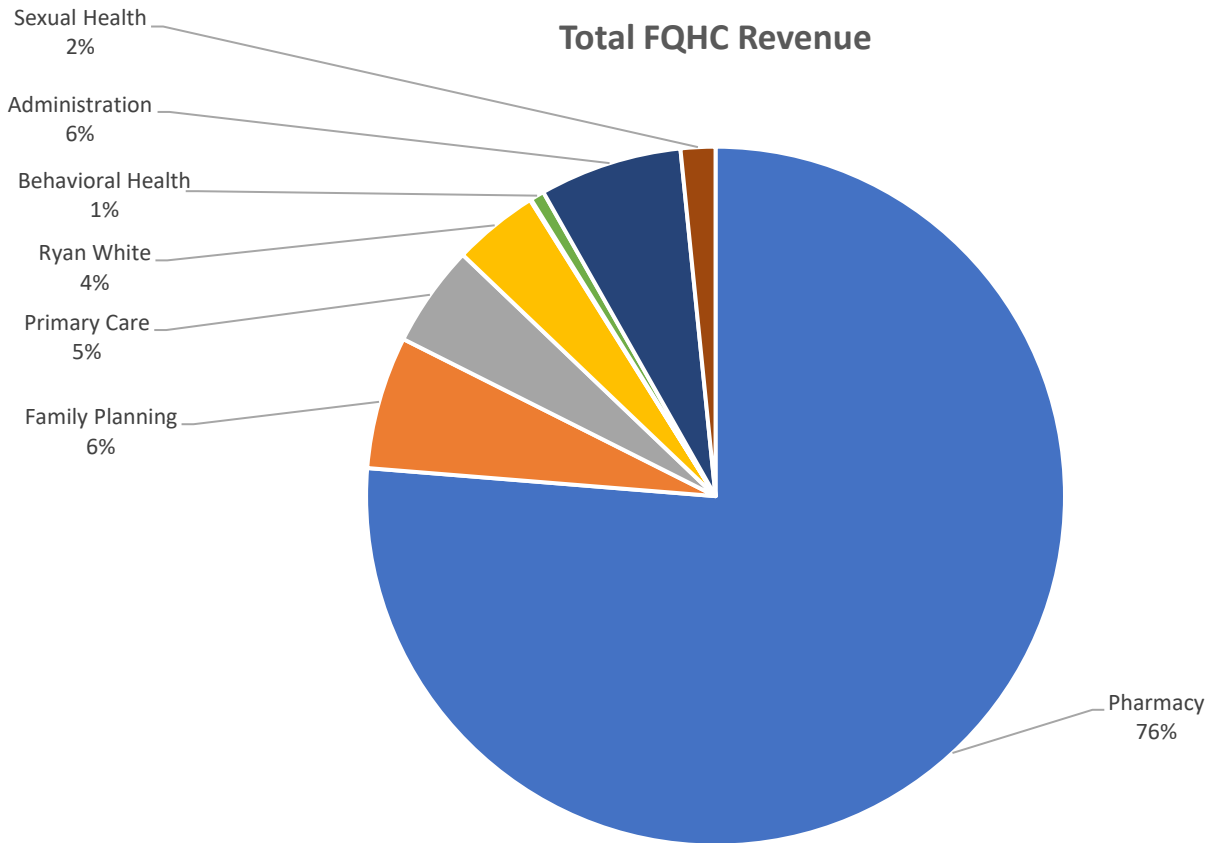
Activity	Budget as of January	Actual as of January	Variance Favorable (Unfavorable)	%
Charges for Services	21,850,366	20,025,852	(1,824,514)	-8%
Other	937,406	1,609,299	671,893	72%
Federal Revenue	1,761,749	1,519,599	(242,150)	-14%
Pass-Thru Revenue	2,258,424	925,739	(1,332,685)	-59%
State Revenue	433,596	260,261	(173,335)	-40%
Total FQHC Revenue	27,241,541	24,340,750	(2,900,791)	-11%
Salaries	6,452,134	5,563,133	889,001	14%
Taxes & Fringe Benefits	3,228,061	2,709,567	518,494	16%
Total Salaries & Benefits	9,680,195	8,272,700	1,407,495	15%
Supplies	17,180,415	16,461,455	718,960	4%
Capital Outlay	11,422	-	11,422	100%
Contractual	894,908	777,145	117,763	13%
Travel & Training	38,407	27,650	10,757	28%
Total Other Operating	18,125,152	17,266,250	858,902	5%
Indirect Costs/Cost Allocations	7,507,444	6,212,639	1,294,805	17%
Transfers IN	(464,741)	(405,441)	(59,300)	13%
Transfers OUT	464,741	405,441	59,300	13%
Total Transfers	7,507,444	6,212,639	1,294,805	17%
Total FQHC Expenses	35,312,791	31,751,589	3,561,202	10%
Net Position	(8,071,250)	(7,410,839)	660,411	-8%

1
2
3

NOTES:

- 1) CHARGES FOR SERVICES INCLUDES FY26 Q1 AND Q2 WRITE-OFF (ANY OUTSTANDING AMOUNT OLDER THAN 12 MONTHS AS OF JANUARY 2026). SEE PHARMACY NOTE ON SLIDE FIVE.
- 2) NEVADA MEDICAID WRAP TRUE-UP/LOOK-BACK PAYMENTS FOLLOWING COMPLETION OF NEW PPS RATE REVIEW (PAID DIFFERENCE BETWEEN INTERIM RATE AND FINALIZED RATE).
- 3) FY26 ADOPTED BUDGET INCLUDED EIGHT ELIGIBILITY WORKERS THAT WOULD HAVE BEEN 100%-GRANT FUNDED WHO WERE NOT HIRED DUE TO CHANGING FEDERAL PRIORITIES. ADDITIONALLY, SOME RYAN WHITE REIMBURSEMENTS WERE DELAYED DUE TO FUNDING CONSTRAINTS.

Percentage of Revenues and Expenses by Department (January 31, 2026)



Revenues by Department

Budget to Actuals

Department	Budget as of January	Actual as of January	Variance Favorable (Unfavorable)	%
Charges for Services, Other, Wrap				
Family Planning	171,250	266,446	95,196	56%
Pharmacy	20,508,648	18,567,624	(1,941,024)	-9%
Primary Care	381,906	607,826	225,920	59%
Ryan White	161,294	28,281	(133,013)	-82%
Refugee Health	11,849	10,731	(1,118)	-9%
Behavioral Health	160,882	157,308	(3,574)	-2%
Administration	937,406	1,606,407	669,001	71%
Sexual Health	454,536	390,529	(64,007)	-14%
OPERATING REVENUE	22,787,771	21,635,152	(1,152,619)	-5%
Grants				
Family Planning	1,347,233	1,226,864	(120,369)	-9%
Primary Care	725,792	539,512	(186,280)	-26%
Ryan White	2,185,827	936,554	(1,249,273)	-57%
Refugee Health	72,596	2,668	(69,928)	-96%
Behavioral Health	122,320	-	(122,320)	-100%
SPECIAL REVENUE	4,453,768	2,705,598	(1,748,170)	-39%
TOTAL REVENUE	27,241,539	24,340,750	(2,900,789)	-11%

NOTES:

- 1) REVENUE REDUCTION DUE TO CHANGES IN PAYER PATIENT ASSISTANCE PROGRAMS FOR HIGH-COST MEDICATIONS (DISCUSSED AT 2/17/26 BOARD MEETING – “PHARMACY UPDATE”. PHARMACY AND FINANCE ARE ACTIVELY MONITORING CHANGES.
- 2) REVENUE LAGGING BECAUSE RYAN WHITE SELF-PAY WRITE-OFF EXCEEDED TOTAL CHARGES FOR SERVICES THROUGH Q2 FY26.
- 3) REFUGEE HEALTH CLINIC PATIENT ENCOUNTERS REDUCED BY 98% YEAR-OVER-YEAR.
- 4) PATIENT ENCOUNTERS TRENDING 9% UNDER PRIOR FISCAL YEAR DUE TO INTEGRATING PROVIDERS ACROSS SH AND PC CLINICS.
- 5) FY26 ADOPTED BUDGET INCLUDED EIGHT ELIGIBILITY WORKERS THAT WOULD HAVE BEEN 100%-GRANT FUNDED WHO WERE NOT HIRED DUE TO CHANGING FEDERAL PRIORITIES.
- 6) BH INCUBATOR GRANT ENDED IN FY25, ALL FY26 EXPENSES AND REVENUES ARE GENERAL FUNDED AND WILL BE UPDATED IN FIRST BUDGET AUGMENTATION.

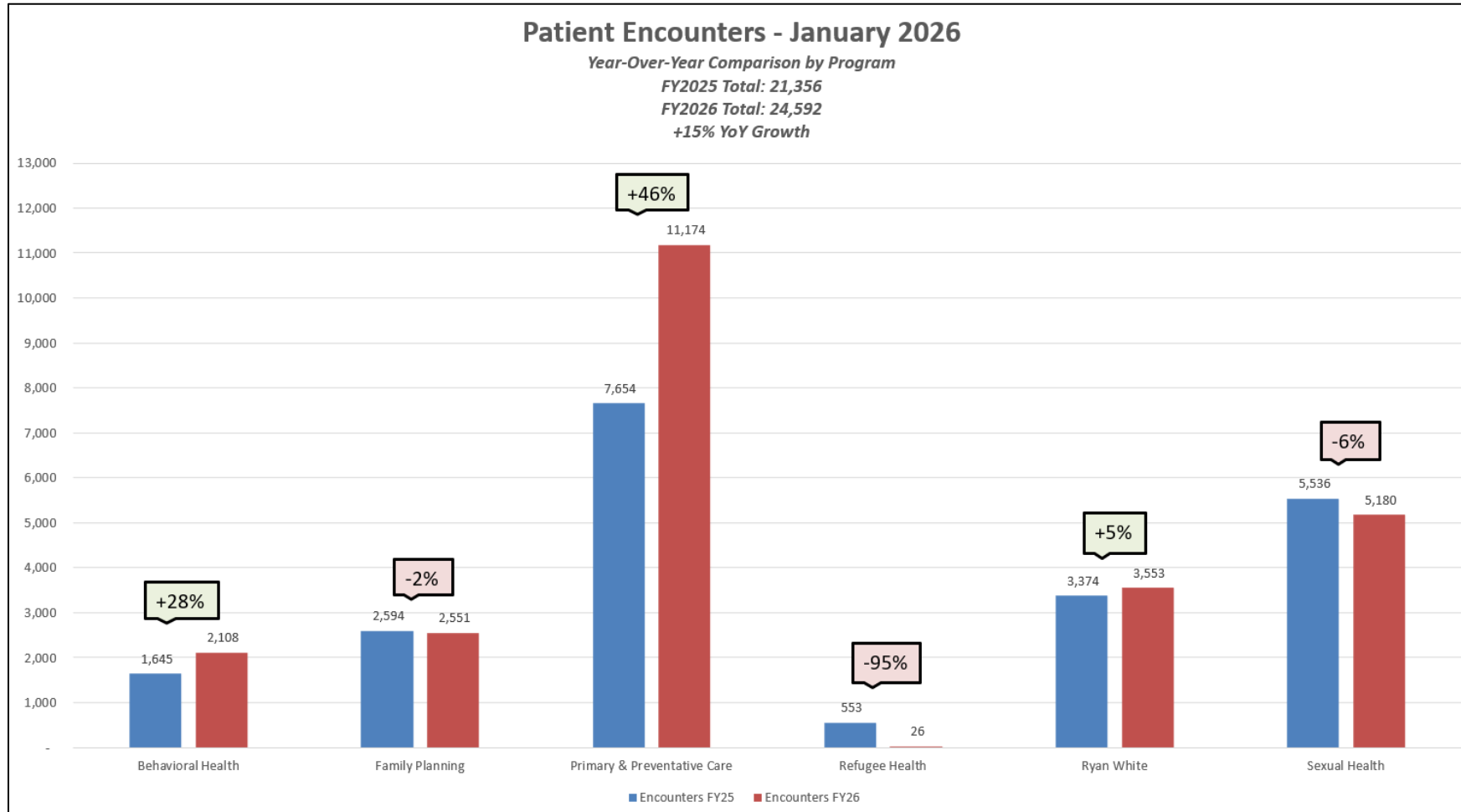
Expenses by Department Budget to Actuals

Department	Budget as of January	Actual as of January	Variance Favorable (Unfavorable)	%
Employment (Salaries, Taxes, Fringe)				
Family Planning	1,371,576	1,107,000	264,576	19%
Pharmacy	370,110	391,951	(21,841)	-6%
Primary Care	3,379,732	3,110,072	269,660	8%
Ryan White	2,304,659	1,655,147	649,512	28%
Refugee Health	175,008	2,334	172,674	99%
Behavioral Health	350,286	440,178	(89,892)	-26%
Administration	221,393	234,915	(13,522)	-6%
Sexual Health	1,507,432	1,331,103	176,329	12%
Total Personnel Costs	9,680,196	8,272,700	1,407,496	15%
Other (Supplies, Contractual, Capital, etc.)				
Family Planning	338,955	329,600	9,355	3%
Pharmacy	16,680,632	16,076,279	604,353	4%
Primary Care	279,854	238,117	41,737	15%
Ryan White	173,824	177,101	(3,277)	-2%
Refugee Health	84,086	8,994	75,092	89%
Behavioral Health	7,000	1,975	5,025	72%
Administration	422,614	301,362	121,252	29%
Sexual Health	138,187	132,822	5,365	4%
Total Other Expenses	18,125,152	17,266,250	858,902	5%
Total Operating Expenses	27,805,348	25,538,950	2,266,398	8%
Indirect Costs/Cost Allocations	7,507,444	6,212,639	1,294,805	17%
Transfers IN	(464,741)	(405,441)	(59,300)	13%
Transfers OUT	464,741	405,441	59,300	13%
Total Transfers & Allocations	7,507,444	6,212,639	1,294,805	17%
TOTAL EXPENSES	35,312,792	31,751,589	3,561,203	10%

NOTES:

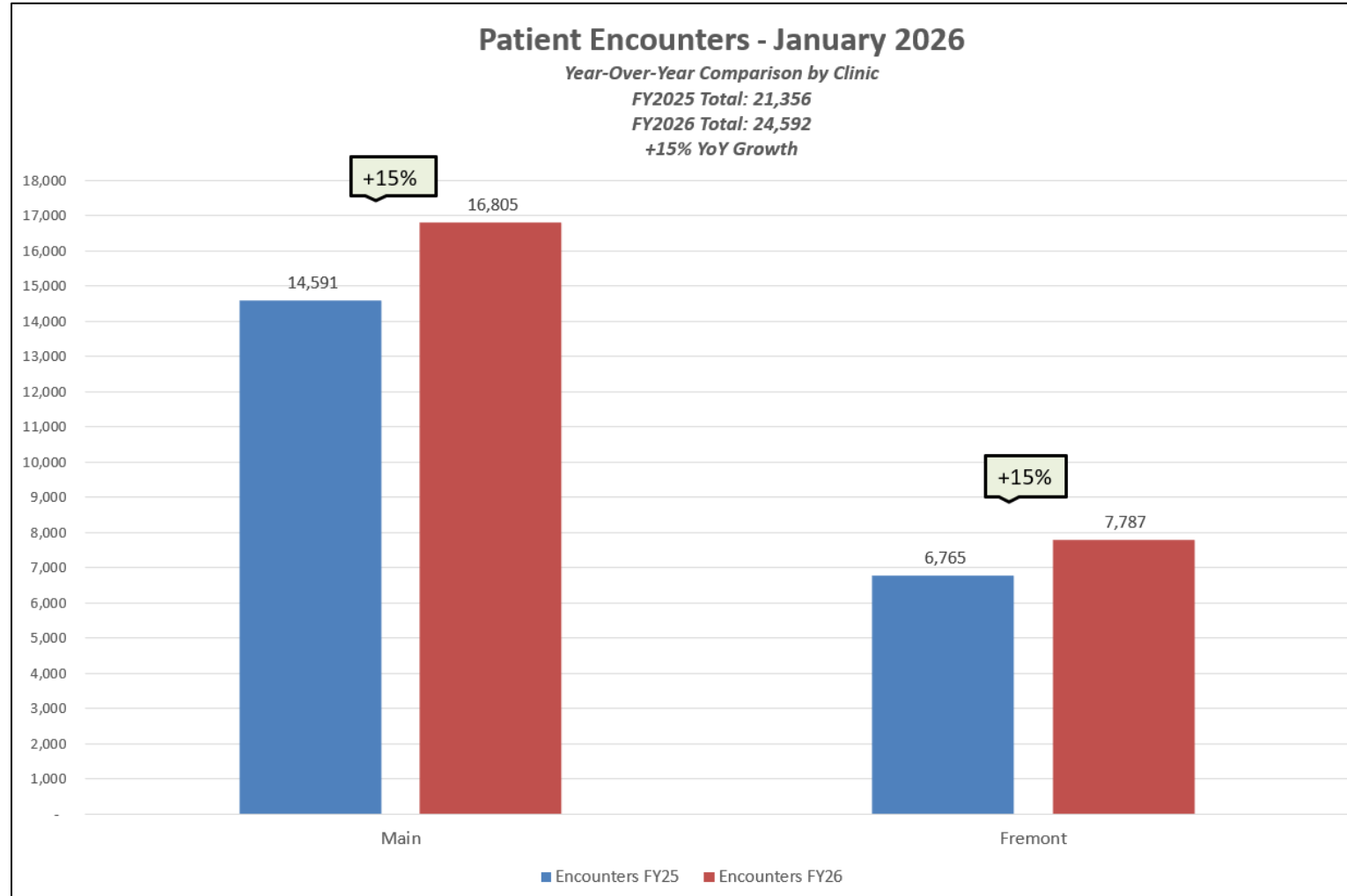
- 1) GRANT-FUNDED VACANCIES ARE DRIVING SAVINGS THROUGH Q2 FY26.
- 2) REFUGEE HEALTH CLINIC PATIENT ENCOUNTERS REDUCED BY 98% YEAR-OVER-YEAR.
- 3) BH FTE ALLOCATIONS UPDATED FOLLOWING END OF THE STATE INCUBATOR GRANT AND PROVIDER TIME AND EFFORT ADJUSTMENTS. ALLOCATIONS WILL BE UPDATED IN FIRST AUGMENTATION TO REFLECT CHANGES.
- 4) MINIMAL DEFERRED ORDERING AND INVOICING FROM DECEMBER RECORDED IN JANUARY.

Patient Encounters By Department



NOTE 1: PATIENT ENCOUNTERS INCLUDE VISITS PROVIDED BY LICENSED INDEPENDENT PRACTITIONERS (LIPS) AND NURSES. FY25 AND FY26 SEXUAL HEALTH CLINIC ENCOUNTERS DO NOT INCLUDE SELECT NURSE VISITS THAT ARE NOW PROVIDED IN THE PRIMARY AND PREVENTIVE CARE DIVISION.

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.)

Month-to-Month Comparisons

Year-to-Date revenues and expenses by department and by type.

YTD by Month – January 31, 2026

By Department

DEPARTMENT	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	YTD TOTALS	YTD AVERAGES
Administration (301)	318,204	107,261	99,282	477,183	212,285	279,474	112,717	1,606,407	242,843
Family Planning (309)	124,841	227,027	154,943	402,202	251,445	182,597	301,287	1,644,342	232,092
Pharmacy (333)	3,079,691	2,482,932	2,894,910	2,680,355	2,094,515	2,831,815	2,503,404	18,567,623	2,646,481
Dental Health (336)	-	-	-	-	-	-	-	-	-
Primary Care (337)	138,587	178,371	146,645	192,671	157,724	142,313	256,876	1,213,187	162,800
Ryan White (338)	173,342	178,531	137,261	180,275	148,184	65,168	270,181	1,152,941	163,518
Refugee Health (344)	(347)	(678)	(111)	90	(706)	(824)	16,430	13,854	(350)
Behavioral Health (345)	33,197	27,124	16,046	38,282	21,181	(9,961)	31,439	157,308	27,166
Sexual Health (350)	72,637	32,065	36,100	25,379	42,113	26,372	155,862	390,529	41,659
TOTAL REVENUES	3,940,152	3,232,635	3,485,075	3,996,436	2,926,741	3,516,955	3,648,197	24,746,191	3,516,208
DEPARTMENT	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	YTD TOTALS	YTD AVERAGES
Administration (301)	70,680	79,215	83,721	138,213	106,752	83,147	106,390	668,118	95,716
Family Planning (309)	138,478	267,099	247,464	432,499	304,127	217,784	324,398	1,931,849	277,933
Pharmacy (333)	3,374,348	3,227,761	2,793,581	2,332,983	2,344,739	3,332,885	3,212,157	20,618,455	2,814,683
Dental Health (336)	-	-	-	-	-	-	-	-	-
Primary Care (337)	485,214	590,367	580,687	755,991	533,944	563,127	678,461	4,187,792	589,241
Ryan White (338)	238,561	305,288	331,241	438,184	319,081	313,915	429,018	2,375,288	326,471
Refugee Health (344)	2,709	-	-	3,695	-	-	8,020	14,424	1,281
Behavioral Health (345)	43,131	67,285	70,044	111,472	74,240	73,510	106,756	546,439	73,234
Sexual Health (350)	193,778	258,395	264,445	333,650	225,408	237,963	301,028	1,814,666	255,135
TOTAL EXPENSES	4,546,898	4,795,412	4,371,183	4,546,688	3,908,290	4,822,332	5,166,228	32,157,030	4,433,694
NET POSITION:	(606,746)	(1,562,777)	(886,107)	(550,251)	(981,549)	(1,305,378)	(1,518,031)	(7,410,839)	(917,486)

YTD by Month – January 31, 2026

By Type

REVENUE TYPE	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	YTD TOTALS	YTD AVERAGES
Charges for Services	3,298,484	2,670,838	2,989,260	2,895,692	2,267,960	2,866,571	3,037,047	20,025,852	2,824,447
Other	318,204	109,026	99,282	478,311	212,285	279,474	112,717	1,609,299	243,422
Contributions	-	-	-	-	-	-	-	-	-
Intergovernmental	280,097	394,677	343,160	535,279	382,876	317,163	452,347	2,705,598	387,218
TOTAL REVENUES	3,896,784	3,174,541	3,431,702	3,909,282	2,863,121	3,463,209	3,602,112	24,340,750	3,455,086
EXPENSE TYPE	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	YTD TOTALS	YTD AVERAGES
Salaries	523,875	723,389	720,359	1,068,768	734,847	721,906	1,069,989	5,563,133	754,248
Taxes and Benefits	264,484	358,856	356,812	488,386	349,107	355,739	536,183	2,709,567	363,529
Travel and Training	6,022	12,281	7,060	1,441	430	313	103	27,650	5,447
Supplies	2,669,901	2,586,910	2,258,924	1,907,228	1,889,343	2,638,802	2,510,348	16,461,456	2,262,461
Contractual	139,335	109,328	102,396	125,570	99,084	95,977	105,455	777,145	115,143
Property	-	-	-	-	-	-	-	-	-
TOTAL EXPENSES	3,603,617	3,790,765	3,445,551	3,591,392	3,072,811	3,812,737	4,222,078	25,538,950	3,500,827
TRANSFER TYPE	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	YTD TOTALS	YTD AVERAGES
Indirect/Cost Allocation	899,914	946,553	872,259	868,141	771,859	955,849	898,066	6,212,639	871,745
Transfer In	(43,368)	(58,094)	(53,374)	(87,155)	(63,620)	(53,746)	(46,084)	(405,441)	(61,122)
Transfer Out	43,368	58,094	53,374	87,155	63,620	53,746	46,084	405,441	61,122
TOTAL TRANSFERS	899,914	946,553	872,259	868,141	771,859	955,849	898,066	6,212,639	871,745
NET POSITION:	(606,746)	(1,562,777)	(886,107)	(550,251)	(981,549)	(1,305,378)	(1,518,032)	(7,410,839)	(917,486)

Questions?



MOTION



*Motion to Accept the January 2026 Year-to-Date
Financial Report, as presented.*

Southern Nevada Community Health Center

Governing Board Meeting

March 2026

- ▶ FY 2026 Augmented Budget
- ▶ Presented by: Donnie (DJ) Whitaker, CFO

Nevada Revised Statute (NRS) 354.626

Unlawful expenditure of money in excess of amount appropriated; penalties; exceptions, states that “No governing body or member thereof, officer, office, department, or agency may, during any fiscal year, expend or contract to expend any money or incur any liability, or enter into any contract which by its terms involves the expenditure of money, in excess of the amounts appropriated for that function, other than bond repayments, medium-term obligation of repayments and any other long-term contract expressly authorized by law.”

SUMMARY

Staffing:

Staffing for FY26 is projected to be **119.5 FTEs** compared to FY26 adopted budget of 126.5 FTEs.

Revenue:

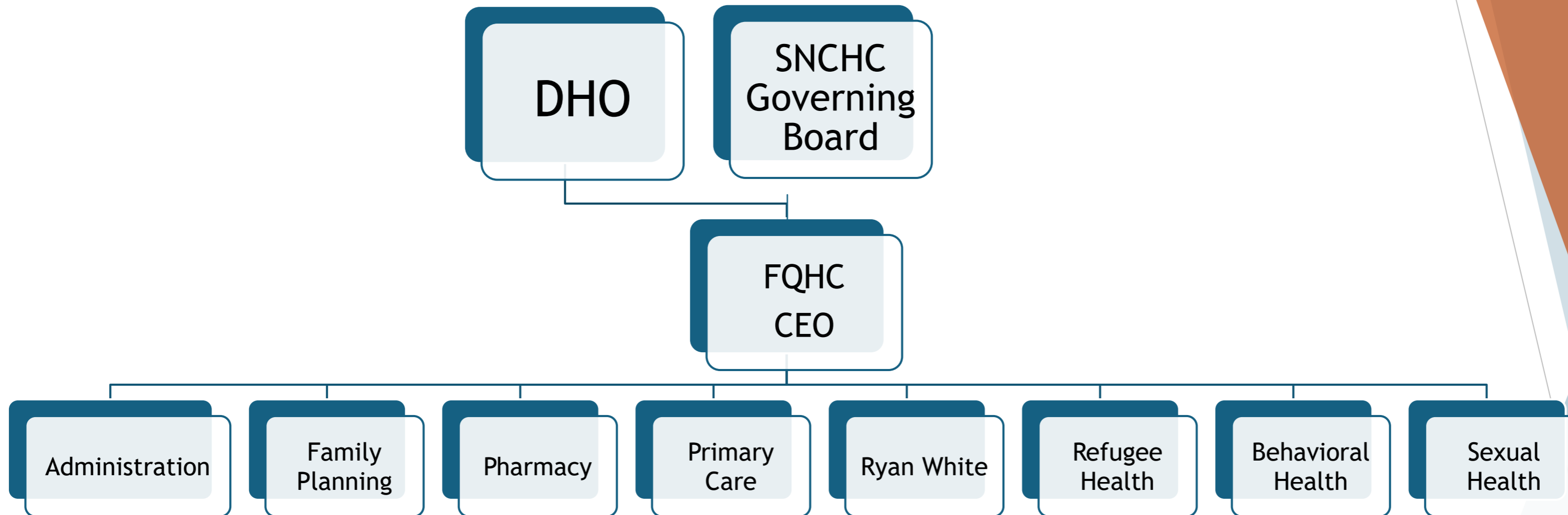
General Fund revenue is projected at **\$38.5M** in FY26, a decrease of \$600K from the FY26 adopted budget.

Special Revenue Fund (Grants) projected at **\$5.1M** in FY26, a decrease of \$2.6M from FY26 adopted budget.

Expense:

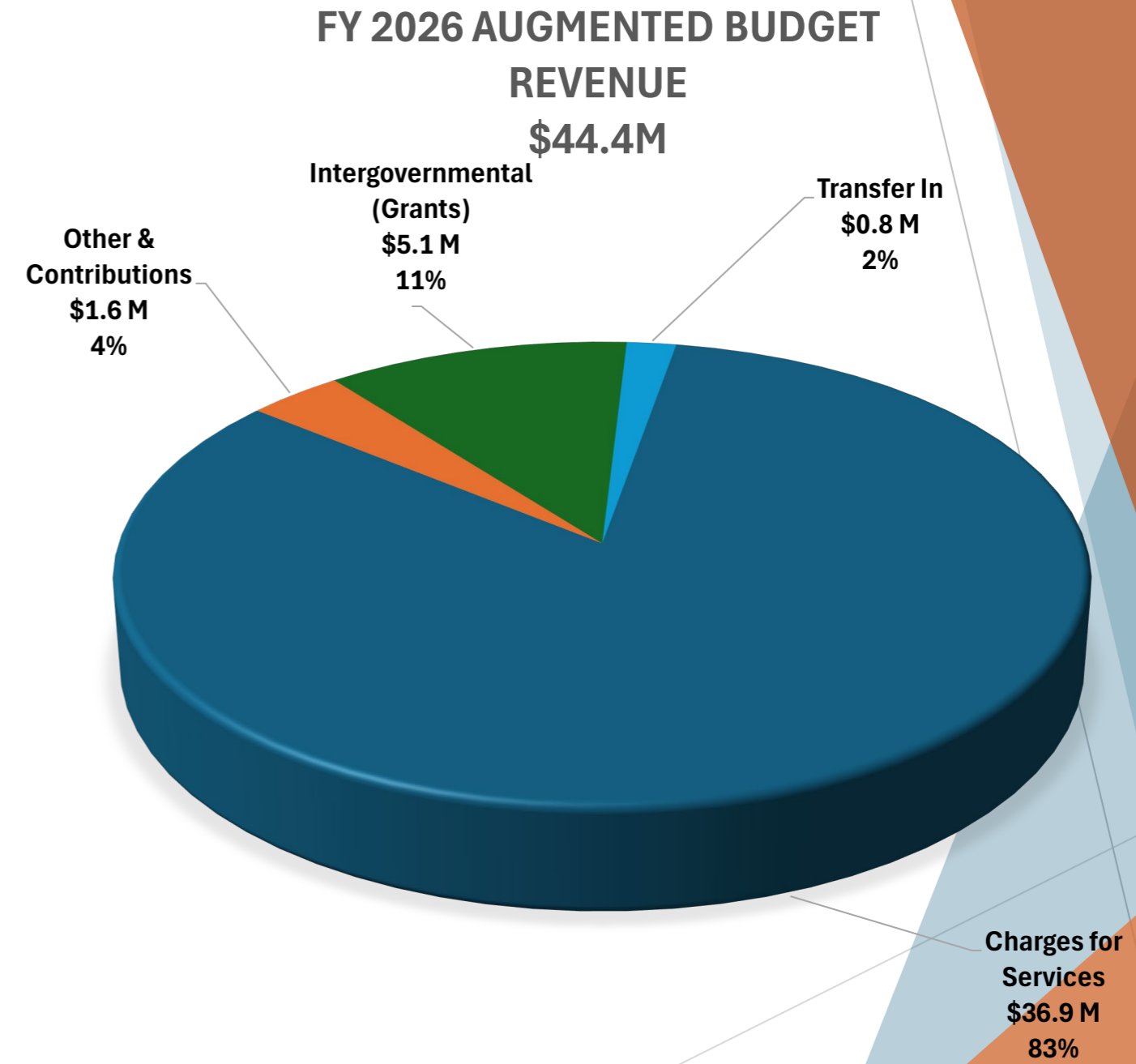
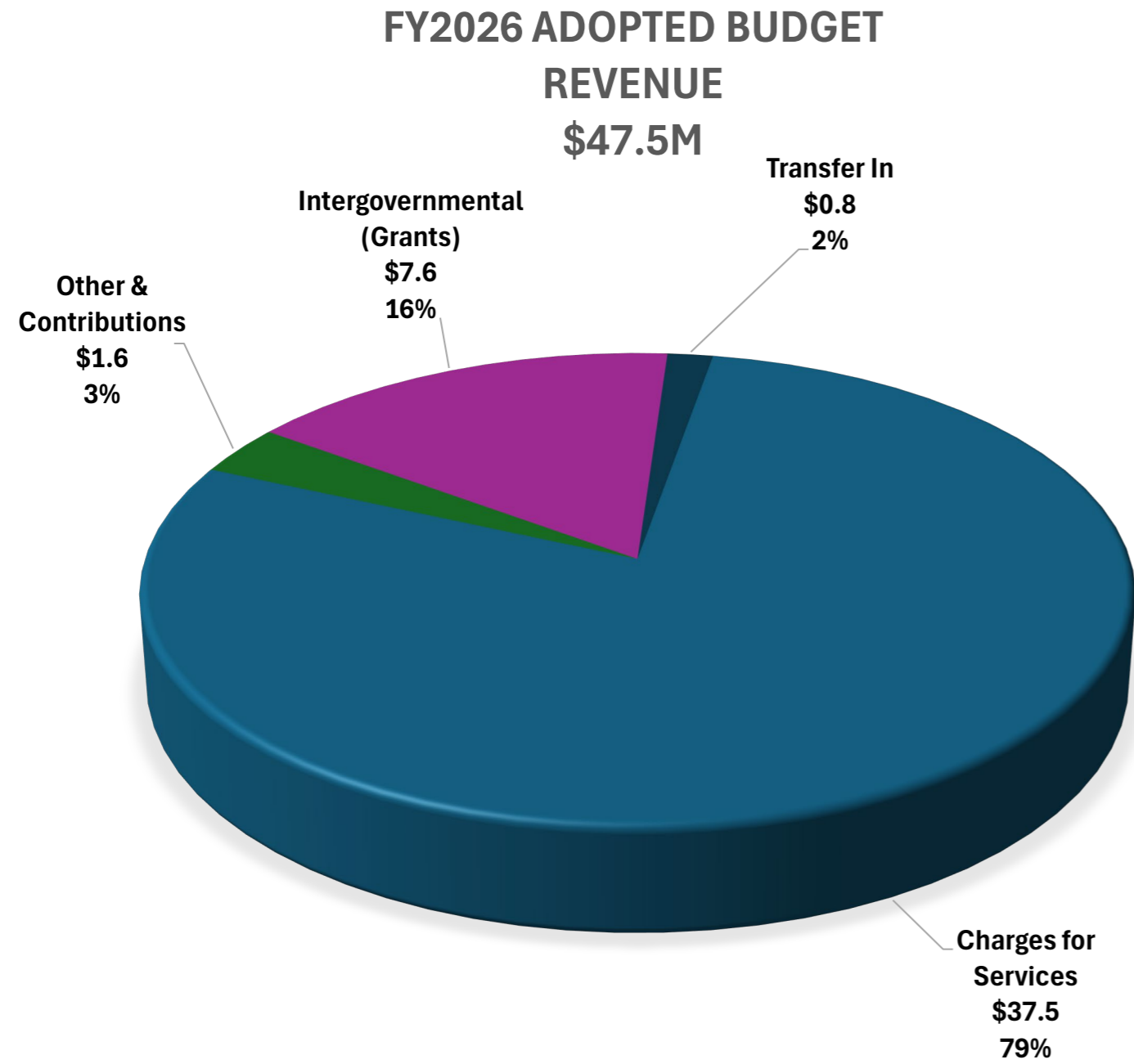
FQHC combined expenditures for FY26 augmented budget is **\$58.4M** compared to \$61.3M from FY26 adopted budget.

FQHC Division Org Chart



REVENUES

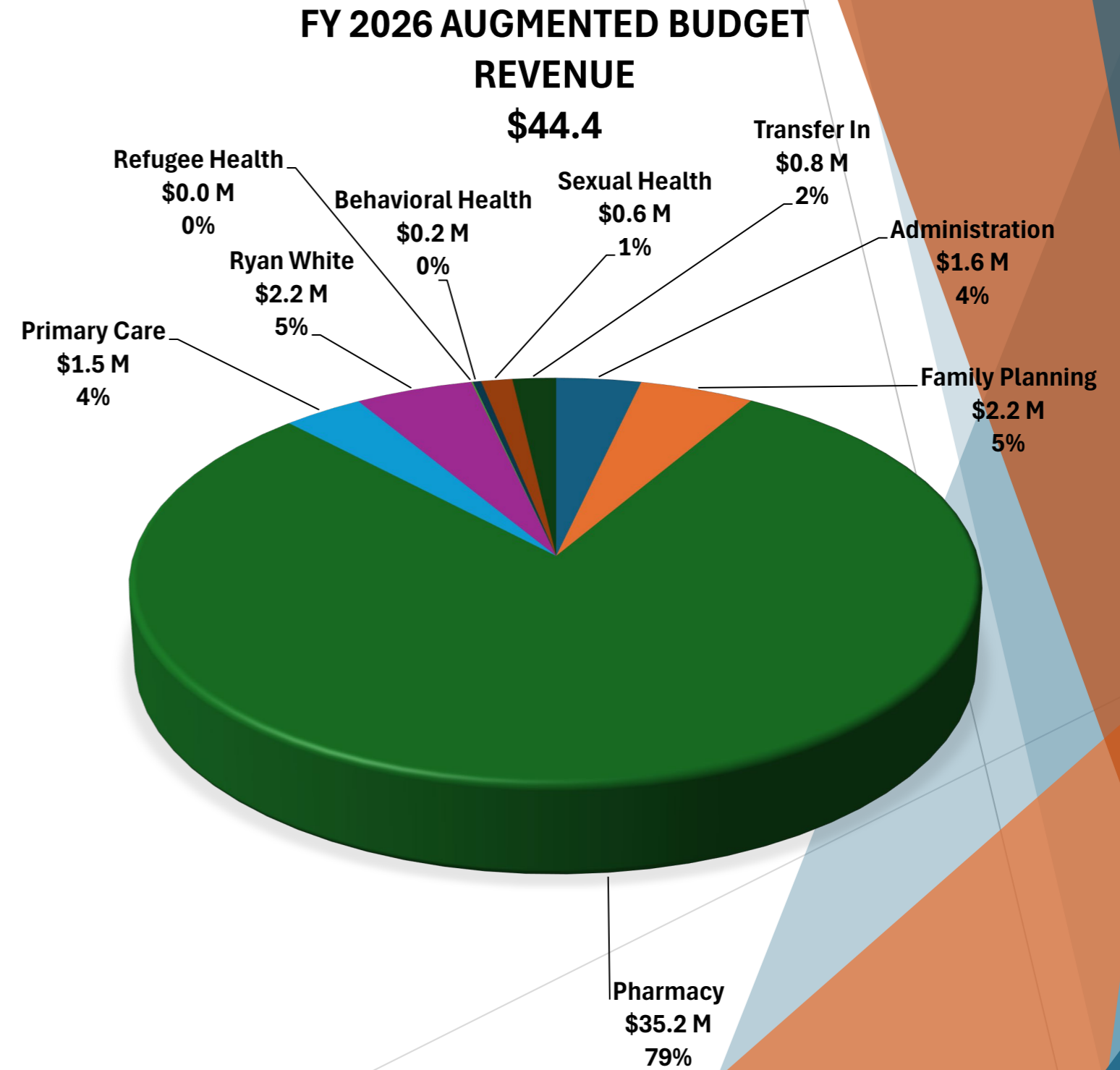
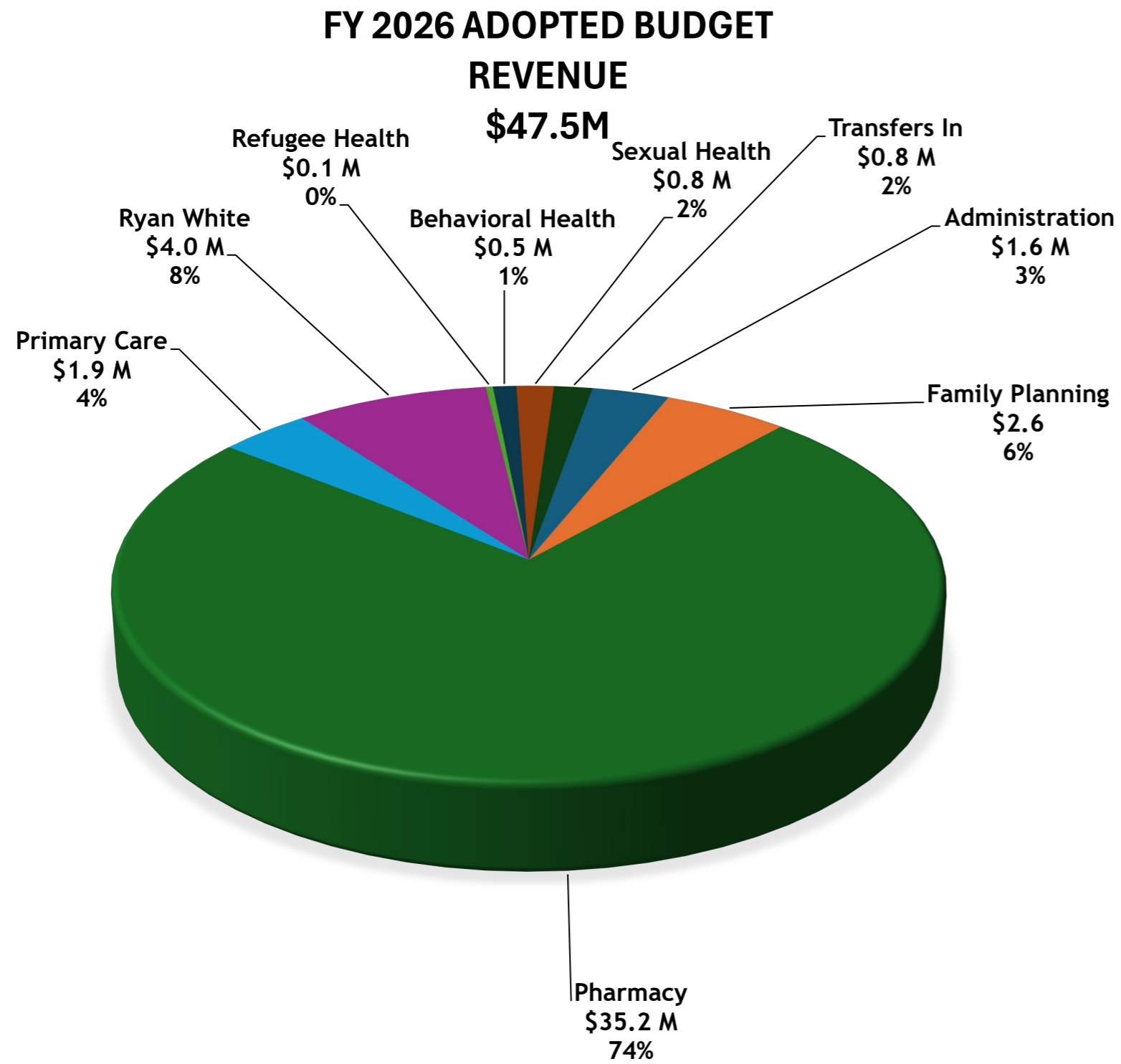
COMBINED REVENUES BY SOURCE - comparison



% Percentages are based on total revenue

REVENUES

COMBINED REVENUES BY DEPARTMENT - comparison



% Percentages are based on total revenue

REVENUES

GENERAL & SPECIAL REVENUE FUND SUMMARY

General Fund:

Total *Charges for Services revenue is augmented at \$36.9M, which is a decrease of \$600k from the adopted budget of \$37.5M

**Major component of Charges for Services revenue is Pharmacy which is projected at \$35.2M for FY26*

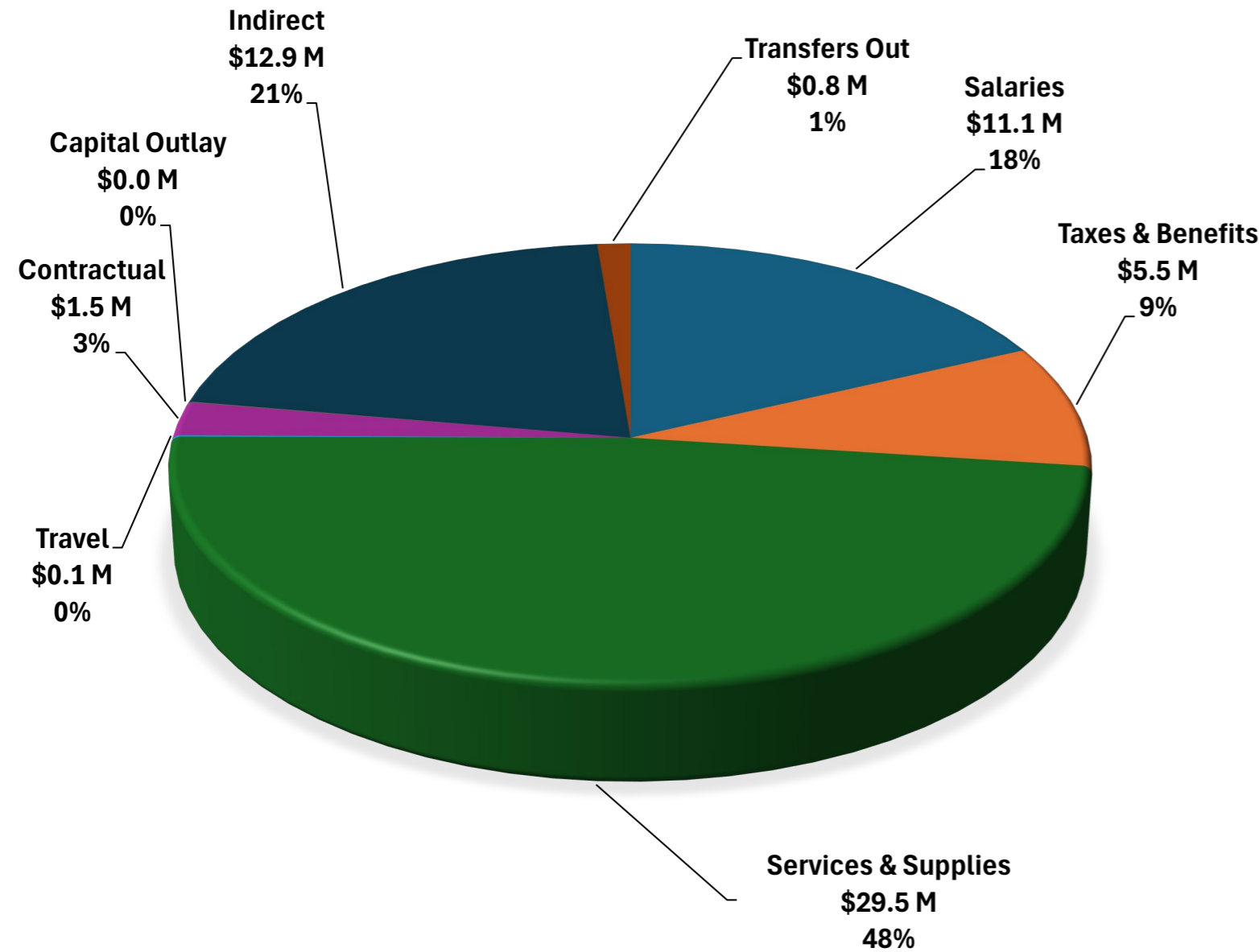
Special Revenue Fund:

Federal (Grants) revenue decreased from \$7.6M to \$5.1M, which is a reduction of \$2.6M. This reduction is primarily due to a \$1.7M reduction of existing grants under Ryan White. Behavioral Health, Refugee Health, and Family Planning also had reductions in their existing grants.

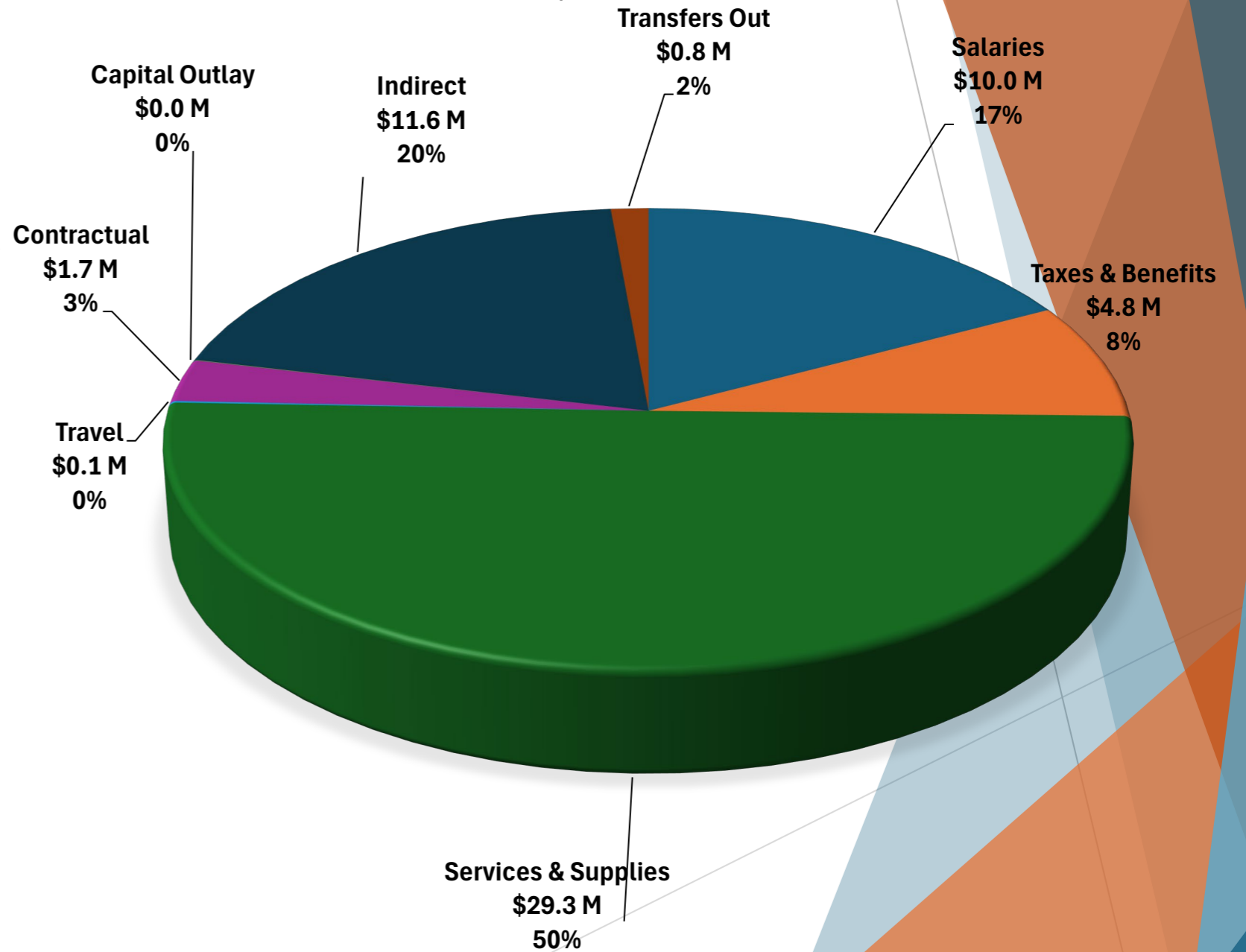
EXPENDITURES

COMBINED EXPENSES BY SOURCE - comparison

**FY2026 ADOPTED BUDGET
EXPENSES
\$61.3M**



**FY2026 AUGMENTED BUDGET
EXPENSES
\$58.4M**



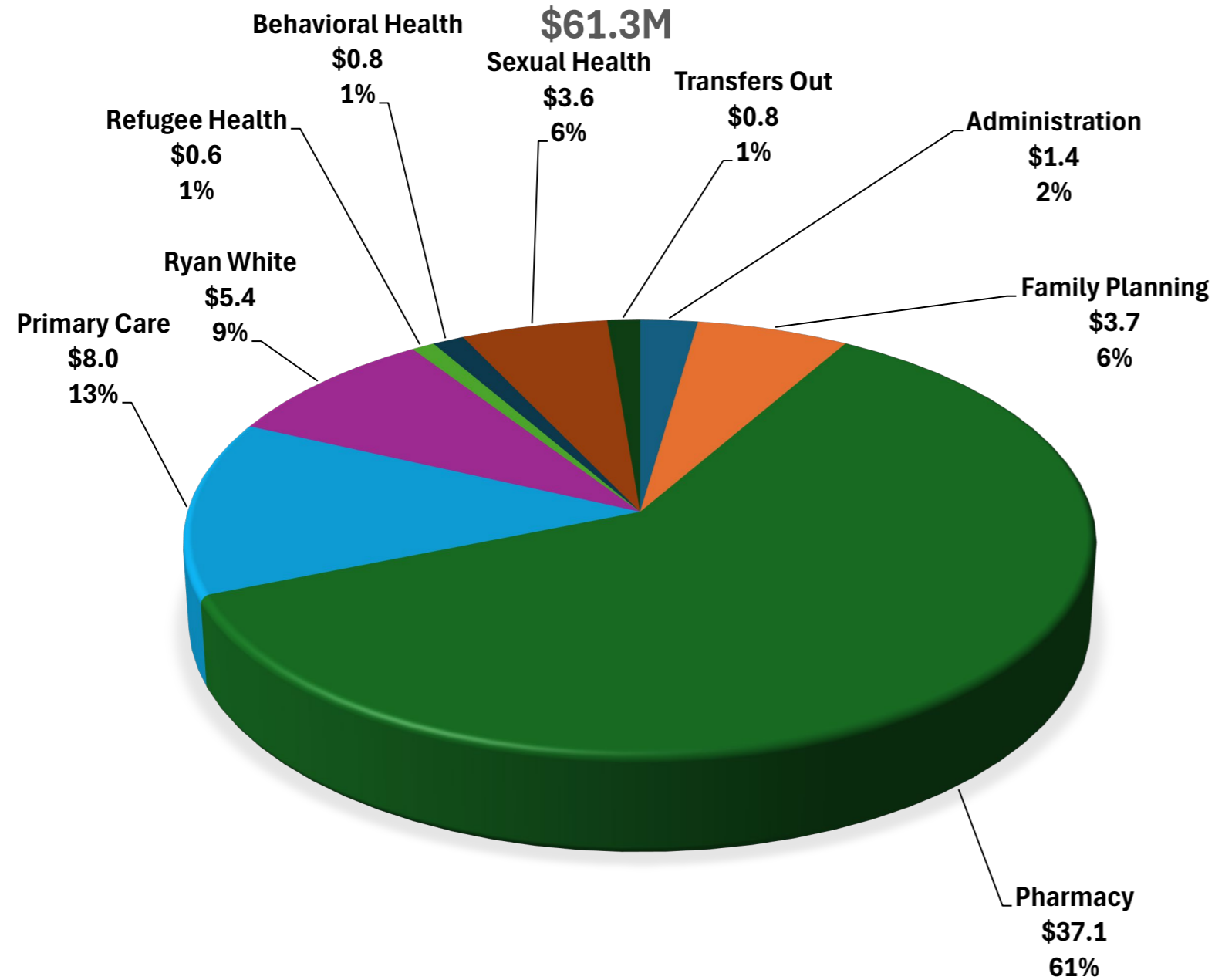
% Percentages are based on total expenses

EXPENDITURES

COMBINED EXPENSES BY DEPARTMENT- comparison

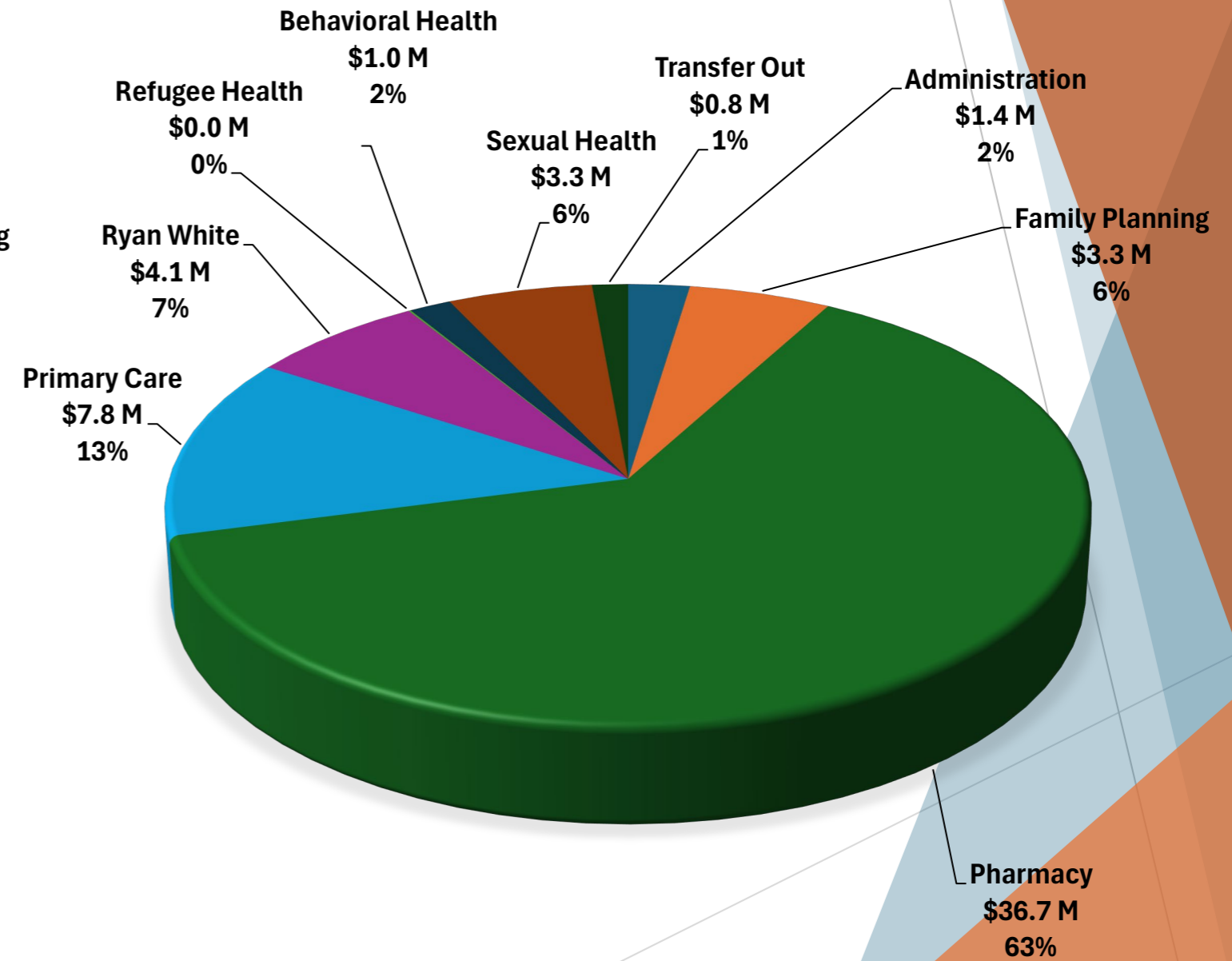
FY2026 ADOPTED BUDGET EXPENSES

\$61.3M



FY2026 AUGMENTED BUDGET EXPENSES

\$58.4M



% Percentages are based on total expenditures

EXPENDITURES

GENERAL & SPECIAL REVENUE FUND SUMMARY

FQHC combined expenditures augmented budget is **\$58.4M** compared to **\$61.3M** from adopted budget

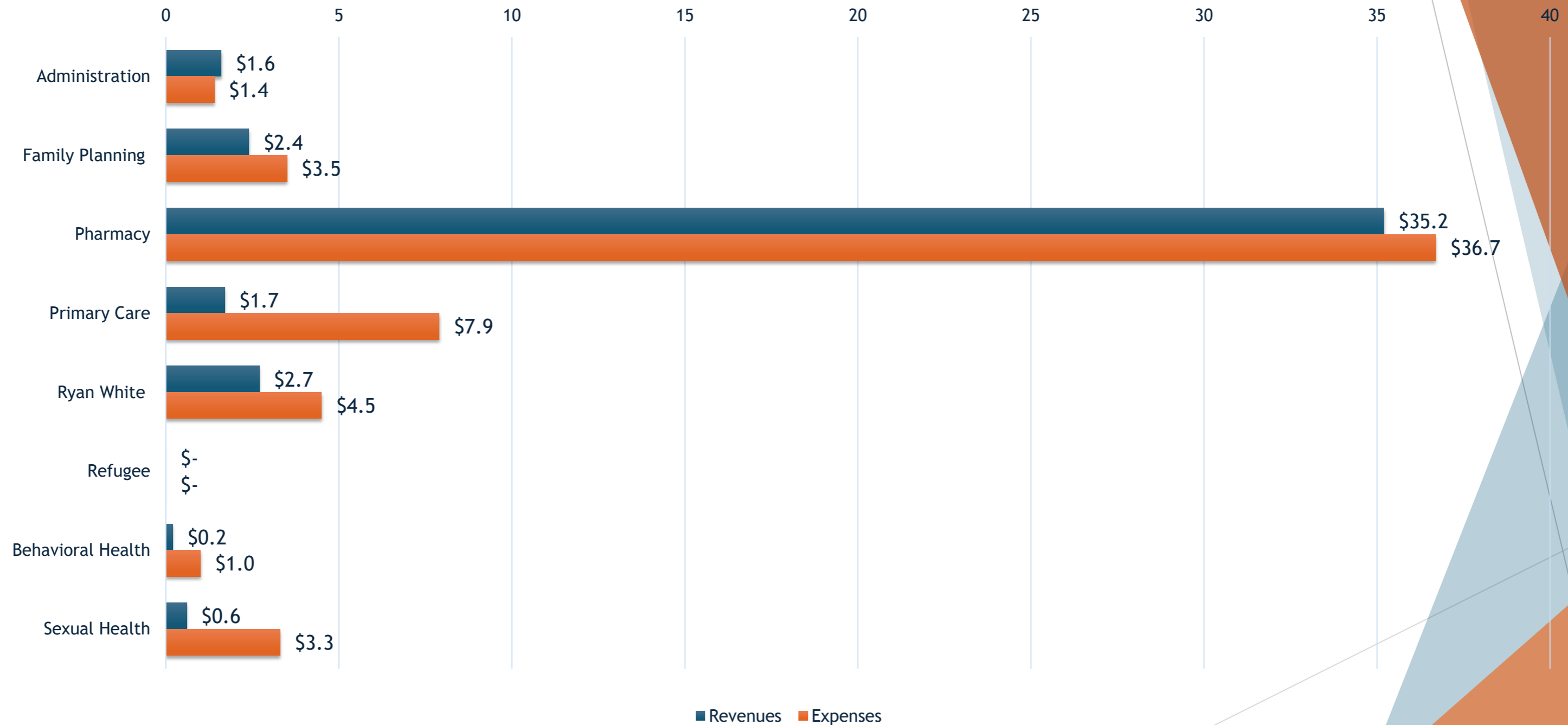
General Fund Pharmacy total expenses is projected at **\$36.7M**, 64% of total FQHC expenses of **\$57.5M**. Pharmacy medication expenses remained the same in FY26 augmented budget at **\$28.4M**

Total salaries and benefits for General & Grants funds is **\$14.8M**, a decrease of **\$1.8M** from the adopted budget of **\$16.6M**. **Total salaries and benefits represent 25.7%** of total FQHC expenditures. More than 30% of personnel expenses are supported by grants.

**FY26 adopted budget includes a full year of salaries and benefits for vacant positions, whereas FY26 augmented budget includes only half year of salaries and benefits for vacant positions.*

REVENUES VS. EXPENDITURES

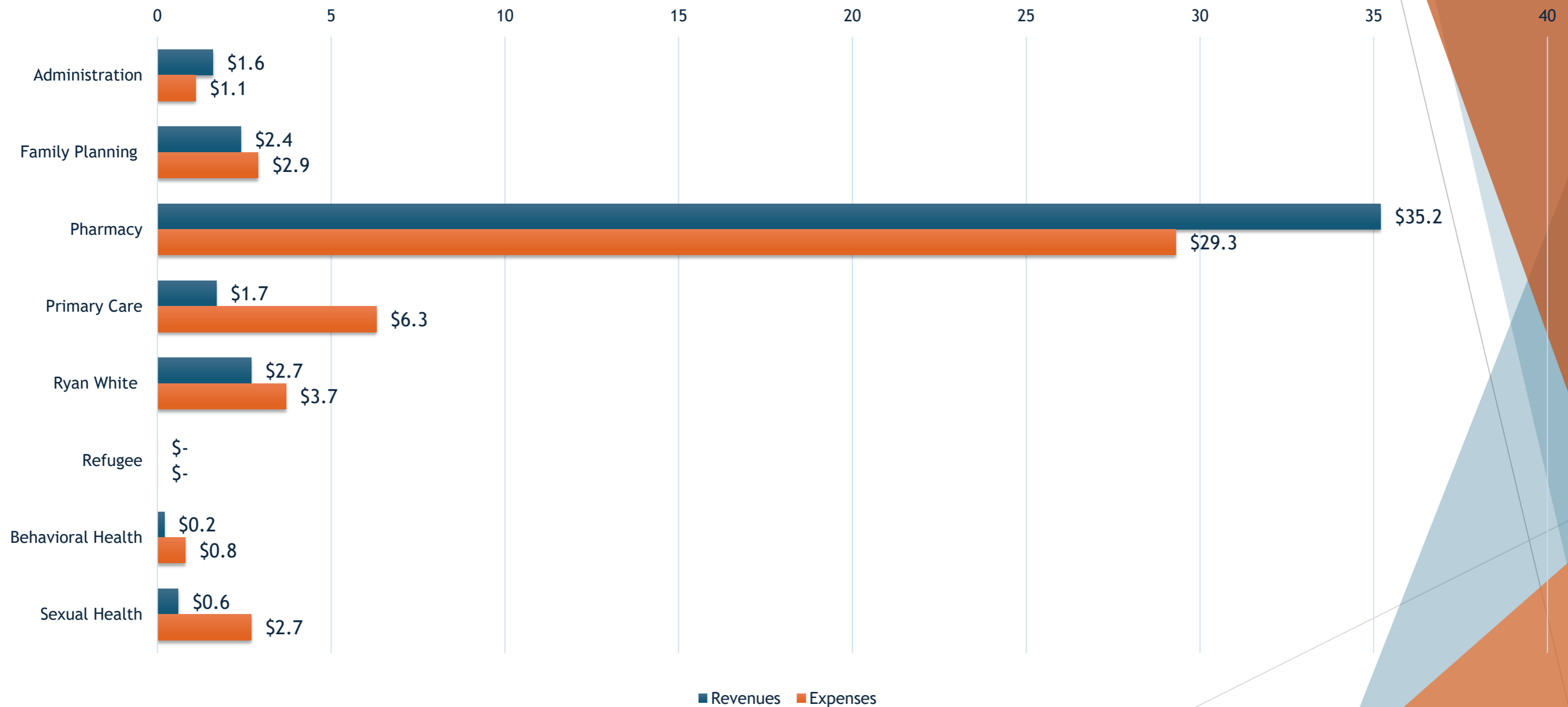
COMBINED FUNDS BY DEPARTMENT



*Amounts are represented in millions

REVENUES VS. EXPENDITURES

COMBINED FUNDS BY DEPARTMENT



*Amounts are represented in millions
*Excludes cost allocations & indirects

Staffing FY2026

FQHC Total FTE

FY26 FTE Counts	2025/2026	2025/2026	FTE Change
Division	Adopted	Amended	FY26 Adopted vs FY26 Amended
ADMINISTRATION ⁽¹⁾	12.0	9.0	-3.0
BEHAVIORAL HEALTH	3.0	3.0	0.0
FAMILY PLANNING ⁽²⁾	18.5	19.5	1.0
SEXUAL HEALTH ⁽³⁾	20.0	19.0	-1.0
PHARMACY ⁽⁴⁾	4.0	5.0	1.0
PRIMARY CARE ⁽⁵⁾	37.0	39.0	2.0
RYAN WHITE ⁽⁶⁾	32.0	25.0	-7.0
Total:	126.5	119.5	-7.0

1. Removal of 2 new/vacant Patient Services Representatives and transfer of 1 Medical Director from FQHC to Administration
2. Addition of 1 Senior Patient Services Representative
3. Removal of 1 Community Health Nurse II.
4. Addition of 1 Clinical Pharmacist
5. Addition of 1 Medical Assistant and 1 Patient Services Representative
6. Removal of vacant grant-funded Eligibility Workers positions that were not hired due to changing federal priorities.

RECOMMENDATION

Acceptance of the FY 2026 budget augmentation, as presented, and Approve Recommendations to the Southern Nevada Community Health Center Governing Board on March 17, 2026.



SNHD Billing Department Review

March 17, 2026



SOUTHERN NEVADA
Community
HEALTH CENTER

AT THE SOUTHERN NEVADA HEALTH DISTRICT

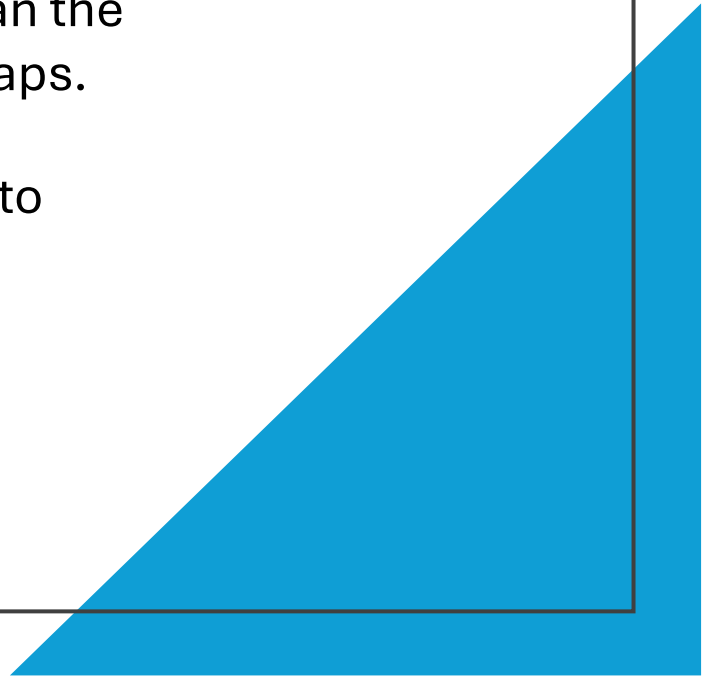
Overview

- Revenue Cycle (medical billing) for SNHD was brought in-house in fiscal year 2022.
- Prior medical billing was performed by external third-party companies.
 - Qualifying encounters for Prospective Payment System (PPS) wrap payments were not submitted.
 - * Denials, rejections and receivable balances were not resolved consistently.
 - * Systematic issues were not consistently identified and resolved.

* Based on our understanding of previous discussions and concerns identified prior to the current FQHC – CEO, CFO and Revenue Cycle Manager joining SNHD.

Nevada Medicaid Wrap Payments

- State Medicaid establishes interim and final rates for Prospective Payment System (PPS) for qualifying encounters provided by Federally Qualified Health Centers (FQHCs).
- Medicaid Managed Care Organizations (MCOs) may pay less than the PPS rate for FQHCs and wrap payments are designed to cover gaps.
- Beginning in CY26, MCOs are providing full PPS reimbursement to FQHCs for qualifying encounters (i.e., shadow billing).

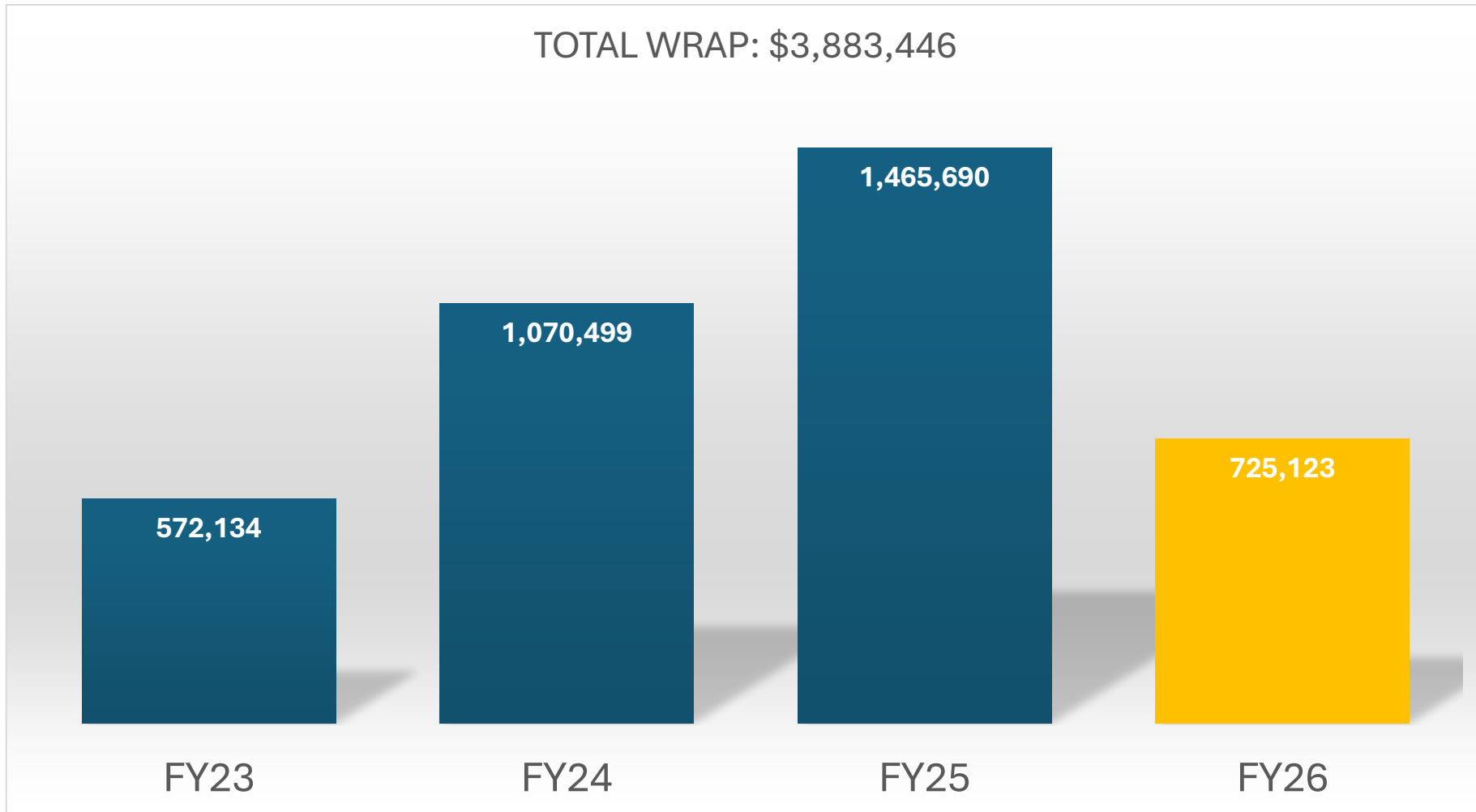


Summary

SNHD Billing Team successes:

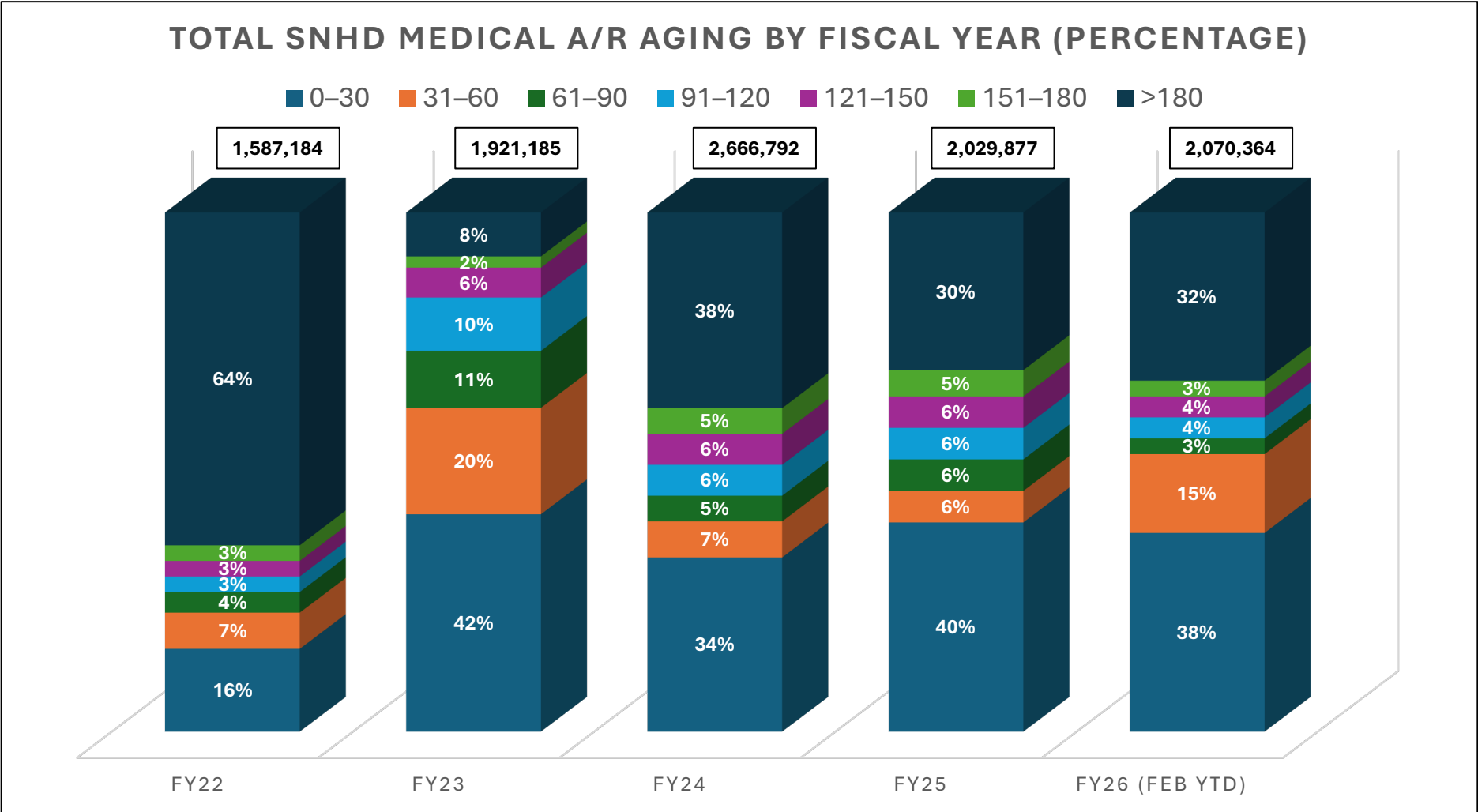
- Wrap payments increased from zero (\$0) to a cumulative of \$3,883,446.
 - Final PPS rate determined in 2025.
- The largest aging categories shifted from >180 to 0-30 days.
- The Billing department actively works denials, rejections, and any issues with the clearinghouse and submits for reprocessing in a timely manner.
- The Revenue Cycle manager works with the provider relations representatives for each payer to correct claims processing issues, pursue contract amendments and reimbursement fee updates.
- A monthly Revenue Cycle meeting between the Revenue Cycle Manager and SNCHC's operations and business teams is in place to optimize the revenue cycle.
- Implemented patient statements to recover additional revenue for activity not collected at time of service.

Wrap Payments Received by Year



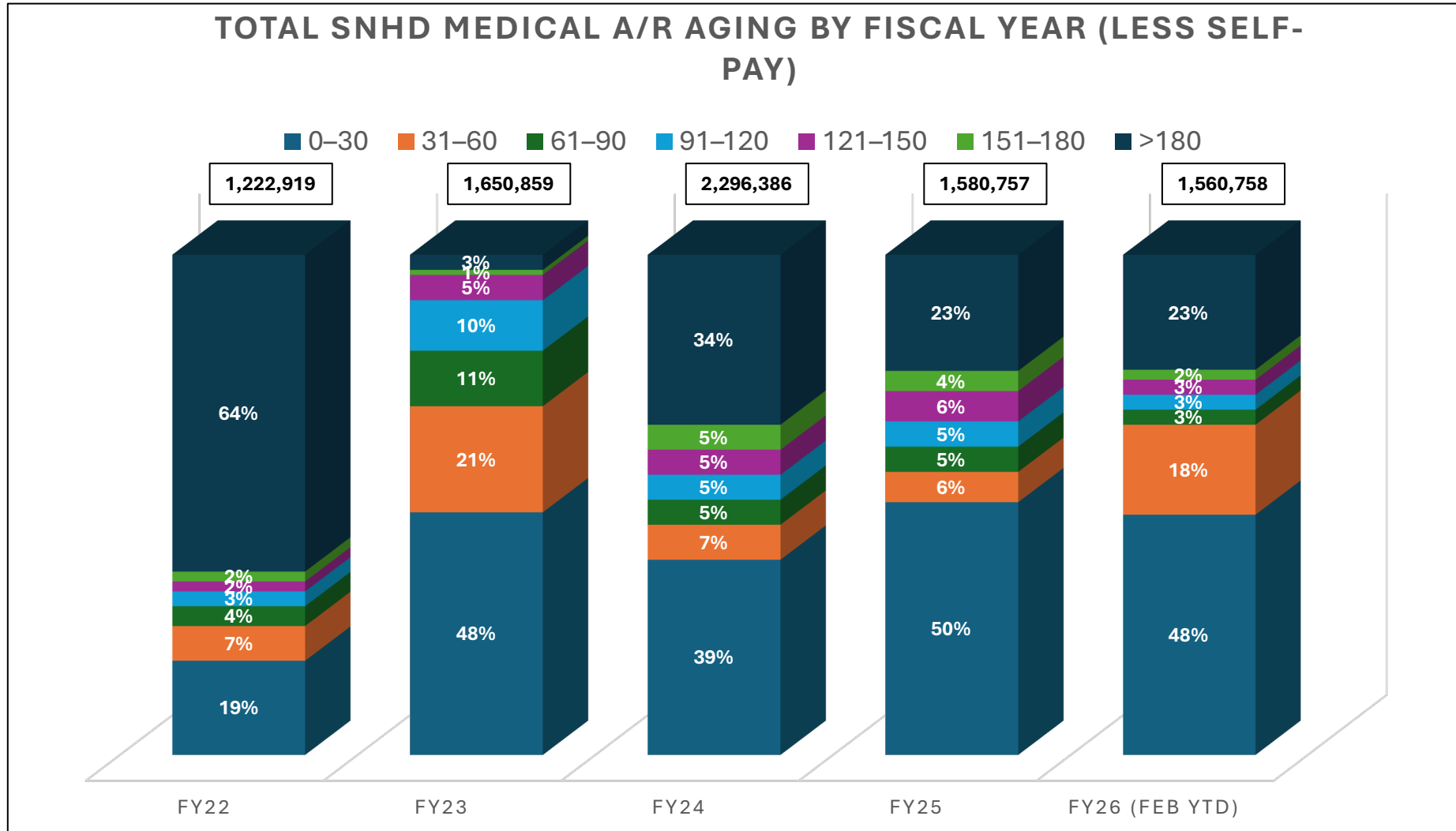
NOTE: Wrap payments through December 2025. Medicaid shadow billing began in January 2026.

Historical A/R Aging by Fiscal Year



NOTE: A payer system configuration error in FY24-FY26 did not recognize SNHD FQHC designation. The Billing department caught the error and negotiated with the payer for settlement based on contractual agreement. Since these settlements carried over fiscal years, the >180 categories were inflated during pending re-processing of claims. Information does not include third-party data.

Historical A/R Aging by Fiscal Year (Less Self-Pay)



NOTE: A payer system configuration error in FY24-FY26 did not recognize SNHD FQHC designation. The Billing department caught the error and negotiated with the payer for settlement based on contractual agreement. Since these settlements carried over fiscal years, the >180 categories were inflated during pending re-processing of claims. Information does not include third-party data.



Questions?



SOUTHERN NEVADA
Community
HEALTH CENTER

AT THE SOUTHERN NEVADA HEALTH DISTRICT

2025 Q4
Quarterly
Risk
Assessment



2025 Q4 Quarterly Risk Assessment

- FTCA requires one risk assessment to be completed each quarter. 2 of the 4 risk assessments must cover a high-risk area.
- The one required risk assessment for Q4 is complete, making the requirement at 100% compliance through Q4.
- The tool used for the Q4 Risk Assessment is called the **ECRI Clinical Risk Management Program Self-Assessment Questionnaire for Bloodborne Pathogens Criteria Audited**

- Conducted by medical director and operations manager on 10/27/2025
- 11/1/20 compliant (92%)
- Action Plan to correct other 9 criteria done and under way.
- Goal is to have 75% or fewer action items open from risk assessments

The collage displays several pages from the ECRI questionnaire. Key sections include:

- Header:** ECRI Institute logo and 'Clinical Risk Management Program Self-Assessment Questionnaire Bloodborne Pathogens'.
- Response Table:** A table with columns for 'Yes', 'No', 'N/A', and 'Comments' for recording assessment results.
- Bloodborne Pathogens Section:** A table for 'Initial assessment by:' with columns for 'Date:' and 'In consultation with:'. It lists staff members: Robin Carter DO, Merylin Yegon, and Ruty Slaus-Rosano.
- Exposure Determination and the Exposure Control Plan:** A detailed section with numbered criteria (1-6) and sub-criteria (a-f). Each criterion is evaluated with 'X' marks in the 'Yes', 'No', 'N/A', and 'Comments' columns. For example, criterion 1 (Occupational Safety and Health Administration, U.S. Department of Labor) is marked 'X' in the 'Yes' column.





CY25 ECRI Self-Assessment Tool for Bloodborne Pathogens - Findings and Action Plan



CY25 ECRI Self-Assessment Tool for Bloodborne Pathogens - Findings and Action Plan

Assessment conducted by: Dr. Robin Carter, DO, Medical Director in consultation with Merylyn Yegon

Q4 Assessment Completed on: 10/27/2025

Overall Score: 111/120 or 92%

Findings/areas of highest risk identified:

1. **Exposure Determination and the Exposure Control Plan –**
 - a. # 5b: Document annual consideration and implementation of safer medical devices, even if the decision is that no new medical devices are required?
 - i. Assessment Notes: This will need to be adopted.
2. **Hygiene Practices**
 - a. #16: After washing visible dirt from skin with soap and water, are employees required to decontaminate their hands with an alcohol-based handrub?
 - i. Assessment Notes: Hand washing is considered clean, hand sanitizer used before each patient
 - b. #17c: In work areas where occupational exposure to BBP is reasonably likely, is it prohibited to: Apply cosmetics or lip balm?
 - i. Assessment Notes: Lip balm is allowed in the clinic but not in the lab area.
3. **Personal Protective Equipment**
 - a. #23: If an employee decides not to use PPE because its use would prevent healthcare delivery or pose an occupational safety hazard, is that incident investigated and documented to determine whether changes can be instituted to prevent such occurrences in the future?
 - i. Assessment Notes: Policy may be needed.
4. **Vaccinations**
 - a. #41: If the postvaccination anti-HBsAg test is negative (<10 mIU/mL), is the three-dose vaccination series repeated and the test for anti-HBsAg given again one to two months after the last dose of the vaccine?
 - i. Assessment Notes: There Can be the 2 or 3 dose series.
 - b. #42: If the test is still negative after a second vaccine series, is the healthcare worker tested for HBsAg and total anti-HB core antibody (anti-HBcAg) to determine his or her HBV infection status?
 - i. Assessment Notes: Employees are sent to their PCP for further evaluation.
 - c. #44: Are healthcare workers found to be HBsAg negative but total anti-HBcAg positive considered to have been infected in the past but not in need of vaccination or treatment?
 - i. Assessment Notes: Needs to be addressed in ECP.
 - d. #45: Are healthcare workers who test positive for both HBsAg and total anti-HBcAg tests considered to have chronic HBV infection and given appropriate counseling for preventing transmission to others as well as a referral for ongoing care for medical management?
 - i. Assessment Notes: Needs to be addressed in ECP

2025 Q4 Quarterly Risk Assessment Findings

9 Findings

2025 Q4 Quarterly Risk Assessment Action Plan

9 Activities will correct and prevent 9 findings by July of 2026.

CY25 Goals	CY25 Activities (What, Who, When)	CY25 Performance
		3 & 6 Month Follow Up
Exposure Determination and the Exposure Control Plan	<ul style="list-style-type: none"> Document annual consideration and implementation of safer medical devices, even if the decision is that no new medical devices are required. <ul style="list-style-type: none"> Led by Medical Director to evaluate annually and implemented by June of 2026. 	Jan 2026 – Apr 2026 – Jul 2026 –
		3 & 6 Month Follow Up
Hygiene Practices	<ul style="list-style-type: none"> Revisit training of hand sanitizing at team huddles, and of lip balm not being used in clinic area <ul style="list-style-type: none"> Medical Director and/or Operations Managers to provide training to team at huddles by April 2026. 	Jan 2026 – Apr 2026 – Jul 2026 –
		3 & 6 Month Follow Up
Personal Protective Equipment	<ul style="list-style-type: none"> If an employee decides not to use PPE because its use would prevent healthcare delivery or pose an occupational safety hazard, is that incident investigated and documented in order to determine whether changes can be instituted to prevent such occurrences in the future? <ul style="list-style-type: none"> Medical Director to incorporate this language and protocol into the existing PPE policy by July 2026. 	Jan 2026 – Apr 2026 – Jul 2026 –
		3 & 6 Month Follow Up
Vaccination	<ul style="list-style-type: none"> Exposure control plan (ECP) needs to be reviewed and revised to address all concerns identified through the risk assessment regarding employee vaccinations. <ul style="list-style-type: none"> Medical Director reviews and revises the language of the ECP and then will present to operations managers and executives for approval and then have the board(s) approve by July 2026. 	Jan 2026 – Apr 2026 – Jul 2026 –
		3 & 6 Month Follow Up
Postexposure Evaluation, Follow-up, and Prophylaxis	<ul style="list-style-type: none"> Meet with clinical and executive leadership whether HBV & HCV rapid testing should be added for employees like HIV. <ul style="list-style-type: none"> Medical Director to conduct a review of current protocols, number of incidents in the last three years, and determination of whether SNHD should carry rapid testing for HBV & HCV, and have those rapid tests added to the CLIA lab license. Currently, Concentra protocols are used to govern activities in this space. SNCHC leadership needs to evaluate the Concentra protocols and determine if updates are necessary and how to implement them. <ul style="list-style-type: none"> Led by Medical Director and Quality Management Coordinator to present to leadership and potentially the Board(s) for approval by July 2026. Conduct further education of the team regarding consultation after possible exposure to HIV according to the most recent U.S. Public Health Service recommendations, including: When the source virus is known or suspected to be resistant to antiretrovirals (although initiation of PEP should not be delayed awaiting results of resistance testing)? <ul style="list-style-type: none"> Led by Medical Director and Operations Managers to educate the team and review at subsequent huddles. 	Jan 2026 – Apr 2026 – Jul 2026 –
		3 & 6 Month Follow Up
Housekeeping	<ul style="list-style-type: none"> Review general practices and SOP protocols for maintaining, cleaning, and disinfecting in patient care areas to control environmental contamination with agents of CJD, and Ebola disinfecting practices. <ul style="list-style-type: none"> Led by Medical Director to review and revise protocols for changes needed by June 2026 Training provided by Operational Managers once the Medical Director has decided which updates and training are needed from their review and revision of the protocols by July 2026. 	Jan 2026 – Apr 2026 – Jul 2026 –

Questions?



2025 Q4
Quarterly
Risk
Management
Report



2025 Q4 Quarterly Risk Management Report

- Grading Scale
- FTCA program requirements mandate that quarterly risk assessments, quarterly risk management reports, and the annual risk management report be presented to the Board for review and approval.

Color Coding Key
Not Compliant
Approaching Compliance
Compliant

2025 Q4 Quarterly Risk Management Report

- Q4 Risk Assessment was completed on 10/27/2025, meeting the expectation of a risk assessment being completed during Q4.
- Clinical Risk Management Program Self-Assessment Questionnaire for Bloodborne Pathogens was conducted by the medical director, Dr. Robin Carter, in consultation with the operations manager, Merylyn Yegon.
- Open action plan items for the year are at 33%.

Risk Assessments			
Person responsible	Measure/ Key Performance Indicator	Threshold	Q4
RM	# Completed annual high-risk assessments	≥ 2/yr	1
RM	# Completed quarterly assessments	Min 1/qtr.	1
RM	% Open action plans	≤75%	33%

2025 Q4 Incident Reporting and Peer Reviews

- FTCA requires SNCHC to track the quantity and level of severity of all incidents.
- Last year 70 incidents were reported
- Q4 of 2025 there were 19 incidents reported, 0 of which were sentinel events, and 4 of which were high risk.
- 6/19 incidents required root cause analysis and follow up.
- The average score for Provider Peer Reviews in Q4 was 96%.

Adverse Events/ Incident Reports			
Person responsible	Measure/ Key Performance Indicator	Threshold	Q4
Center staff	# Sentinel Incidents	Total /qtr.	0
Center staff	# High Risk Incidents	Total /qtr.	4
Center staff	# Medium Risk Incidents	Total /qtr.	10
Center staff	# Low Risk Incidents/Near Misses	Total /qtr.	5
Quarterly Incident Totals		Prior Year - 70	19
RM	# Root Cause Analyses (RCA) completed per qtr.	Total /qtr.	6
Quarterly Peer Review Audit			
Medical Director	# Peer review audits completed (5/provider/qtr.)	80%	96%

2025 Q4 FTCA Required Annual Training Compliance

- There are five FTCA required trainings that all clinical staff MUST participate in each year.
- By the end of Q4, 100% of SNCHC's clinical staff had completed 2025's annual required trainings for FTCA.
- FTCA requires that the Risk Manager take two FTCA risk related trainings each year.
- The Risk Manager, Dave Kahananui, completed the two required annual trainings in May of 2025.

Training and Education			
Person responsible	Measure/ Key Performance Indicator	Threshold	Q4
FQHC Leadership	Planning, review and completion of annual OB training.	≥90% by year-end	100.00%
FQHC Leadership	Planning, review and completion of annual High-Risk Area (Safe Injection) training.	≥90% by year-end	100.00%
FQHC Leadership	Planning, review and completion of annual High-Risk Area (HIPAA Privacy) training.	≥90% by year-end	100.00%
FQHC Leadership	Planning, review and completion of annual Infection Prevention (BBP) training.	≥90% by year-end	100.00%
FQHC Leadership	Planning, review and completion of annual High-Risk Area (Basics of Hand Hygiene for Healthcare Settings) training.	≥90% by year-end	100.00%
Average Completion Rate of Mandatory FTCA Trainings			
RM	Annual Training Completion Rate Goal of 90%	≥90% by year-end	100.00%
Risk Manager Annual Training Requirement			
RM	Required Risk Manager Annual Training	2 Required FTCA trainings by End of Year	100.00%

2025 Q4 Risk and Patient Safety Activities

- Patient satisfaction score averaged 97% for Q4.
- 0 grievances filed in Q4.
- No pharmacy packaging and labeling errors.
- 0 HIPAA breaches during Q4.
- 97% of all referrals ordered were processed and sent.
- 56% of Pts eligible for Pregnancy Intention Screening were screened.
- 5 pregnant patients were referred out for OB care to contracted providers. Manual process tracking this measure.
- 0 patients who had a baby this quarter have birthweight/race data documented for their newborn.
- 100% of LIP/OLCPs had current credentialing at the end of Q4.

Risk and Patient Safety Activities			
Person responsible	Measure/ Key Performance Indicator	Threshold	Q4
QI/MD/Ops Mgrs/RM	Patient satisfaction score	90%	97%
QI/MD/Ops Mgrs/RM	# Grievances	Avg/qtr	0
QI/MD/Ops Mgrs/RM	# Grievances resolved	100%	100
QI/Phar Mgr	Pharmacy packaging and labeling error rate	<5%	0%
Compliance/RM	HIPAA breaches	Total # of breaches	0
QI/MD/Ops Mgrs/RM	Referral completion rate	>90%	97%
QI/MD/Ops Mgrs/RM	% of Pts Screened for Pregnancy Intention	>75%	56.0%
QI/MD/Ops Mgrs/RM	# of Pts Screened for Pregnancy Intention	Total Screened	646
QI/MD/Ops Mgrs/RM	# of Pts eligible for Pregnancy Intention Screening	Total Eligible	1154
QI/MD/Ops Mgrs/RM	# of Pregnant Pts Seen	Total #	0
QI/MD/Ops Mgrs/RM	# of Prenatal pts referred out for prenatal care	# of Prenatal Pts Referred	5
QI/MD/Ops Mgrs/RM	# of Prenatal Pts w Documented Trimester of Pregnancy When First Seen	# of Prenatal Pts Referred	0
QI/MD/Ops Mgrs/RM	% of Prenatal Pts w Documented Trimester of Pregnancy When First Seen	>75%	0%
QI/MD/Ops Mgrs/RM	# of Birthweights by Race Captured	Total #	0
RM/HR	Credentialing and privileging file review rate	100%	100%

2025 Q4 Claims Management

- No claims were reported or filed in Q4.

Claims Management			
Person responsible	Measure/ Key Performance Indicator	Threshold	Q4
CM	# Claims submitted to HHS	NA	0
CM	# Claims settled or closed	NA	0
CM	# Claims open	NA	0
CM	# Lawsuits filed	NA	0
CM	# Lawsuits settled	NA	0
CM	# Lawsuits litigated	NA	0

Questions?



2025
Annual
Risk
Management
Report



2025 Annual Risk Management Report

- Grading Scale
- FTCA program requirements mandate that quarterly risk assessments, quarterly risk management reports, and the annual risk management report be presented to the Board for review and approval.

Color Coding Key
Not Compliant
Approaching Compliance
Compliant

2025 Annual Risk Assessment Report

- FTCA requirements mandate that a risk assessment be conducted once per quarter.
- Two of the quarterly risk assessments should be related to areas of high-risk.

Risk Assessments							
Person responsible	Measure/ Key Performance Indicator	Threshold	Q1	Q2	Q3	Q4	Annual Total
RM	# Completed annual high-risk assessments	≥ 2/yr	1	1	-	1	3
RM	# Completed quarterly assessments	Min 1/qtr.	1	1	1	1	4
RM	% Open action plans	≤75%	0%	0%	20%	33%	22%

2025 Annual Incident Reporting and Peer Reviews

- FTCA requires SNCHC to track the quantity and level of severity of all incidents.
- 87 incidents were reported in 2025 (24% increase in the number of incidents reported YOY)
- 12 incidents reported in 2025 had a high-risk severity.
- 20/87 incidents required root cause analysis and follow up.
- The average score for Provider Peer Reviews in 2025 was 96%.

Adverse Events/ Incident Reports							
Person responsible	Measure/ Key Performance Indicator	Threshold	Q1	Q2	Q3	Q4	Annual Total
Center staff	# Sentinel Incidents	Total /qtr.	0	0	0	0	0
Center staff	# High Risk Incidents	Total /qtr.	1	5	2	4	12
Center staff	# Medium Risk Incidents	Total /qtr.	15	18	23	10	66
Center staff	# Low Risk Incidents/Near Misses	Total /qtr.	2	2	0	5	9
Quarterly Incident Totals		Prior Year - 70	18	25	25	19	87
RM	# Root Cause Analyses (RCA) completed per qtr.	Total /qtr.	5	1	8	6	20
Quarterly Peer Review Audit							
Medical Director	# Peer review audits completed (5/provider/qtr.)	80%	95%	95%	98%	96%	96.00%

Severity of incident:

- Low** (Simple in nature, low risk level, requires issue filing and closure.)
- Medium** (Multiple causes, medium risk level, requires some follow-up, then filing and closure.)
- High** (High risk to safety of the team, the patients, and/or the brand, high risk level, abusive behavior, requires follow-up, a formal incident review, and possible dismissal. Needs possible prevention strategy, and intervention.)
- Sentinel** (Dangerous risk of injury or death as well as safety of the team, the patients, and/or the brand, highest risk level, abusive behavior, requires follow-up, a formal incident review, and possible dismissal. Needs possible prevention strategy, and intervention.)

2025 Annual FTCA Required Annual Training Compliance

- There are five FTCA required trainings that all clinical staff MUST participate in each year.
- By the end of Q4, 100% of SNCHC's clinical staff had completed 2025's annual required trainings for FTCA.
- FTCA requires that the Risk Manager take two FTCA risk related trainings each year.
- The Risk Manager, Dave Kahananui, completed the two required annual trainings in May of 2025.

Training and Education							
Person responsible	Measure/ Key Performance Indicator	Threshold	Q1	Q2	Q3	Q4	Annual Total Completion Rate
FQHC Leadership	Planning, review and completion of annual OB training.	≥90% by year-end	97.30%	100.00%	100.00%	100.00%	100.00%
FQHC Leadership	Planning, review and completion of annual High-Risk Area (Safe Injection) training.	≥90% by year-end	89.33%	100.00%	100.00%	100.00%	100.00%
FQHC Leadership	Planning, review and completion of annual High-Risk Area (HIPAA Privacy) training.	≥90% by year-end	84.26%	99.07%	99.02%	100.00%	100.00%
FQHC Leadership	Planning, review and completion of annual Infection Prevention (BBP) training.	≥90% by year-end	81.51%	99.13%	100.00%	100.00%	100.00%
FQHC Leadership	Planning, review and completion of annual High-Risk Area (Basics of Hand Hygiene for Healthcare Settings) training.	≥90% by year-end	86.90%	100.00%	100.00%	100.00%	100.00%
Average Completion Rate of Mandatory FTCA Trainings							
RM	Annual Training Completion Rate Goal of 90%	≥90% by year-end	88.10%	99.64%	99.76%	100.00%	100.00%
Risk Manager Annual Training Requirement							
RM	Required Risk Manager Annual Training	2 Required FTCA trainings by End of Year	100.00%	100.00%	100.00%	100.00%	100.00%

2025 Annual Risk and Patient Safety Activities

- Patient satisfaction score averaged 98% for 2025.
- 3 grievances filed in 2025 all of which were resolved.
- No pharmacy packaging and labeling errors in 2025.
- 0 HIPAA breaches during 2025.
- 97% of all referrals ordered were processed and sent in 2025.
- 47.8% of Pts eligible for Pregnancy Intention Screening were screened.
- 17 pregnant patients were referred out for OB care to contracted providers. Manual process tracking this measure.
- 1 health center patient who had a baby in 2025 had birthweight/race data documented for their newborn.
- 100% of LIP/OLCPs had current credentialing at the end of 2025.

Risk and Patient Safety Activities							
Person responsible	Measure/ Key Performance Indicator	Threshold	Q1	Q2	Q3	Q4	Annual Total
QI/MD/Ops Mgrs/RM	Patient satisfaction score	90%	98.4%	97.8%	98.3%	97%	98%
QI/MD/Ops Mgrs/RM	# Grievances	Avg/qtr	2	1	0	0	3
QI/MD/Ops Mgrs/RM	# Grievances resolved	100%	100%	100%	100%	100	100%
QI/Phar Mgr	Pharmacy packaging and labeling error rate	<5%	0%	0%	0%	0%	0%
Compliance/RM	HIPAA breaches	Total # of breaches	0	0	0	0	0
QI/MD/Ops Mgrs/RM	Referral completion rate	>90%	96%	97%	98%	97%	97%
QI/MD/Ops Mgrs/RM	% of Pts Screened for Pregnancy Intention	>75%	37.6%	45.2%	54.8%	56.0%	47.8%
QI/MD/Ops Mgrs/RM	# of Pts Screened for Pregnancy Intention	Total Screened	527	588	643	646	2404
QI/MD/Ops Mgrs/RM	# of Pts eligible for Pregnancy Intention Screening	Total Eligible	1403	1301	1174	1154	5032
QI/MD/Ops Mgrs/RM	# of Pregnant Pts Seen	Total #	22	25	19	0	66
QI/MD/Ops Mgrs/RM	# of Prenatal pts referred out for prenatal care	# of Prenatal Pts Referred	4	2	6	5	17
QI/MD/Ops Mgrs/RM	# of Prenatal Pts w Documented Trimester of Pregnancy When First Seen	# of Prenatal Pts Referred	0	0	0	0	0
QI/MD/Ops Mgrs/RM	% of Prenatal Pts w Documented Trimester of Pregnancy When First Seen	>75%	0%	0%	0%	0%	0%
QI/MD/Ops Mgrs/RM	# of Birthweights by Race Captured	Total #	0	0	1	0	1
RM/HR	Credentialing and privileging file review rate	100%	97%	100%	100%	100%	100%*

2025 Q4 Claims Management

- No claims were reported or filed in 2025.

Claims Management							
Person responsible	Measure/ Key Performance Indicator	Threshold	Q1	Q2	Q3	Q4	Annual Total
CM	# Claims submitted to HHS	NA	0	0	0	0	0
CM	# Claims settled or closed	NA	0	0	0	0	0
CM	# Claims open	NA	0	0	0	0	0
CM	# Lawsuits filed	NA	0	0	0	0	0
CM	# Lawsuits settled	NA	0	0	0	0	0
CM	# Lawsuits litigated	NA	0	0	0	0	0

Questions?





2025 Annual Risk Management Report (ARMR)

Annual Risk Management Report (ARMR) to Governing Board for 2025

Title: 2025 Annual Risk Management Report to the Southern Nevada Community Health Center Governing Board

Date: January 1, 2025, to December 31, 2025

Submitted by: David Kahananui, MBA-HM, FQHC Administrative Manager/FQHC Risk Manager

Reviewed/approved by: Randy Smith, MBA, FQHC Chief Executive Officer

Date ARMR submitted to the board: Presentation scheduled for March 17, 2026

Date board approved the ARMR: Vote for approval scheduled for March 17, 2026

Date board approved the meeting minutes containing board approval of the ARMR: Approval of minutes scheduled for April 21, 2026.

Introduction

The purpose of this report is to provide an account of Southern Nevada Community Health Center's (SNCHC) annual performance, relative to the risk management plan, and to evaluate the effectiveness of risk management activities for the 2025 calendar year. SNCHC participates in risk management planning, reporting, and activities to reduce the risk of adverse outcomes that could result in medical malpractice or other health or health-related litigation. Topics presented include quarterly risk assessments, incidents, provider peer review reporting, risk management training, risk and patient safety activities, and claims management. Each topic includes:

- An introduction to explain the relevance of the topic
- A data summary to highlight performance relative to established goals
- A SWOT (Strengths, Weaknesses, Opportunities, Threats) analysis to identify additional factors related to performance
- Follow-up actions to note activities aimed at maintaining or improving performance throughout the year
- A conclusion to summarize findings at year-end
- Proposed future activities to respond to identified areas of high organizational risk

See the attached Risk Management Dashboard for a complete data summary of all topics presented.



2025 Annual Risk Management Report (ARMR)

Quarterly Risk Assessments

Introduction

The [Health Center Program Compliance Manual](#) requires quarterly risk assessments focused on patient safety. A risk assessment is a structured process used to identify potential hazards within the organization's operations, departments, and services. Evidence-based risk assessment tools used by SNCHC are provided by the Emergency Care Research Institute (ECRI), which is the recommended risk management resource for the Health Resources and Services Administration (HRSA). Risk assessments are conducted when member(s) of leadership walk around the building, evaluate conditions, and ask employees about potential risks and concerns while observing processes in action. Collecting data on practices, policies, and safety cultures in various areas generates information that can be used to proactively target patient safety activities and prioritize risk prevention and reduction strategies. The purpose of conducting regular risk assessments is to reduce the risk of adverse outcomes that could result in medical malpractice or other health or health-related litigation.

Risk Activity Focus Area/Measure	Summary Description of Assessment/Methodology/Indicators
Quarterly risk assessments	<ul style="list-style-type: none"> • The health center conducts a minimum of one risk assessment quarterly/four per year. • When high risk issues are identified within the health center, quarterly risk assessments conducted correlate with identified areas of high-risk. • All four risk assessments have an emphasized focus on patient safety. • The findings and action plans that are produced as a part of the risk assessments are reviewed for opportunities for improvement by the Quality Work Group (QWG), leadership, and then presented to the governing board and the FQHC staff. • Areas of high concern are elevated to the medical director, senior leadership, QWG, and/or the board as appropriate. • Additional risk assessments may be conducted as new risks are identified. • In 2025, the names of the four quarterly risk assessment tools used were: the Managing Risks in Ambulatory Care - Clinical Management, the HIPAA Risk Assessment, the Risk Assessment and Mitigation Tool: Safeguards for Behavioral Health Services, and the Self-Assessment Tool for Bloodborne Pathogens. • Three common areas of improvement were identified throughout the assessments which included: developing and implementing policy and/or standard practices, appointing a responsible role for clinical oversight, and improving workflows to reduce risk to patients, staff, and organizational liability.



2025 Annual Risk Management Report (ARMR)

<p>≤75% Open action plans</p>	<p>Action plans are created from the results of the quarterly risk assessments, and other risk related activities. Each action plan is assigned a deadline upon creation. Action plans contain meaningful risk reduction strategies to improve overall patient safety and should be implemented in a timely manner.</p> <p>The health center's goal is to have no more than 75% of action plans open past their initial deadline. This allows for continued work from previous quarters to continue while new ones are discovered through subsequent assessments. Any action plan open past the deadline is elevated to senior leadership, including the Medical Director, and/or the board as appropriate for further discussion and intervention.</p>
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Data Summary - See the dashboard below for completed risk management activities and status of the health center's performance relative to established risk management goals.

Risk Assessments							
Person responsible	Measure/ Key Performance Indicator	Threshold	Q1	Q2	Q3	Q4	Annual Total
RM	# Completed annual high-risk assessments	≥ 2/yr	1	1	-	1	3
RM	# Completed quarterly assessments	Min 1/qtr.	1	1	1	1	4
RM	% Open action plans	≤75%	0%	0%	20%	33%	22%

SWOT Analysis

Strengths	Weaknesses	Opportunities	Threats
<ul style="list-style-type: none"> New medical director leading clinical growth and improvements. Data integrity improvements. 	<ul style="list-style-type: none"> First time going through many of the standardized risk assessments has exposed areas not monitored before. Policies specific to risk management need development, updating, and improvement. 	<ul style="list-style-type: none"> Improving reputable and reliable external resources to meet all compliance expectations. Finding another training resource that enhances what is available on ECRI website. ECRI training cannot be repeated. 	<ul style="list-style-type: none"> New Executive orders and policy changes that impact operational workflows. Las Vegas is a very litigious community. Funding insecurities.

Follow-up Actions from Risk Assessments



2025 Annual Risk Management Report (ARMR)

Q1 Risk Assessment Findings & Action Plan: ECRI Managing Risks in Ambulatory Care - Clinical Management – Conducted by FQHC Medical Director on 3/26/2025. Score: 201/217 – 92.6%

CY25 Goals	CY25 Activities (What, Who, When)	CY25 Performance
3 & 6 Month Follow Up		
<p>Goal #1: Correct findings in the medication safety section of the risk assessment.</p>	<ul style="list-style-type: none"> • Create, gain approval of, and train a new policy to address a drug-sample control program that includes inventory, periodic checks of expiration dates, and a recall system, and how drug samples are to be logged with the amount received from the pharmaceutical representative, expiration dates, and lot numbers. <ul style="list-style-type: none"> ○ Dr. Carter and Dr. Bleak to lead, and Randy Smith, CEO, to approve and present to board for approval. Policy approval due date December 31, 2025. • Create, gain approval of, and train a new policy to address the prohibition of the use of pre-signed and/or post-dated prescription forms, and training on how staff will adhere to this policy. <ul style="list-style-type: none"> ○ Dr. Carter and Dr. Bleak to lead, and Randy Smith, CEO, to approve and present to board for approval. Policy approval due date December 31, 2025. • Create, gain approval of, and train a new policy to require a “read back” of the complete order by the person taking verbal or telephone medication orders to confirm that they are correct. <ul style="list-style-type: none"> ○ Dr. Carter and Dr. Bleak to lead, and Randy Smith, CEO, to approve and present to board for approval. Policy approval due date December 31, 2025. 	<p>Completed in June of 2025.</p>
3 & 6 Month Follow Up		
<p>Goal #2: Correct findings in the health information management section of the risk assessment.</p>	<ul style="list-style-type: none"> • Medical Director, QMC, Ops Managers, and Leadership will establish protocols and train and establish workflows to correct the following identified areas of improvement identified by the end of September 2025: <ul style="list-style-type: none"> • Documentation of treatment or procedures performed in the facility does not include patient condition at discharge. <ul style="list-style-type: none"> ○ Dr. Carter has already provided training on this for the practitioners. ○ Due June 30, 2025. • The facility does not have a standardized set of abbreviations, acronyms, and symbols for use throughout the facility. <ul style="list-style-type: none"> ○ Dr. Carter, Operations Managers, QMC, and CEO. ○ Due August 31, 2025. • The facility does not have a “do not use” list of abbreviations, acronyms, and symbols. • The facility does not have a policy to document end-of-life discussions and decisions in the medical record. 	<p>Completed in May of 2025.</p>



2025 Annual Risk Management Report (ARMR)

	<ul style="list-style-type: none"> • Regarding electronic medical records: computers in exam rooms are not positioned to avoid creating a barrier between the practitioner and the patient. • Assessment Item # 97.b: Regarding electronic medical records: computers in exam rooms do not have the computer screen shielded to protect confidentiality. • Assessment Item # 97.e: Missing policy addressing addendums, late entries, and corrections needing to be entered into the electronic record. 	
		3 & 6 Month Follow Up
<p>Goal #3: Correct findings in the health information management section of the quality improvement (QI) section.</p>	<ul style="list-style-type: none"> • Medical Director, QMC, Ops Managers, and Leadership will establish protocols and train and establish workflows to correct the following identified areas of improvement identified by the end of September 2025: <ul style="list-style-type: none"> • At least one practitioner needs to be assigned to participate in the QI program. • Refine the formal policy to audit critical processes (e.g., follow up on diagnostic tests, test results, and communication of same.) 	Completed in August of 2025
<p>Goal #4: Correct findings in the health information management section of the Risk Management section.</p>	<ul style="list-style-type: none"> • Medical Director, Risk Manager, QMC, Ops Managers, and Leadership will establish protocols and train and establish workflows to correct the following identified areas of improvement identified by the end of September 2025: <ul style="list-style-type: none"> • Develop and implement a documented definition of a near-miss or good-catch event. • Train and assess/verify that staff can recall the process to report a near-miss event. 	Completed in May of 2025



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Q2 Risk Assessment Findings & Action Plan: SNHD HIPAA Risk Assessment Tool. – Conducted by FQHC Medical Director on 6/9/2025. Score: NA

CY25 Goals	CY25 Activities (What, Who, When)	CY25 Performance
3 & 6 Month Follow Up		
<p>Goal #1: Close HIPAA Privacy gaps discovered in 2025 HIPAA Risk Assessment under category, Oral Communications.</p>	<ul style="list-style-type: none"> Operations Managers & Medical Director regularly walk through potential risk areas throughout the day with the intention of observing continued confidentiality in oral communication regarding PHI. Operations Managers & Medical Director cover expectations and risks at huddles regularly. Operations Managers & Medical Director identify and define areas for verbally discussing PHI, so communication only occurs away from other patients. Complete by October 2025. 	<p>Completed by operations managers in August of 2025.</p>
3 & 6 Month Follow Up		
<p>Goal #2: Close HIPAA Privacy gaps discovered in 2025 HIPAA Risk Assessment under category, Protecting Confidentiality of Electronic PHI.</p>	<ul style="list-style-type: none"> Operations Managers & Medical Director regularly walk through potential risk areas at the end of the day to ensure team members are signed out of their systems. Operations Managers & Medical Director will walk through the clinic for continuous monitoring of team members signing out of their system as required. Complete by October 2025. 	<p>Complete by operations managers and medical director in September of 2025.</p>
3 & 6 Month Follow Up		
<p>Goal #3: Close HIPAA Privacy gaps discovered in 2025 HIPAA Risk Assessment under category, Electronic Mail.</p>	<ul style="list-style-type: none"> Operations Managers & Medical Director cover the need for the confidentiality notices in their email signatures and have all team members send an email with their signature lines to verify. Complete by October 2025. 	<p>Completed by operations managers and medical director in July of 2025.</p>



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Q3 Risk Assessment Findings & Action Plan: HRSA ECRI Risk Assessment and Mitigation Tool: Safeguards for Behavioral Health Service – Conducted by FQHC Medical Director and Behavioral Health Manager on 9/15/2025. Score: 61/67 – 91%

CY25 Goals	CY25 Activities (What, Who, When)	CY25 Performance
3 & 6 Month Follow Up		
Correct Criterion #1a – The health center conducts debriefing and safety huddles to support safe and effective behavioral health services.	<ul style="list-style-type: none"> BH Manager & Medical Director consult on policy verbiage and workflow for huddles by January 2026. Identify what constitutes a safety issue (consult with safety officer and security as needed) and what needs to be communicated to mitigate and prevent future safety incidents by January 2026. Define workflow and procedure for huddles with ops teams and BH team. Create a procedure in the proper SNHD/SNCHC format and have CEO review by January 2026. Implement new debriefing and safety huddles process for all BH and Clinic operations teams by April 2026. 	Completed by behavioral health manager and medical director in November 2025 and will be reviewed annually.
3 & 6 Month Follow Up		
Correct Criterion #2a – The health center utilizes patient navigators specific to behavioral health services.	<ul style="list-style-type: none"> CEO, BH Manager, & Medical Director must decide what this role entails and if another FTE is required, or if these responsibilities can be shouldered by existing staff. Job descriptions need to be updated as determined by April 2026. Once duties have been defined, and whether a new or existing FTE will assume those duties, a process must be developed for tracking the activities of this team member for reporting, transparency, and quality improvement by July of 2026. 	Completed by behavioral health manager and medical director in December 2025. Workflow has corrected the gap here with CHW and PSR support.
3 & 6 Month Follow Up		
Correct Criterion #3a – The health center has a plan to identify and address behavioral health workforce shortages and burnout.	<ul style="list-style-type: none"> BH Manager & Medical Director will define what burnout is and identify mitigation and planning tactics to minimize burnout. Cadence of review and first meeting will occur by July 2026. BH Manager & Medical Director will regularly review staffing levels and patient demands and proactively plan access and service provision growth through new providers and operational efficiencies where, when, and how it is logistically possible. 	January 2026 – This is still in process of development for identifying issues by the behavioral health manager. April 2026 – July 2026 –
3 & 6 Month Follow Up		
Correct Criterion #4a – The health center provides soothing music, toys, and comfortable furniture.	<ul style="list-style-type: none"> BH Manager & Medical Director will work with Business Office on budget needs for ambiance in patient areas, which items to purchase. BH Manager will work with AA to place a purchase order and get materials in and 	Completed by behavioral health manager and medical director in January of 2026.



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	activate or place all new supplies appropriately for the BH Center by April 2026.	Items budgeted and purchased have been implemented.
3 & 6 Month Follow Up		
Correct Criterion #4b – The health center counsels patients and their families about firearms and gun safety.	<ul style="list-style-type: none"> BH Manager and Medical Director will work with the Safety Officer to post current SNHD policy compliant firearm and gun safety disclaimers in the BH waiting area by January 2026. 	Completed by behavioral health manager in January of 2026 with support from the safety officer, security, and medical director, Signs are posted at the district.

Q4 Risk Assessment Findings & Action Plan: HRSA ECRI Self-Assessment Tool for Bloodborne Pathogens - Conducted by FQHC Medical Director and Behavioral Health Manager on 10/27/2025. Score: 111/120 – 92%

CY25 Goals	CY25 Activities (What, Who, When)	CY25 Performance
3 & 6 Month Follow Up		
Correct Criteria found to be out of compliance or in need of improvement for the section titled: Exposure Determination and the Exposure Control Plan.	<ul style="list-style-type: none"> Document annual consideration and implementation of safer medical devices, even if the decision is that no new medical devices are required. <ul style="list-style-type: none"> Led by Medical Director to evaluate annually and implemented by June of 2026. 	Completed in January of 2026. Maintenance of clinical devices has been reviewed, and no new devices are required.
3 & 6 Month Follow Up		
Correct Criteria found to be out of compliance or in need of improvement for the section titled: Hygiene Practices.	<ul style="list-style-type: none"> Revisit training of hand sanitizing at team huddles, and of lip balm not being used in clinic area <ul style="list-style-type: none"> Medical Director and/or Operations Managers to provide training to team at huddles by April 2026. 	Review and training provided in February of 2026.
3 & 6 Month Follow Up		
Correct Criteria found to be out of compliance or in need of improvement for the section titled: Personal Protective Equipment.	<ul style="list-style-type: none"> If an employee decides not to use PPE because its use would prevent healthcare delivery or pose an occupational safety hazard, is that incident investigated and documented in order to determine whether changes can be instituted to prevent such occurrences in the future? <ul style="list-style-type: none"> Medical Director to incorporate this language and protocol into the existing PPE policy by July 2026. 	Jan 2026 – In process Apr 2026 – Jul 2026 –
3 & 6 Month Follow Up		



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<p>Correct Criteria found to be out of compliance or in need of improvement for the section titled: Vaccination.</p>	<p>Exposure control plan (ECP) needs to be reviewed and revised to address all concerns identified through the risk assessment regarding employee vaccinations.</p> <ul style="list-style-type: none"> ○ Medical Director reviews and revises the language of the ECP and then will present to operations managers and executives for approval and then have the board(s) approve by July 2026. 	<p>Jan 2026 – In process Apr 2026 – Jul 2026 –</p>
		<p>3 & 6 Month Follow Up</p>
<p>Correct Criteria found to be out of compliance or in need of improvement for the section titled: Postexposure Evaluation, Follow-up, and Prophylaxis.</p>	<ul style="list-style-type: none"> ● Meet with clinical and executive leadership whether HBV & HCV rapid testing should be added for employees like HIV. <ul style="list-style-type: none"> ○ Medical Director conducts a review of current protocols, number of incidents in the last three years, and determination of whether SNHD should carry rapid testing for HBV & HCV, and have those rapid tests added to the CLIA lab license. ● Currently, Concentra protocols are used to govern activities in this space. SNCHC leadership needs to evaluate the Concentra protocols and determine if updates are necessary and how to implement them. <ul style="list-style-type: none"> ○ Led by Medical Director and Quality Management Coordinator to present to leadership and potentially the Board(s) for approval by July 2026. ● Conduct further education of the team regarding consultation after possible exposure to HIV according to the most recent U.S. Public Health Service recommendations, including: When the source virus is known or suspected to be resistant to antiretrovirals (although initiation of PEP should not be delayed awaiting results of resistance testing)? <ul style="list-style-type: none"> ○ Led by Medical Director and Operations Managers to educate the team and review at subsequent huddles. 	<p>Completed in February 2026 - All issues were reviewed with medical director and employee health nurse for revision. All protocols were found to follow standards of medicine and local, state, and federal law. Protocols were reviewed with team at huddles and through meetings..</p>
		<p>3 & 6 Month Follow Up</p>
<p>Correct Criteria found to be out of compliance or in need of improvement for the section titled: Housekeeping.</p>	<ul style="list-style-type: none"> ● Review general practices and SOP protocols for maintaining, cleaning, and disinfecting in patient care areas to control environmental contamination with agents of CJD, and Ebola disinfecting practices. <ul style="list-style-type: none"> ○ Led by Medical Director to review and revise protocols for changes needed by June 2026 ○ Training provided by Operational Managers once the Medical Director has decided which updates and training are needed from their review and revision of the protocols by July 2026. 	<p>Completed in January 2026 – protocols reviewed, training reviewed at huddles and meetings</p>



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Conclusion

The number of quarterly risk assessments met the threshold. Three of the quarterly risk assessments completed were also high-risk assessments. The percentage of open action plans was 22% for the year, which was an improvement over the previous year's results. This means that there are only 22% of the action plan items that are not complete for the year with a threshold of 75% or less. 2/6 of the Q4 action plan items, and 1/5 Q3 action plan items were not corrected/completed, but all action items have been facilitated for correction/completion.

Proposed Future Activities

The number of quarterly risk assessments that were completed met the Health Center's goal. Due to the Health Center's aim to reduce the risk of adverse outcomes that could result in medical malpractice or other health or health-related litigation, all four risk assessments for 2026 are recommended to have a focus of patient safety in nature with support from the behavioral health manager, the clinical operations managers and the medical director for evaluation and recommended action items.

Three of the areas assessed for risk included high-risk categories: Risks in ambulatory care, HIPAA compliance, and Blood-borne pathogen risk.

- Medical Director is the clinical champion leading change and improvement in clinical execution with support from the Quality Management Coordinator, the Operations Managers, the Risk Manager, and the FQHC CEO as needed.
- Quarterly Risk Assessments are presented to the Quality Risk Management and Credentialing Committee and to the governing board.



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Incident Reporting and Provider Peer Reviews

Introduction – Incident reporting is an essential component of the risk management program and is considered part of the performance and quality improvement process. Each provider, employee, or volunteer is responsible for reporting all incidents and near misses at the time they are discovered to his or her immediate supervisor and/or the risk manager. Provider Peer Reviews are chart audits conducted by a provider on patient charts that were documented by their peers in the health center. Both the incident reporting and provider peer review processes provide opportunities for a health center to identify potential issues, mitigate problems discovered, conduct root cause analysis, and implement proactive prevention strategies and mitigation tactics to enhance efficiency and reduce risk.

The “Risk Manager Informal Review” and the Risk Manager Formal Incident Review” forms are critical to determining the cause of the incident, who else needs to be alerted, what trainings need to be provided, analysis of the process, and outcomes.



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Data Summary

See the dashboard below for completed risk management activities and status of the health center’s performance relative to established risk management goals.

Adverse Events/ Incident Reports							
Person responsible	Measure/ Key Performance Indicator	Threshold	Q1	Q2	Q3	Q4	Annual Total
Center staff	# Sentinel Incidents	Total /qtr.	0	0	0	0	0
Center staff	# High Risk Incidents	Total /qtr.	1	5	2	4	12
Center staff	# Medium Risk Incidents	Total /qtr.	15	18	23	10	66
Center staff	# Low Risk Incidents/Near Misses	Total /qtr.	2	2	0	5	9
Quarterly Incident Totals		Prior Year - 70	18	25	25	19	87
RM	# Root Cause Analyses (RCA) completed per qtr.	Total /qtr.	5	1	8	6	20
Quarterly Peer Review Audit							
Medical Director	# Peer review audits completed (5/provider/qtr.)	80%	95%	95%	98%	96%	96.00%

- 59% of all incidents reported involved a medical issue where staff had to respond with the provision of medical care, monitoring, and follow-up, which is all documented, compared to 62% from last year.
 - 23 medical-event incidents that were reported involved staff responding to non-emergent medical issues.
 - 28 medical-event incidents that were reported involved staff responding to emergent medical issues that required a call to for EMS support.
- 20% of incidents reported involved a patient’s behavior compared to 23% last year.
 - 6 incidents reported were for patients behaving aggressively but did not escalate to a level requiring the need for SNHD security support.
 - 1 incident reported was for a patient behaving aggressively and it did escalate to a level requiring the need for SNHD security support.



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- 7 incidents reported were for patient complaints regarding a poor experience.
- 4 medication errors were reported in 2025
 - 1 was due to the incorrect vaccine being administered.
 - 1 was due to a miscommunication between provider and clinical support staff.
 - 1 was due to due to a medication being administered before it was due to be administered.
 - 1 was due to a medication being administered because of an expired lab test.
- 1% of incidents reported were lab errors, which originated from incorrect lab orders.
- 21% of incidents reported were for a variety of reasons across multiple categories from injuries to power and water outages.
- 85.25% of all medical event incidents were reported as occurring in the FQHC division.
 - Of the medical-event incidents reported in the FQHC division, Fremont reported 44.26% of the medical event incidents in the FQHC division, demonstrating their commitment to reporting all incidents to support mitigation and prevention efforts.
 - Of the medical-event incidents reported in the FQHC division, Decatur's Sexual Health Clinic reported 11.48% of the medical event incidents in the FQHC division.
 - Of the medical-event incidents reported in the FQHC division, 29.51% of the incidents were in common areas of the FQHC division.
- 14.75% of all medical event incidents were reported as occurring in non-FQHC divisions.
- Root cause analysis was performed on 22.98% of incidents.
 - Most RCAs were performed on incidents that were high risk or medium risk incidents that could have escalated into becoming sentinel/high risk.
- Annual peer review scores averaged 96%, which is:
 - Improvement over previous year because of medical director and quality management coordinator involvement and leadership.
 - The "Ongoing Professional Practice Evaluation – Peer Review" policy and procedure being followed.



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SWOT Analysis

Strengths	Weaknesses	Opportunities	Threats
<ul style="list-style-type: none"> Three consecutive years in a row, there has been an increase in the number of incidents being reported versus prior year. A Peer Review process is being monitored. A new medical director has been overseeing this process. Staff are familiar with and execute the incident reporting process. 	<ul style="list-style-type: none"> Several iterations of incident reports and confusion about when to use each one Some departments in the FQHC division are not reporting incidents commensurate with other departments who are sometimes less busy. Interdepartmental priorities and processes. 	<ul style="list-style-type: none"> Technological systems or reporting templates are being explored to provide regular comprehensive reports to leadership, the QRMC Board Committee and the Governing Board. ECRI/HRSA resources are being used to develop tools, reports, assessments, and dashboards. 	<ul style="list-style-type: none"> Monitoring executive orders and how they affect SNCHC's policies, procedures, and workflows.

Follow-up Actions

The incident tracking and communication process was made available to SNHD's legal and risk management leadership for consistency and cooperation across the district with the intent to collaborate on risk mitigation efforts. No peer review process in place and needs to be developed. Below is a snippet of the statistical data provided by the tracker for count, type, and severity of incidents.

Assigned Incident #	Date of Incident	Time of Incident	Type of Incident Choose One and Type an "x" in Correct Category																												Severity - Type an "x"															
			Customer/Patient								Employee								Misc												Low	Medium	High	Sentinel												
			Complaint	Injury	Security	Safety	Vehicle	Ethical	HIPAA	Critical Lab Result	Drug Seeking Behavior	Aggressive	Illness	Injury	Security	Vehicle	Ethical	HIPAA	Lab Issue	Aggressive	District vehicle damage	District property loss	Personal property loss	Fire Hazard	Dr. Redbird	Dr. Bluebird	Non Bluebird Medical Event	Lab Order Error	Power Outage	Water Outage	EMR Outage	Cash Handling	Cybersecurity	Medication Error	Legal Threat	Aggressive Vendor	Alarm	Criminal	Other							
87			7	2	1	0	0	0	1	0	0	6	1	1	0	0	0	0	3	0	0	0	0	0	1	0	0	23	28	1	1	2	0	1	0	4	0	0	0	0	0	4	9	66	12	0
			% of Total																												% of Total															



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Incident Review Forms

SOUTHERN NEVADA Community HEALTH CENTER Informal Review Report Document #2025-____-____

Risk Manager Informal Review

Severity of incident:

Low (Simple in nature, low risk level, requires issue filing and closure.)

Medium (Multiple causes, medium risk level, requires some follow-up, then filing and closure.)

High (High risk to safety of the team, the patients, and/or the brand, high risk level, abusive behavior, requires follow-up, a formal incident review, and possible dismissal. Needs possible prevention strategy, and intervention.)

Sentinel (Dangerous risk of injury or death as well as safety of the team, the patients, and/or the brand, highest risk level, abusive behavior, requires follow-up, a formal incident review, and possible dismissal. Needs possible prevention strategy, and intervention.)

Is there any follow-up needed for this report to be resolved? Yes No NA
 If yes, is a Formal Incident Review form required? Yes No NA

Findings: including if internal professionals were contacted, and any recommendations made: _____

If external parties were contacted, who, and were any recommendations made, including an Against Medical Advice (AMA) form, ambulance, transport, police report, arrest, etc.? _____

Risk Manager: _____ Date: _____
 Signature: _____

SOUTHERN NEVADA Community HEALTH CENTER RM Formal Incident Review Document #2024-____-____

Formal Review and Resolution (Risk Manager Only)

Document Number is created by the Risk Manager during the documentation and filing process.

Risk level of incident as determined by the Risk Manager = **Low** **Med** **High** **Sentinel**

Was Security alerted? Yes No NA
 Was Legal alerted? Yes No NA
 Was Human Resources alerted? Yes No NA
 Was IT alerted? Yes No NA

Was the Safety Officer alerted? Yes No NA
 Was the Medical Director alerted? Yes No NA
 Was the Compliance Officer alerted? Yes No NA
 Was the Risk Manager alerted? Yes No NA

Was a patient or customer contacted? Yes No NA
 Was a patient or customer discharged/banned? Yes No NA
 If patient was discharged/banned, was proper discharge protocol followed? Yes No NA
 If patient or customer was discharged/banned, was security informed? Yes No NA
 If patient was discharged, was an alert placed in the pt's EMR account? Yes No NA

Was an insurance payor alerted? Yes No NA
 Was a nursing or medical board alerted? Yes No NA
 Was the OIG alerted? Yes No NA
 Was there a HIPAA breach? Yes No NA
 Were any authorities alerted? Yes No NA

Was the incident preventable? Yes No NA
 Were resources, tools, and training available to prevent the incident? Yes No NA
 Are mitigation efforts being employed to prevent another incident? Yes No NA

Incident Resolution Narrative Risk Manager's narrative of the timeline and steps taken to resolve the incident, who was contacted, how the incident was resolved, and if quality coordinator and/or operations leadership have identified ways to prevent similar subsequent incidents.



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Recommended Next Steps to Prevent Future Incidents: Lessons learned, are there adequate access to resources, tools, and training to prevent future occurrences, are there new protocols, procedures, or policies recommended, etc.? Also note what specific training, intervention, and mitigation steps are to be taken, by whom, and on what timeline, for appropriate implementation and execution to prevent subsequent incidents of like kind.

Is more follow-up required? Yes No If yes, when is the next review due? _____

Incident Resolution Date _____

Number of Days from Incident to Resolution _____

Risk Manager: _____

Signature: _____ Date: _____

- Efforts to improve the response time of the emergency response team to medical events were made this last year, improving response time. The efforts were led by the medical director, chief nursing director, and the operations managers.



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- Although the peer review process was finalized and implemented the loss of the medical director left the process without clinical oversight. While a new medical director is being recruited the practice of peer review began. Incident reporting numbers are improving. The medical director has led the peer review process for 6 quarters now and the results are consistent and positive. The quality management coordinator monitors the data and trends produced by the peer reviews

Provider	Q1	Q2	Q3	Q4	Total Avg
1	99%	94%	99%	94%	97%
2	99%	94%	100%	93%	97%
3	87%	100%	98%	100%	96%
4	100%	95%	95%	98%	97%
5	93%	90%	99%	89%	93%
6	96%	96%	95%	TBD	94%
7	100%	100%	100%	TBD	100%
8	96%	96%	98%	91%	95%
9	100%	94%	95%	100%	97%
10	97%	92%	98%	80%	92%
11	99%	97%	91%	TBD	96%
12	94%	96%	96%	88%	94%



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13	96%	97%	98%	100%	98%
14	95%	93%	100%	98%	97%
15	100%	100%	100%	93%	98%
16	100%	97%	91%	98%	97%
17	100%	92%	97%	100%	97%
18	94%	97%	100%	95%	97%
19	91%	95%	100%	100%	97%
20	n/a	100%	100%	96%	99%
21	n/a	88%	n/a	95%	92%

Conclusion

SNCHC’s newly established risk management workflows, processes, policies, and operations have improved the quantity and quality of outcomes over the last two years.

Proposed Future Activities

A risk management refresher course still needs to be created and added to the annual training course bundle in the learning management system. A “good catch” program has been implemented, called an “On the Spot” award. This program encourages and rewards staff for identifying near-miss events and unsafe conditions through event reporting and mitigation tactics used when a risk presents itself.

Risk Management Training



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Introduction

The [Health Center Program Compliance Manual](#) requires risk management training for all staff members and documentation that all appropriate staff complete training at least annually. Risk management education and training are critical for clinical and nonclinical staff to improve safety and mitigate risk related to patient care. Clinical risk training is required by all Licensed Independent Practitioners (LIPs), Other Licensed Clinical Practitioners (OLCPs), and Other Clinical Staff (OCS) that engage in patient care. Other staff may be assigned to participate in the training as SNHD policy/leadership requires. The risk manager collaborates with the medical director and the operations managers to identify areas of highest risk within the context of the health center's risk management plan and selects risk management training topics that will reduce risk to patient and staff safety.

Risk Activity Focus Area/Measure	Summary Description of Assessment/Methodology/Indicators
FQHC Leadership annually reviews the previous year's high-risk areas, and existing training programs to ensure FTCA compliance, best fit for Health Center, patient safety focused, reputable & evidence-based training programs.	The health center provides mandatory evidence-based virtual training to all health center clinical staff on the following risk related topics: Obstetrics: Safe, Equitable Care for All Women and Primary Care of the Postpartum Patient, Safe Injection Training, HIPAA Privacy Rule, Bloodborne Pathogens Awareness, and The Basics of Hand Hygiene for Healthcare Settings.
Obstetrics: Safe, Equitable Care for All Women and Primary Care of the Postpartum Patient Series	Threshold for this training is 90% of the relevant clinical staff having completed the required training annually. 100% is preferred, however the 90% threshold has been set to allow for newly hired team members to complete their training within 90 days of hire per SNHD/SNCHC policy. Training must be completed annually by each clinical staff team member, which includes LIPs, OLCPs, and OCS staff. Certificates of completed training are then sent to the medical director, and the medical director updates the training tracker. The training tracker is then reviewed at FQHC Leadership meetings at least quarterly to ensure the required training gaps are being closed.
Safe Injection Training	Threshold for training is a 90% compliance rate. 100% is preferred, however the 90% threshold has been set to allow for newly hired team members to complete their training within 90 days of hire per SNHD/SNCHC policy. Training must be completed annually by each clinical staff team member, which includes LIPs, OLCPs, and OCS staff. Certificates of completed training are then sent to the medical director, and the medical director updates the training tracker. The training tracker is then reviewed at FQHC Leadership meetings at least quarterly to ensure the required training gaps are being closed.



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<p>HIPAA Privacy Rule</p>	<p>Threshold for training is a 90% compliance rate. 100% is preferred, however the 90% threshold has been set to allow for newly hired team members to complete their training within 90 days of hire per SNHD/SNCHC policy. Training must be completed annually by each staff team member. Certificates of completed training are then sent to the medical director, and the medical director updates the training tracker. The training tracker is then reviewed at FQHC Leadership meetings at least quarterly to ensure the required training gaps are being closed.</p>
<p>Bloodborne Pathogens Awareness</p>	<p>Threshold for training is a 90% compliance rate. 100% is preferred, however the 90% threshold has been set to allow for newly hired team members to complete their training within 90 days of hire per SNHD/SNCHC policy. Training must be completed annually by each clinical staff team member, which includes LIPs, OLCs, and OCS staff. Certificates of completed training are then sent to the medical director, and the medical director updates the training tracker. The training tracker is then reviewed at FQHC Leadership meetings at least quarterly to ensure the required training gaps are being closed.</p>
<p>The Basics of Hand Hygiene for Healthcare Settings</p>	<p>Threshold for training is a 90% compliance rate. 100% is preferred, however the 90% threshold has been set to allow for newly hired team members to complete their training within 90 days of hire per SNHD/SNCHC policy. Training must be completed annually by each clinical staff team member, which includes LIPs, OLCs, and OCS staff. Certificates of completed training are then sent to the medical director, and the medical director updates the training tracker. The training tracker is then reviewed at FQHC Leadership meetings at least quarterly to ensure the required training gaps are being closed.</p>



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Data Summary

See the dashboard below for completed risk management activities and status of the health center’s performance relative to established risk management goals.

Training and Education							
Person responsible	Measure/ Key Performance Indicator	Threshold	Q1	Q2	Q3	Q4	Annual Total Completion Rate
FQHC Leadership	Planning, review and completion of annual OB training.	≥90% by year-end	97.30%	100.00%	100.00%	100.00%	100.00%
FQHC Leadership	Planning, review and completion of annual High-Risk Area (Safe Injection) training.	≥90% by year-end	89.33%	100.00%	100.00%	100.00%	100.00%
FQHC Leadership	Planning, review and completion of annual High-Risk Area (HIPAA Privacy) training.	≥90% by year-end	84.26%	99.07%	99.02%	100.00%	100.00%
FQHC Leadership	Planning, review and completion of annual Infection Prevention (BBP) training.	≥90% by year-end	81.51%	99.13%	100.00%	100.00%	100.00%
FQHC Leadership	Planning, review and completion of annual High-Risk Area (Basics of Hand Hygiene for Healthcare Settings) training.	≥90% by year-end	86.90%	100.00%	100.00%	100.00%	100.00%
Average Completion Rate of Mandatory FTCA Trainings							
RM	Annual Training Completion Rate Goal of 90%	≥90% by year-end	88.10%	99.64%	99.76%	100.00%	100.00%
Risk Manager Annual Training Requirement							
RM	Required Risk Manager Annual Training	2 Required FTCA trainings by End of Year	100.00%	100.00%	100.00%	100.00%	100.00%



2025 Annual Risk Management Report (ARMR)

Training Tracker:

Department	Job Title	Clinical Non-Clinical	Manager	Obstetrics: Safe, Equitable Care for All Women and Primary of the Postpartum Patient (CLINICAL STAFF) (ECRI)	Safe Injection Training (CLINICAL STAFF)	HIPAA Privacy Rule (ALL)	Bloodborne Pathogens Awareness (Annual) NEOGOV (CLINICAL STAFF)	The Basics of Hand Hygiene for Settings https://www.cbrmc.usrg/main/course/1084875/details (CLINICAL STAFF)
Primary Care Center	Medical Assistant	Clinical	Bernadette Meilly	03/19/25	03/19/25	03/21/25	03/21/25	03/21/25
Family Planning	Adv Prctcl Registered Nurse I	Clinical	Bernadette Meilly	03/13/25	03/19/25	03/18/25	03/19/25	03/18/25
Primary Care Center	Laboratory Assistant	Non Clinical	Merylyn Yegon	03/18/25	03/18/25	03/18/25	03/18/25	03/18/25
Pharmacy	Pharmacy Technician	Clinical	Todd Bleak	N/A	03/13/25	03/13/25	03/13/25	03/13/25
Family Planning	Medical Assistant	Clinical	Merylyn Yegon	03/13/25	03/24/25	04/01/25	03/31/25	03/31/25
Family Planning	Adv Prctcl Registered Nurse I	Clinical	Merylyn Yegon	03/18/25	03/18/25	02/04/25	04/07/25	04/08/25
Ryan White	Community Health Worker I	Non Clinical	Merylyn Yegon	N/A	N/A	03/18/25	N/A	03/18/25
Family Planning	Community Health Nurse I	Clinical	Bernadette Meilly	03/18/25	03/27/25	03/18/25	03/28/25	03/18/25
Primary Care Center	Patient Services Representative	Non Clinical	Cassandra Major	N/A	N/A	03/17/25	N/A	03/13/25
	Medical Assistant	Clinical	Merylyn Yegon	03/18/25	03/17/25	03/17/25	03/18/25	03/18/25
Administration	Senior Administrative Specialist	Non Clinical	Randy Smith	N/A	N/A	04/16/25	N/A	N/A
Family Planning	Community Health Nurse II	Clinical	Bernadette Meilly	03/18/25	04/01/25	04/01/25	04/01/25	04/01/25
Pharmacy	Pharmacy Manager	Clinical	Randy Smith	03/18/25	03/13/25	03/13/25	03/13/25	03/13/25
Family Planning	Mobile Unit Operator	Non Clinical	Bernadette Meilly	N/A	N/A	N/A	N/A	N/A
Sexual Health Clinic	Administrative Assistant II	Non Clinical	Cassandra Major	N/A	N/A	03/18/25	N/A	03/24/25
Sexual Health Clinic	Medical Assistant	Clinical	Bernadette Meilly	03/18/25	03/18/25	04/01/25	04/01/25	03/18/25
Family Planning	Administrative Assistant II	Non Clinical	Bernadette Meilly	N/A	N/A	03/13/25	N/A	03/19/25
Ryan White	Community Health Nurse I/Certified C	Clinical	Merylyn Yegon	03/26/25	03/27/25	03/27/25	03/27/25	03/27/25
Sexual Health Clinic	Community Health Nurse I	Clinical	Karin Dinda	03/12/25	03/12/25	03/13/25	03/13/25	03/13/25
Family Planning	Administrative Assistant II	Non Clinical	Cassandra Major	N/A	N/A	03/18/25	N/A	03/18/25
Administration	CMO/Medical Director	Clinical	Randy Smith	03/12/25	03/11/25	02/03/25	03/13/25	03/13/25
Family Planning	Patient Services Representative	Non Clinical	Cassandra Major	N/A	N/A	04/01/25	N/A	04/03/25
Ryan White	Care Coordinator	Non Clinical	Merylyn Yegon	N/A	N/A	03/18/25	N/A	03/18/25
Ryan White	Community Health Worker I	Non Clinical	Cassandra Major	N/A	N/A	03/13/25	N/A	03/18/25
Ryan White	Community Health Nurse III	Clinical	Merylyn Yegon	03/18/25	03/31/25	03/31/25	03/31/25	03/31/25
Ryan White	Community Health Nurse III	Clinical	Merylyn Yegon	03/18/25	03/12/25	03/17/25	03/12/25	03/13/25
Ryan White	Sr Community Health Nurse	Clinical	Merylyn Yegon	03/12/25	03/13/25	03/13/25	03/13/25	03/13/25
Primary Care Center	Laboratory Assistant	Non Clinical	Merylyn Yegon	03/18/25	03/18/25	03/18/25	03/18/25	03/18/25
Sexual Health Clinic	Administrative Assistant	Non Clinical	Cassandra Major	N/A	N/A	03/31/25	N/A	03/18/25
Family Planning	Community Health Nurse II	Clinical	Merylyn Yegon	03/14/25	03/14/25	03/14/25	03/13/25	03/13/25
Primary Care Center	Medical Assistant	Clinical	Bernadette Meilly	04/08/25	04/08/25	04/08/25	04/08/25	04/08/25
Ryan White	Medical Assistant	Clinical	Merylyn Yegon	03/25/25	03/12/25	04/01/25	03/26/25	03/26/25
Family Planning	Community Health Nurse I	Clinical	Bernadette Meilly	04/01/25	03/13/25	03/13/25	03/13/25	03/13/25
Sexual Health Clinic	CHN Supervisor	Clinical	Merylyn Yegon	03/17/25	03/13/25	03/13/25	03/13/25	03/13/25
Primary Care Center	Medical Assistant	Clinical	Merylyn Yegon	03/12/25	03/12/25	03/12/25	03/12/25	03/12/25
Sexual Health Clinic	Physician's Assistant II	Clinical	Karin Dinda	03/12/25	03/18/25	04/07/25	04/07/25	04/08/25
Primary Care Center	Info & Referral Specialist	Non Clinical	Cassandra Major	N/A	N/A	03/17/25	N/A	03/13/25
Primary Care Center	Medical Assistant	Clinical	Merylyn Yegon	03/17/25	03/18/25	03/18/25	03/18/25	03/18/25
Family Planning	Community Health Worker I	Non Clinical	Bernadette Meilly	N/A	03/19/25	03/19/25	03/19/25	03/19/25
Sexual Health Clinic	Sr Community Health Nurse	Clinical	Karin Dinda	03/12/25	03/18/25	01/16/25	03/18/25	03/18/25
Sexual Health Clinic	Community Health Nurse I	Clinical	Karin Dinda	03/25/25	03/27/25	03/25/25	03/25/25	03/27/25
Family Planning	Medical Assistant	Clinical or Non	Bernadette Meilly	03/18/25	03/18/25	03/18/25	03/19/25	04/01/25
Primary Care Center	Adv Prctcl Registered Nurse I	Clinical	Bernadette Meilly	03/20/25	03/20/25	04/01/25	03/31/25	04/01/25
Primary Care Center	Community Health Worker I	Non Clinical	Cassandra Major	N/A	N/A	03/13/25	N/A	03/17/25
	Medical Assistant	Clinical	Merylyn Yegon	03/18/25	03/18/25	03/18/25	03/18/25	03/18/25
Ryan White	Adv Prctcl Registered Nurse II	Clinical	Merylyn Yegon	03/19/25	03/19/25	04/07/25	04/07/25	04/08/25
Behavioral Health	Behavioral Health Manager	Non Clinical	Randy Smith	03/11/25	03/13/25	01/02/25	03/11/25	03/13/25
Refugee Program	Medical Assistant	Clinical	Bernadette Meilly	03/18/25	03/18/25	04/08/25	04/01/25	04/03/25



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Stats from Training Tracker:

Clinical or Non-Clinical	Manager	Obstetrics: Safe, Equitable Care for All Women and Primary Care of the Postpartum Patient (CLINICAL STAFF) (ECRI)	Safe Injection Training (CLINICAL STAFF)	HIPAA Privacy Rule (ALL)	Bloodborne Pathogens Awareness (Annual) NEOGOV (CLINICAL STAFF)	The Basics of Hand Hygiene for Healthcare Settings https://www.train.org/main/course/1084875/details (CLINICAL STAFF)
# of rows		111	111	111	111	111
# of blank cells		0	0	0	0	0
# of N/A		43	42	1	36	8
# of trainings compliant		68	69	110	75	103
# of late trainings		0	0	0	0	0
# of expired trainings		0	0	0	0	0
% of non compliant & blank		0.00%	0.00%	0.00%	0.00%	0.00%
% of compliant		100.00%	100.00%	100.00%	100.00%	100.00%

Risk Manager Annual Training:





2025 Annual Risk Management Report (ARMR)

SWOT Analysis

Strengths	Weaknesses	Opportunities	Threats
Virtual, evidence-based, patient-safety focused, reputable, readily available training. New medical director. Regular monitoring is occurring.	Available virtual trainings.	Other training resources can be researched for supplemental relevant training courses that enhance existing training.	Training from virtual organizations depends on those organizations to maintain relevance, accessibility, and compliance with medical standards, and relies on them to continue to provide new training. Some current training is not allowed to be taken more than once.

Follow-up Actions

Training plan updated and approved by the Board in 2025. Training tracker is updated in real time when a team member sends their certificate to the medical director and results are reviewed at quarterly leadership meetings for progress.

Conclusion

During 2025, SNCHC staff were 100% compliant with FTCA training expectations by the end of Q2. This is a significantly improved outcome compared to 2024. Training was still monitored quarterly to ensure new hires were also compliant. Training selected by the leadership team and Risk Manager were focused on risks to patients' safety in a primary care setting.

Proposed Future Activities

Searching for additional training that can be provided to staff in 2026, because some of the available trainings in ECRI are not accessible once the training has been taken. New training courses are needed to remain compliant. SNCHC reached out to BPHC inquiring about what other trainings may be recommended for obstetric training because their Obstetric training series are no longer available since everyone has already taken those trainings. Their guidance in response was: "In response to your inquiry, Health centers may choose from various training sources, such as HRSA trainings, ECRI trainings, in-house trainings, or other public or private training resources.



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Health centers have the flexibility to choose the delivery method and format of the OB training. Options may include in-person, virtual, or hybrid training. Additionally, health centers may utilize different training formats, such as lectures, videos, presentations, labs or online modules.

Content covered during OB training: Health centers can determine the specific content covered during each OB training session based on health center data, assessments, and other available information. For example, a health center may require applicable staff members to complete OB training focused on topics such as maternal mortality, post-partum depression, shoulder dystocia, pregnancy and diabetes, or pregnancy and obesity.

By considering these factors, health centers can tailor their OB training programs to effectively address the needs of their staff and meet the requirements for FTCA deemed status.” Guidance will be followed as SNCHC moves forward and continues to provide required training for FTCA compliance.



2025 Annual Risk Management Report (ARMR)

Risk and Patient Safety Activities

Introduction

The objective of the health center's patient safety and risk management program is to continuously improve patient safety and minimize and/or prevent the occurrence of errors, events, and system breakdowns leading to harm to patients, staff, volunteers, visitors, and others through proactive risk management and patient safety activities.

Risk Activity Focus Area/Measure	Summary Description of Assessment/Methodology/Indicators
Patient Satisfaction Scores	Patient satisfaction scores are expected to be at or above 90%. Surveys are offered to every patient that visits SNCHC. Surveys are available by a link provided to the patient or by QR code. Scores are monitored and reported to leadership monthly, and mitigation tactics are deployed immediately for areas of opportunity identified. Patient feedback is critical to SNCHC's ability to adapt, innovate, correct, and improve.
# of Patient Grievances	<p>A patient grievance is a formal written or verbal complaint filed by a patient that cannot be resolved promptly by staff present. All grievances are investigated and reviewed for opportunities for improvement.</p> <p>The health center monitors the number of grievances opened per quarter. No minimum nor maximum threshold is set.</p>
% of Patient Grievances Resolved	The health center responds to and resolves grievances in a timely manner. To resolve the grievance, the health center calls and speaks with the patient to gain greater understanding and when appropriate, provides the patient with written notice that the health center is in reception of their grievance. The Health Center representative contacting the complainant takes steps to correct the causes of the grievance and communicates the root causes to the Health Center's leadership team for dissemination to the team and improvement of process. An incident report is completed for the grievances, and the Health Center documents steps taken on behalf of the patient to investigate the grievance, the results of the grievance process, and the date of completion. The health center's goal is to resolve a grievance within 10 business days from initial receipt of notification, and to have fixes in place to improve process and personnel to prevent further grievances within 60 days.
Pharmacy packaging and error rate	The rate of pharmacy packaging errors that caused a medication dispensing error, or an incident where a patient took incorrect medication because of a packaging error. Ideally this number is 0% but the target is set to be less than 5%.
# of HIPAA breaches	The health center encourages all staff to report suspected HIPAA breaches. This year the health center continues to work on process improvements as identified that are associated with these types of breaches. The health center monitors the number of HIPAA breaches involving visit handouts per quarter. No minimum nor maximum is set, although the ideal number of HIPAA breaches is 0.



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Risk Activity Focus Area/Measure	Summary Description of Assessment/Methodology/Indicators
Referral completion rate	The percentage of referrals ordered by an SNCHC provider that were processed and sent to the referred provider, changing the status of the referral in the EMR from “open” to “completed”. Many factors can impede this process, especially referred provider accessibility and insurance authorizations, so the target is set to be 90%.
% of Pts Screened for Pregnancy Intention	The percentage of health center patients that have a visit with a health center provider, and are eligible to be screened for pregnancy intention, and are screened using a PISQ tool. This is UDS required data.
# of Pts Screened for Pregnancy Intention	The number of female patients who are of reproductive age that are seen at the health center, who <i>were</i> screened for their intent to become pregnant in the next 12 months using a standardized pregnancy intention screening questionnaire (PISQ) tool. This is a new UDS measurement required by HRSA.
# of Pts eligible for Pregnancy Intention Screening	The number of female patients who are of reproductive age that are seen at the health center, who are eligible to be screened for their intent to become pregnant in the next 12 months. This is a new UDS measurement required by HRSA.
# of Pregnant Pts seen	The number of female health center patients that are seen, who report to be pregnant during the health center appointment.
# of Pregnant pts referred out for prenatal care	The number of female health center patients that are seen, who report to be pregnant during the health center appointment and are referred to an OB who has an active MOU/MOA with SNCHC not receive prenatal care. This is UDS required data. Target depends on how many pregnant health center patients are seen and if a referral to a contracted OB provider is documented in the EMR.
# of Pregnant Pts w Documented Trimester of Pregnancy When First Seen	The number of female health center patients that are seen, who report to be pregnant during the health center appointment. The age of the pregnant patient, and the trimester in which the patient’s pregnancy is at the time of the visit. This is UDS required data. Target depends on how many pregnant health center patients are seen and if the trimester in which they are pregnant has been documented in the EMR.
% of Prenatal Pts w Documented Trimester of Pregnancy When First Seen	% of female pregnant patients who had a visit with a Health Center provider whose age and trimester of pregnancy was documented. Target is to have this data documented in the EMR 75% of the time.
# of Birthweights by Race Captured	The number of babies born, who have documented race and birthweight data documented in the EMR, who were born to health center patients that reported being pregnant at the time the pregnant patient had a health center visit. Target depends on how many babies are born to health center patients during the calendar year.
Credentialing and privileging file review rate	The health center maintains files for all clinical staff that contain documentation of licensure, credentialing verification, and applicable privileges, consistent with the health center’s operating procedures as required by the Health Center Program Compliance Manual . The health center monitors for timely renewal of privileges. The goal is to complete all renewals within the month they are due 100% of the time. The credentialing and privileging information of each provider must be reviewed and updated as necessary at least every two years.



2025 Annual Risk Management Report (ARMR)

Data Summary

See the dashboard below for completed risk management activities and status of the health center's performance relative to established risk management goals.

Risk and Patient Safety Activities							
Person responsible	Measure/ Key Performance Indicator	Threshold	Q1	Q2	Q3	Q4	Annual Total
QI/MD/Ops Mgrs/RM	Patient satisfaction score	90%	98.4%	97.8%	98.3%	97%	98%
QI/MD/Ops Mgrs/RM	# Grievances	Avg/qtr	2	1	0	0	3
QI/MD/Ops Mgrs/RM	# Grievances resolved	100%	100%	100%	100%	100	100%
QI/Phar Mgr	Pharmacy packaging and labeling error rate	<5%	0%	0%	0%	0%	0%
Compliance/RM	HIPAA breaches	Total # of breaches	0	0	0	0	0
QI/MD/Ops Mgrs/RM	Referral completion rate	>90%	96%	97%	98%	97%	97%
QI/MD/Ops Mgrs/RM	% of Pts Screened for Pregnancy Intention	>75%	37.6%	45.2%	54.8%	56.0%	47.8%
QI/MD/Ops Mgrs/RM	# of Pts Screened for Pregnancy Intention	Total Screened	527	588	643	646	2404
QI/MD/Ops Mgrs/RM	# of Pts eligible for Pregnancy Intention Screening	Total Eligible	1403	1301	1174	1154	5032
QI/MD/Ops Mgrs/RM	# of Pregnant Pts Seen	Total #	22	25	19	0	66
QI/MD/Ops Mgrs/RM	# of Prenatal pts referred out for prenatal care	# of Prenatal Pts Referred	4	2	6	5	17



2025 Annual Risk Management Report (ARMR)

QI/MD/Ops Mgrs/RM	# of Prenatal Pts w Documented Trimester of Pregnancy When First Seen	# of Prenatal Pts Referred	0	0	0	0	0
QI/MD/Ops Mgrs/RM	% of Prenatal Pts w Documented Trimester of Pregnancy When First Seen	>75%	0%	0%	0%	0%	0%
QI/MD/Ops Mgrs/RM	# of Birthweights by Race Captured	Total #	0	0	1	0	1
RM/HR	Credentialing and privileging file review rate	100%	97%	100%	100%	100%	100%*



2025 Annual Risk Management Report (ARMR)

2025 Patient Satisfaction Scores:

Month	Overall Monthly Score	Overall Quarterly Score	Overall Annual Score
Jan	98.77%	98.42%	98.19%
Feb	98.39%		
Mar	98.11%		
Apr	98.16%	97.81%	
May	97.84%		
Jun	97.43%		
Jul	98.50%	98.79%	
Aug	99.09%		
Sep	98.79%		
Oct	97.09%	97.72%	
Nov	97.38%		
Dec	98.68%		

Question	Ave Annual Score
Was the recent visit as soon as you needed?	94.69%
Providers explain well?	98.86%
Providers listen well?	98.57%
Providers respect you?	98.83%
Providers spend enough time with you?	97.99%
Staff helpful?	98.43%
Staff courteous and respectful?	99.26%
Easy to schedule appt?	98.20%
Cleanliness and appearance of facility?	99.45%
Overall Care	97.58%



2025 Annual Risk Management Report (ARMR)

SWOT Analysis

Strengths	Weaknesses	Opportunities	Threats
<p>Grievance responses to patients were immediately upon incidents being reported</p> <p>No HIPAA breaches were reported for 2025.</p>	<p>Data for pregnant patients, the trimesters of pregnancy when first presenting are being captured, but not in a structured reportable manner. Manual work is currently providing these data. This is an ongoing challenge because the workflows are not supported well with technology yet. PDSA cycles for these measures are still underway and being tested.</p> <p>Outreach follow up efforts are currently being made to attempt to capture race and birthweight data of the babies born to health center patients who reported being pregnant. Outreach has not been very successful. Patients report being uneasy about reporting this data.</p>	<p>Outreach process for connecting with patients who were pregnant was underway, and manual tracking has been tested and is working. Monthly meetings with Informatics to review system limitations are under way. Meetings are continuing, slowly and steadily improving process and results.</p>	<p>AZARA mapping has been a big challenge for these criteria. Work is being done to test where clinical staff are entering data, and whether it is being mapped into a report or not, and if the data is not displaying correctly, more trial-and-error attempts are being made. In the meantime, data is being tracked manually, so SNCHC has correct data to report for UDS</p>

Follow-up Actions

Monthly UDS Data Integrity meetings occur on the second Thursday of each month to review manually tracked and automated data in AZARA, eCW, and other reports, so the quality of data being reported is as accurate as possible. The Quality Work Group (QWG) consists of the medical director, the FQHC administrative manager, IT, Informatics, operations managers, clinical office supervisor, and is led by the quality management coordinator. The QWG plans, implements, executes, monitors, and reports on strategies to improve all areas in which there are deficiencies. If desired results are not achieved according to monthly reports, efforts made are then analyzed and adjusted. Revisions to the mitigation tactics are then deployed to see if results can be improved. The QWG will continue to meet monthly in 2026 to further progress made in 2025.



2025 Annual Risk Management Report (ARMR)

Conclusions

Progress has been made in several areas of this report, and many tactics to reduce risk have been expanded beyond the responsibilities of the risk manager. The medical director is overseeing much of the clinical impact and training needed to improve outcomes. The operations managers are improving workflows and efficiencies in day-to-day operations to maximize patient access to services while balanced with a safe and conscientious environment. More work is needed to filter out the cause of the data issues for pregnant health center patients, and to overcome patient hesitancy to provide data.

Proposed Future Activities

Reaching out to other health centers that have similar populations as SNHD and to national and state resource organizations may allow SNCHC to find best practices or policies that may help improve the overall automation of data being captured and reported more accurately.



2025 Annual Risk Management Report (ARMR)

Claims Management

Introduction

The [Health Center Program Compliance Manual](#) requires health centers to have a claims management process for addressing any potential or actual health or health-related claims. The health center identifies risk areas most likely to lead to claims based on previous claims activity, claims prevention guidance from professional organizations, and published research.

Claims Management Focus Area/ Measure	Summary Description of Assessment/Methodology/Indicators
# Claims submitted to HHS	The health center immediately sends court complaints or notices of intent to the HHS Office of the General Counsel. The health center monitors the number of claims sent per quarter. No minimum nor maximum threshold is set.
# Claims settled or closed	The health center monitors the number of claims settled or closed per quarter. No minimum nor maximum threshold is set.
# Claims open	The health center monitors the number of claims opened per quarter. No minimum nor maximum threshold is set.
# Lawsuits filed	The health center monitors the number of lawsuits resulting from a claim are filed per quarter. No minimum nor maximum threshold is set.
# Lawsuits settled	The health center monitors the number of lawsuits settled per quarter. No minimum nor maximum threshold is set.
# Lawsuits litigated	The health center monitors the number of lawsuits litigated per quarter. No minimum nor maximum threshold is set.



2025 Annual Risk Management Report (ARMR)

Data Summary

See the dashboard below for completed risk management activities and status of the health center's performance relative to established risk management goals.

Claims Management							
Person responsible	Measure/ Key Performance Indicator	Threshold	Q1	Q2	Q3	Q4	Annual Total
CM	# Claims submitted to HHS	NA	0	0	0	0	0
CM	# Claims settled or closed	NA	0	0	0	0	0
CM	# Claims open	NA	0	0	0	0	0
CM	# Lawsuits filed	NA	0	0	0	0	0
CM	# Lawsuits settled	NA	0	0	0	0	0
CM	# Lawsuits litigated	NA	0	0	0	0	0

SWOT Analysis

Strengths	Weaknesses	Opportunities	Threats
N/A	N/A	N/A	N/A

Follow-up Actions

No claims activities occurred in 2025. Continued prevention strategies are being deployed to keep this statistic as low as possible.

Conclusion

No claims activities occurred in 2025. Continued prevention strategies are being deployed to keep this statistic as low as possible.



2025 Annual Risk Management Report (ARMR)

Proposed Future Activities

Continue current claims management processes that include monitoring for emerging concerns, preserving claims-related documentation, and promptly communicating with HHS Office of the General Counsel, General Law Division regarding any actual or potential claim or complaint.

Report Submission

The 2025 Annual Risk Management Report to the Southern Nevada Community Health Center Governing Board is respectfully submitted to demonstrate the ongoing risk management program to reduce the risk of adverse outcomes and provide safe, efficient, and effective care and services.



2025 Annual Risk Management Report (ARMR)

Risk Management Dashboard

Components of this report are provided according to standards that must be met to meet FTCA deeming requirements related to risk management. Such guidance can be found using the following resources: [Chapter 21: Federal Tort Claims Act \(FTCA\) Deeming Requirements](#), [Chapter 10: Quality Improvement/Assurance](#), and [Health Center Program Compliance Manual](#).

Risk Assessments							
Person responsible	Measure/ Key Performance Indicator	Threshold	Q1	Q2	Q3	Q4	Annual Total
RM	# Completed annual high-risk assessments	≥ 2/yr	1	1	-	1	3
RM	# Completed quarterly assessments	Min 1/qtr.	1	1	1	1	4
RM	% Open action plans	≤75%	0%	0%	20%	33%	22%

Adverse Events/ Incident Reports							
Person responsible	Measure/ Key Performance Indicator	Threshold	Q1	Q2	Q3	Q4	Annual Total
Center staff	# Sentinel Incidents	Total /qtr.	0	0	0	0	0
Center staff	# High Risk Incidents	Total /qtr.	1	5	2	4	12
Center staff	# Medium Risk Incidents	Total /qtr.	15	18	23	10	66
Center staff	# Low Risk Incidents/Near Misses	Total /qtr.	2	2	0	5	9
Quarterly Incident Totals		Prior Year - 70	18	25	25	19	87
RM	# Root Cause Analyses (RCA) completed per qtr.	Total /qtr.	5	1	8	6	20

Quarterly Peer Review Audit							
Medical Director	# Peer review audits completed (5/provider/qtr.)	80%	95%	95%	98%	96%	96.00%

Training and Education



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Person responsible	Measure/ Key Performance Indicator	Threshold	Q1	Q2	Q3	Q4	Annual Total Completion Rate
FQHC Leadership	Planning, review and completion of annual OB training.	≥90% by year-end	97.30%	100.00%	100.00%	100.00%	100.00%
FQHC Leadership	Planning, review and completion of annual High Risk Area (Safe Injection) training.	≥90% by year-end	89.33%	100.00%	100.00%	100.00%	100.00%
FQHC Leadership	Planning, review and completion of annual High Risk Area (HIPAA Privacy) training.	≥90% by year-end	84.26%	99.07%	99.02%	100.00%	100.00%
FQHC Leadership	Planning, review and completion of annual Infection Prevention (BBP) training.	≥90% by year-end	81.51%	99.13%	100.00%	100.00%	100.00%
FQHC Leadership	Planning, review and completion of annual High Risk Area (Basics of Hand Hygiene for Healthcare Settings) training.	≥90% by year-end	86.90%	100.00%	100.00%	100.00%	100.00%
Average Completion Rate of Mandatory FTCA Trainings							
RM	Annual Training Completion Rate Goal of 90%	≥90% by year-end	88.10%	99.64%	99.76%	100.00%	100.00%
Risk Manager Annual Training Requirement							
RM	Required Risk Manager Annual Training	2 Required FTCA trainings by End of Year	100.00%	100.00%	100.00%	100.00%	100.00%
Risk and Patient Safety Activities							
Person responsible	Measure/ Key Performance Indicator	Threshold	Q1	Q2	Q3	Q4	Annual Total
QI/MD/Ops Mgrs/RM	Patient satisfaction score	90%	98.4%	97.8%	98.3%	97%	98%



2025 Annual Risk Management Report (ARMR)

QI/MD/Ops Mgrs/RM	# Grievances	Avg/qtr	2	1	0	0	3
QI/MD/Ops Mgrs/RM	# Grievances resolved	100%	100%	100%	100%	100	100%
QI/Phar Mgr	Pharmacy packaging and labeling error rate	<5%	0%	0%	0%	0%	0%
Compliance/RM	HIPAA breaches	Total # of breaches	0	0	0	0	0
QI/MD/Ops Mgrs/RM	Referral completion rate	>90%	96%	97%	98%	97%	97%
QI/MD/Ops Mgrs/RM	% of Pts Screened for Pregnancy Intention	>75%	37.6%	45.2%	54.8%	56.0%	47.8%
QI/MD/Ops Mgrs/RM	# of Pts Screened for Pregnancy Intention	Total Screened	527	588	643	646	2404
QI/MD/Ops Mgrs/RM	# of Pts eligible for Pregnancy Intention Screening	Total Eligible	1403	1301	1174	1154	5032
QI/MD/Ops Mgrs/RM	# of Pregnant Pts Seen	Total #	22	25	19	0	66
QI/MD/Ops Mgrs/RM	# of Prenatal pts referred out for prenatal care	# of Prenatal Pts Referred	4	2	6	5	17
QI/MD/Ops Mgrs/RM	# of Prenatal Pts w Documented Trimester of Pregnancy When First Seen	# of Prenatal Pts Referred	0	0	0	0	0
QI/MD/Ops Mgrs/RM	% of Prenatal Pts w Documented Trimester of Pregnancy When First Seen	>75%	0%	0%	0%	0%	0%
QI/MD/Ops Mgrs/RM	# of Birthweights by Race Captured	Total #	0	0	1	0	1
RM/HR	Credentialing and privileging file review rate	100%	97%	100%	100%	100%	100%*



2025 Annual Risk Management Report (ARMR)

Claims Management							
Person responsible	Measure/ Key Performance Indicator	Threshold	Q1	Q2	Q3	Q4	Annual Total
CM	# Claims submitted to HHS	NA	0	0	0	0	0
CM	# Claims settled or closed	NA	0	0	0	0	0
CM	# Claims open	NA	0	0	0	0	0
CM	# Lawsuits filed	NA	0	0	0	0	0
CM	# Lawsuits settled	NA	0	0	0	0	0
CM	# Lawsuits litigated	NA	0	0	0	0	0

CY27 FTCA Redeeming Application Approval



FTCA

Redeeming Application due 6/26/2026 for 2027 coverage

- What is FTCA?
 - Federal Tort Claims Act
 - Malpractice coverage for Health Centers and Health Center individuals registered with HRSA who are Licensed Independent Practitioners, Other Licensed Clinical Practitioners, and Other Clinical Staff.
- Deeming and redeeming criteria must be met to qualify for FTCA.



Low-cost, high-quality health care is here in your neighborhood.

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FTCA Redeeming Application due 6/26/2026 for 2027 coverage

- Federal Tort Claims Act
 - Application sections mirror the risk management dashboard.

- Quarterly risk assessments
- Incident reporting, provider peer reviews, and training
- Risk and patient safety activities
- Claims management

1.

Risk Assessments							
Person responsible	Measure/ Key Performance Indicator	Threshold	Q1	Q2	Q3	Q4	Annual Total
RM	# Completed annual high-risk assessments	≥ 2/yr	1	1	-	1	3
RM	# Completed quarterly assessments	Min 1/qtr.	1	1	1	1	4
RM	% Open action plans	≤75%	0%	0%	20%	33%	22%

2.

Adverse Events/ Incident Reports								
Person responsible	Measure/ Key Performance Indicator	Threshold	Q1	Q2	Q3	Q4	Annual Total	
Center staff	# Sentinel Incidents	Total /qtr.	0	0	0	0	0	
Center staff	# High Risk Incidents	Total /qtr.	1	5	2	4	12	
Center staff	# Medium Risk Incidents	Total /qtr.	15	18	23	10	66	
Center staff	# Low Risk Incidents/Near Misses	Total /qtr.	2	2	0	5	9	
Quarterly Incident Totals			Prior Year - 70	18	25	25	19	87
RM	# Root Cause Analyses (RCA) completed per qtr.	Total /qtr.	5	1	8	6	20	

Training and Education							
Person responsible	Measure/ Key Performance Indicator	Threshold	Q1	Q2	Q3	Q4	Annual Total Completion Rate
FQHC Leadership	Planning, review and completion of annual OB training.	≥90% by year-end	97.30%	100.00%	100.00%	100.00%	100.00%
FQHC Leadership	Planning, review and completion of annual High Risk Area (Safe Injection) training.	≥90% by year-end	89.33%	100.00%	100.00%	100.00%	100.00%
FQHC Leadership	Planning, review and completion of annual High Risk Area (HIPAA Privacy) training.	≥90% by year-end	84.26%	99.07%	99.02%	100.00%	100.00%
FQHC Leadership	Planning, review and completion of annual Infection Prevention (BBP) training.	≥90% by year-end	81.51%	99.13%	100.00%	100.00%	100.00%
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3.

Risk and Patient Safety Activities							
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QI/MD/Ops Mgrs/RM	# Grievances	Avg/qtr	2	1	0	0	3
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QI/MD/Ops Mgrs/RM	# of Birthweights by Race Captured	Total #	0	0	1	0	1
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4.

Claims Management							
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CM	# Claims settled or closed	NA	0	0	0	0	0
CM	# Claims open	NA	0	0	0	0	0
CM	# Lawsuits filed	NA	0	0	0	0	0
CM	# Lawsuits settled	NA	0	0	0	0	0
CM	# Lawsuits litigated	NA	0	0	0	0	0

FTCA

Redeeming Application due 6/26/2026 for 2027 coverage

- Initial Deeming occurred in 2023 for 2024 coverage.
- Redeeming FTCA applications are submitted each year in June for the following calendar year using performance results from the previous year and current policy compliance.
- SNCHC is asking the Governing Body to approve SNCHC's risk manager to complete and submit the 2026 FTCA application in the EHB for 2027 redeeming coverage.



SOUTHERN NEVADA
Community
HEALTH CENTER



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Questions?



IX. CHIEF EXECUTIVE OFFICER & STAFF REPORTS

Randy Smith, MPA, Chief Executive Officer - FQHC

Funding and Administrative Updates

- Title X Funding
- CY25 UDS Report/Submitted marked as complete
- Vacant Community Board Member Recruitment
- Board Retreat

Thank you.



MEMORANDUM

Date: March 17, 2026

To: Southern Nevada Community Health Center Governing Board

From: Randy Smith, MPA, Chief Executive Officer, FQHC ^{RS}
Cassius Lockett, PhD, District Health Officer ^{CL}

Subject: Community Health Center FQHC Chief Executive Officer Report – February 2026

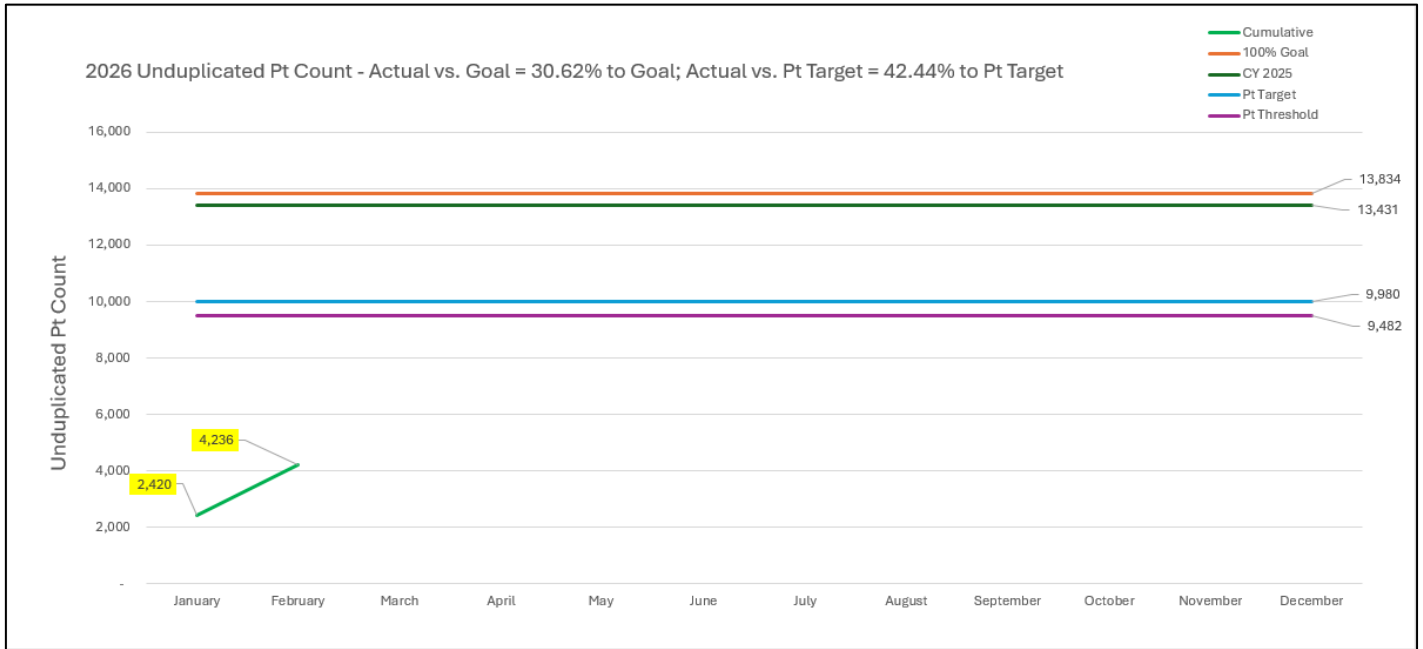
Division Information/Highlights: The Southern Nevada Community Health Center, a division of the Southern Nevada Health District, mission is to serve residents of Clark County from underserved communities with appropriate and comprehensive outpatient health and wellness services, emphasizing prevention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

February Highlights - Administrative

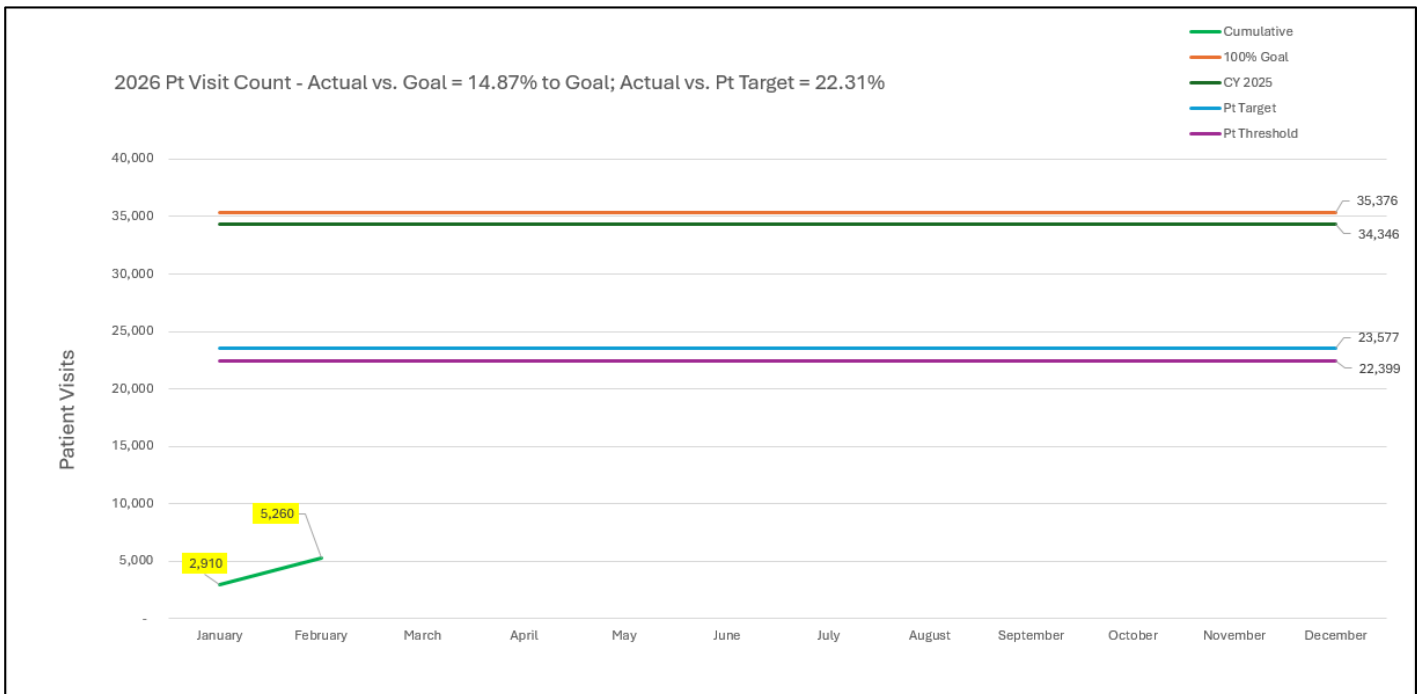
- Office of Population Affairs (OPA) Title X – Family Planning funding expires on March 31, 2026.
- Health Resources and Services Administration (HRSA) CY25 Uniform Data System report submitted.
- Patient Centered Medical Home (PCMH) transformation activities underway.
- CY26 FTCA Redeeming application due June 26, 2026
- Sliding Fee Discount program patient survey completed.
- Sliding Fee Discount program FQHC market analysis completed.
- Two (2) medical assistants authorized to move from hold to recruitment status.
- A new mid-level provider (i.e., APRN or PA) authorized for recruitment.
- Recruitment for a doctor for the Fremont Public Health Center ongoing.
- New SNCHC Employee Engagement Committee commenced planning on CY26 engagement activities.
- One primary care medical assistance recognized as a SNHD employee of the month

Access

Unduplicated Patients – February 2026



Patient Visits Count – February 2026



Provider Visits by Program and Site – February 2026

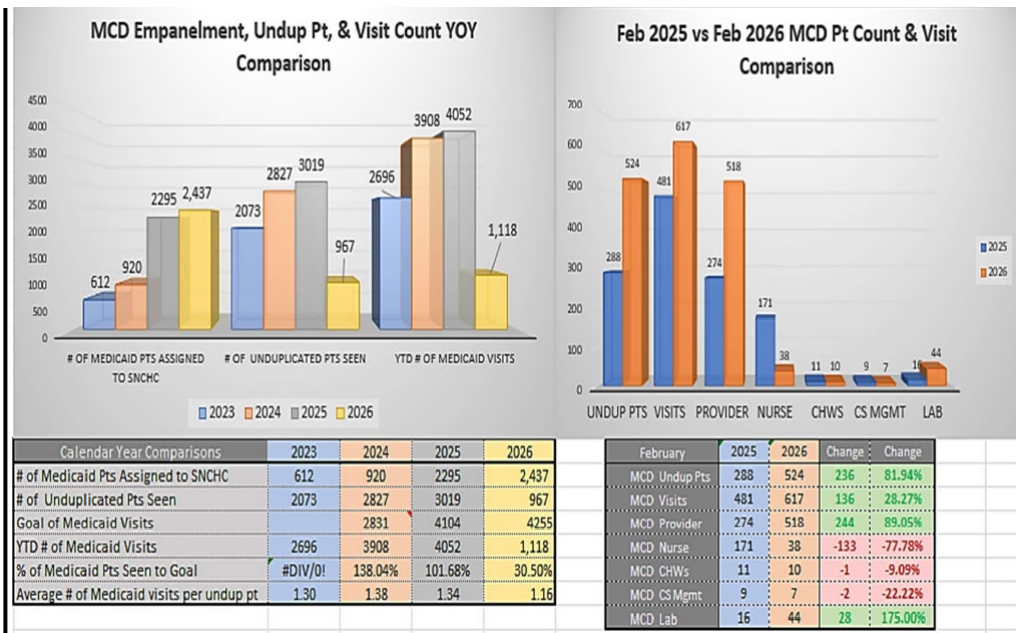
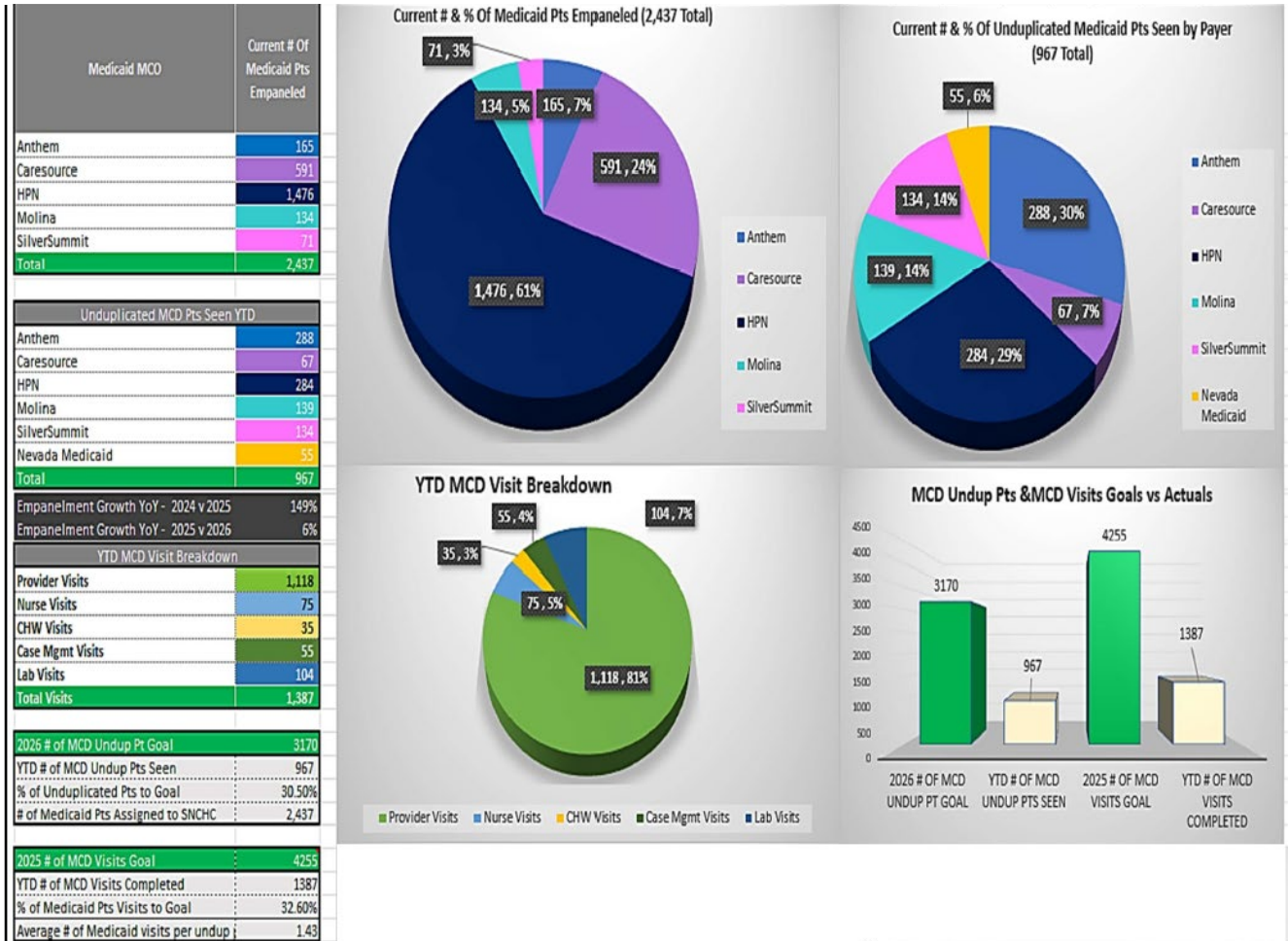
Facility	Program	FEB '26	FEB '25	FEB YoY %	FY26 YTD	FY25 YTD	FY YTD YoY%
Decatur	Family Health	701	678	3%	6,177	4,830	22%
Fremont	Family Health	543	424	22%	3,913	2,828	28%
Total	Family Health	1,244	1,102	11%	10,090	7,658	24%
Decatur	Family Planning	153	174	-14%	1,078	1,287	-19%
Fremont	Family Planning	202	186	8%	1,354	1,095	19%
Total	Family Planning	355	360	-1%	2,432	2,382	2%
Decatur	Sexual Health	533	532	0%	4,332	4,064	6%
Fremont	Sexual Health	130	170	-31%	926	1,059	-14%
ASEC	Sexual Health				0	113	
Total	Sexual Health	663	702	-6%	5,258	5,236	0%
Decatur	Behavioral Health	194	144	26%	1,419	980	31%
Fremont	Behavioral Health	151	125	17%	1,149	922	20%
Total	Behavioral Health	345	269	22%	2,568	1,902	26%
Decatur	Ryan White	191	231	-21%	1,824	1,807	1%
Fremont	Ryan White	31	14	55%	216	188	13%
Total	Ryan White	222	245	-10%	2,040	1,995	2%
FQHC Total		2,829	2,678	5%	22,388	19,173	14%

Pharmacy Services

	26-Feb	25-Feb		FY26 YTD	FY25 YTD		% Change YOY
Client Encounters (Pharmacy)	1,715	1,478	↑	13,604	11,287	↑	20.5%
Prescriptions Filled	3,157	2,538	↑	25,223	18,842	↑	33.9%
Client Clinic Encounters (Pharmacist)	43	71	↓	437	482	↓	-9.3%
Financial Assistance Provided	20	47	↓	120	271	↓	-55.7%
Insurance Assistance Provided	13	19	↓	114	87	↑	31.0%

- A. Dispensed 3,157 prescriptions for 1,715 clients.
- B. Pharmacist completed 43 client clinic encounters.
- C. Assisted 20 clients to obtain medication financial assistance.
- D. Assisted 13 clients with insurance approvals.

Medicaid Managed Care Organization (MCO)



Behavioral Health Services

- A. The Ryan White group therapy program, Evolve, is experiencing an increase in patient participation.
- B. The Behavioral Health Manager served as a panelist during the Nevada Senior Services Stakeholder Meeting, contributing to a discussion focused on community collaboration to support the aging population.
- C. The Behavioral Health team continues to partner with the Office of Communications on its marketing plan and recently participated in the filming of a commercial now airing on multiple channels to promote its services.

Family Planning Services

- A. Family Planning program access was down 1% in January and is up 2% year-over-year. Program team administrators and clinical staff are working with SNHD's Quality Improvement and Accreditation Program Manager on a quality improvement project to increase access to care. Same day walk-ins are emerging as a viable strategy to overcome high no-show rates amongst patients with scheduled appointments. This project is ongoing.
- B. No guidance has been received from the Office of Population Affairs regarding the submission of a non-competing continuous grant application for funding for year five of five for Title X Family Planning services. The annual award amount is approximately \$1.4M and supports salary expenses for 12.6 FTEs. Contingency planning is underway.

HIV/Ryan White Program Services

- A. The Ryan White program received 77 referrals between February 1st and February 28. There were two (2) pediatric clients referred to the Medical Case Management in February, and the program received two (2) referrals for pregnant women living with HIV during this time.
- B. There were 699 service encounters provided by the Ryan White Linkage Coordinator, Eligibility Worker, Care Coordinators, Nurse Case Managers, Community Health Workers, and Health Educator. There were 332 unique clients served under these programs in February.
- C. The Ryan White ambulatory clinic provided a total of 432 visits in the month of February, including 27 initial provider visits, 165 established provider visits including one (1) tele-visit to an established patient. Additionally, there were 17 nursing visits and 201 lab visits provided. There were 56 Ryan White services provided under Behavioral Health by licensed mental health practitioners and the Psychiatric APRN during the month of February. There were 22 Ryan White clients seen by the Registered Dietitian under Medical Nutrition services in February.
- D. The Ryan White clinic provides Rapid StART services, with 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 seven (7) patients seen under the Rapid StART Program in February.

FQHC-Sexual Health Clinic (SHC)

- A. The Sexual Health Clinic (SHC) clinic provided 892 unique services to 782 unduplicated patients for the month of February.
- B. There are currently more than 100 patients receiving injectable treatment for HIV prevention (PrEP).
- C. The 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) on 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. The SHC continues to refer pregnant patients with syphilis and patients needing complex STI evaluation and treatment to PPC SHOPP for nurse case management services.

Refugee Health Program (RHP)

Refugee Health Program for the month of February.

Client required medical follow- up for Communicable Diseases	-
Refugee Health Screening for Ova and Parasites (positive tests)	0
Referrals for TB issues	0
Referrals for Chronic Hep B	0
Referrals for STD	0
Pediatric Refugee Exams	2
Clients encounter by program (adults)	2
Refugee Health Screening for February 2026	4
Total for FY25-26	32

Outreach/In Reach Activity

Number of events	1– Outreach 0 – In reach
Number of people reached	128
Number of people linked to the clinic	0
Number of hours dedicated to outreach	3

Eligibility and Insurance Enrollment Assistance

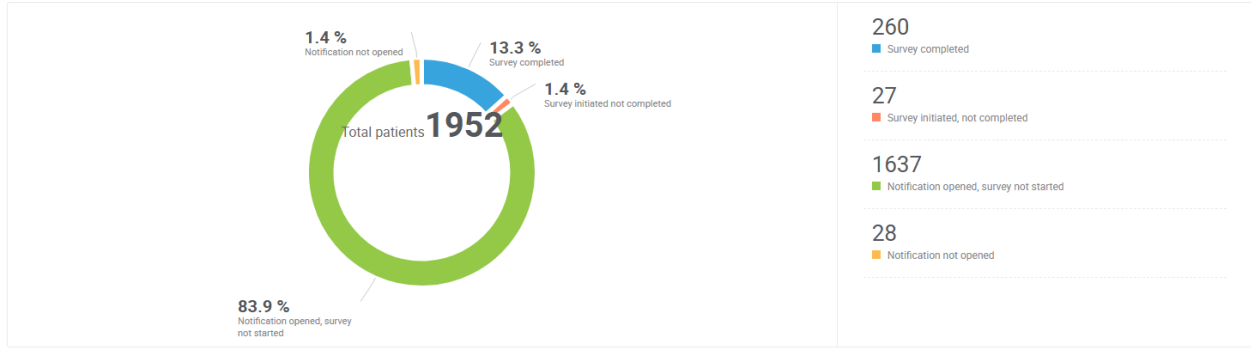
Patients in need of assistance continue to be identified and referred to community partners for help with determining eligibility for insurance and assistance with completing applications. Partner agencies are collocated at both health center sites to facilitate warm handoffs for patients in need of support.

Patient Satisfaction: See attached survey results.

SNCHC continues to receive generally favorable responses from survey participants when asked about ease of scheduling an appointment, waiting 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 – February 2026

Overview



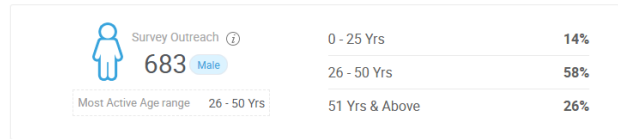
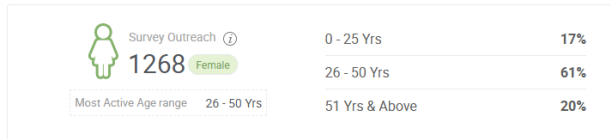
260
Survey completed

27
Survey initiated, not completed

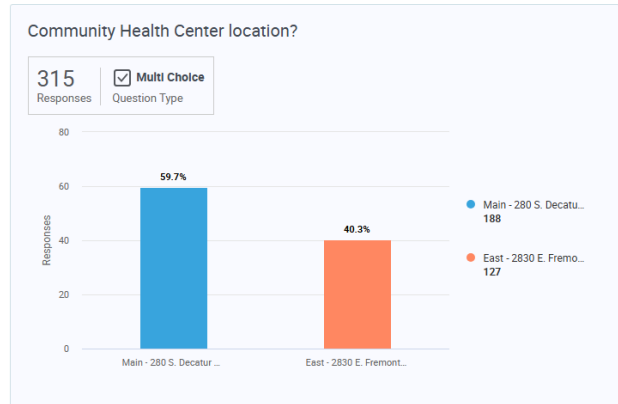
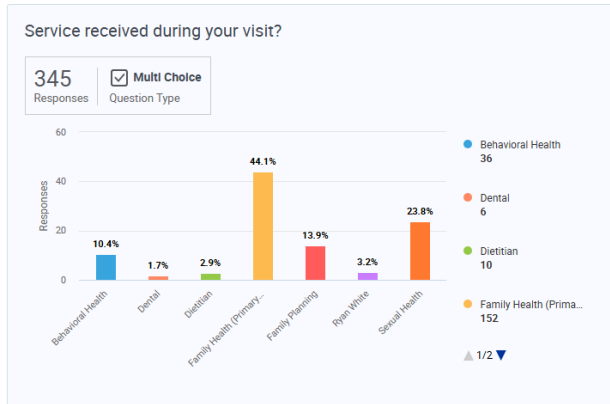
1637
Notification opened, survey not started

28
Notification not opened

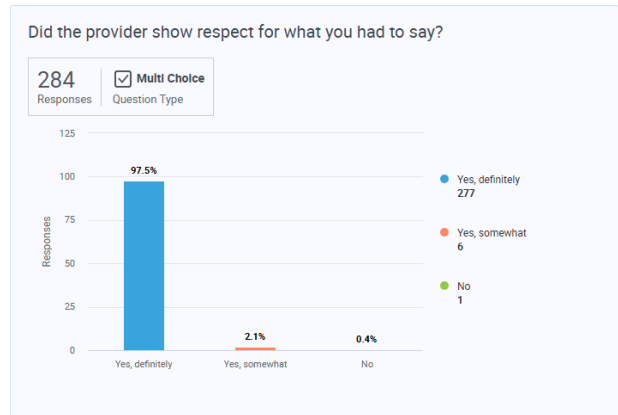
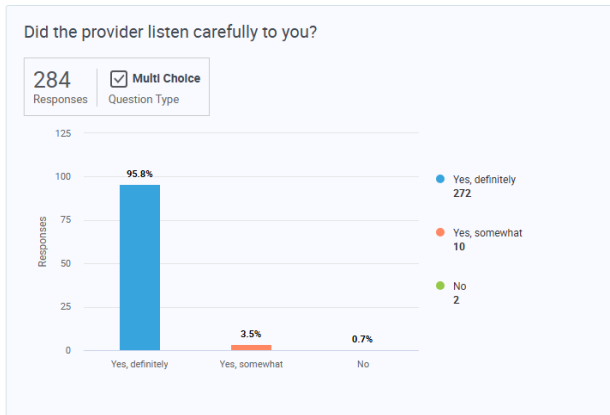
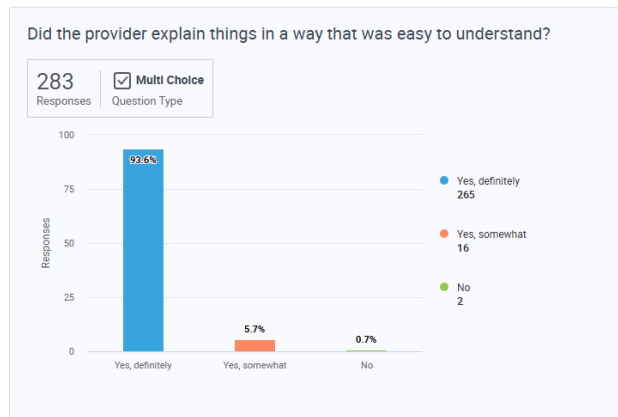
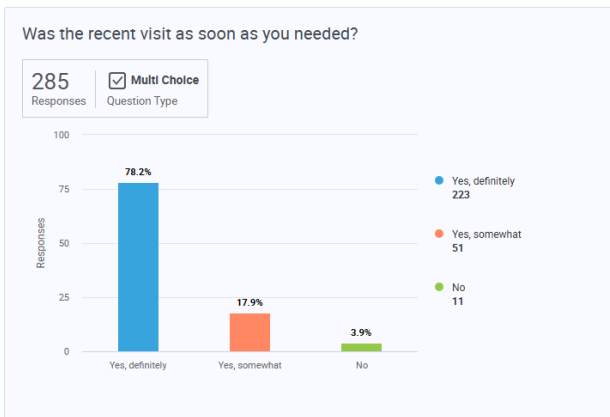
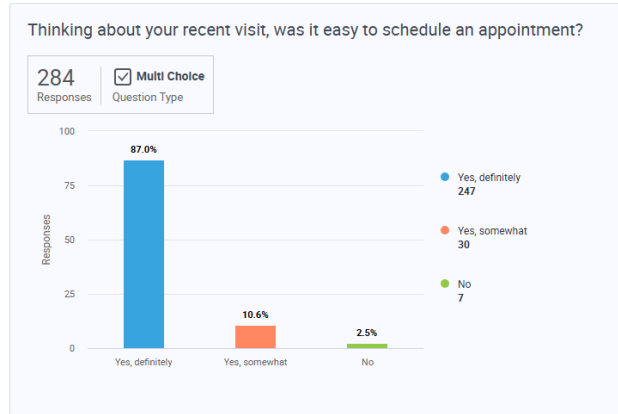
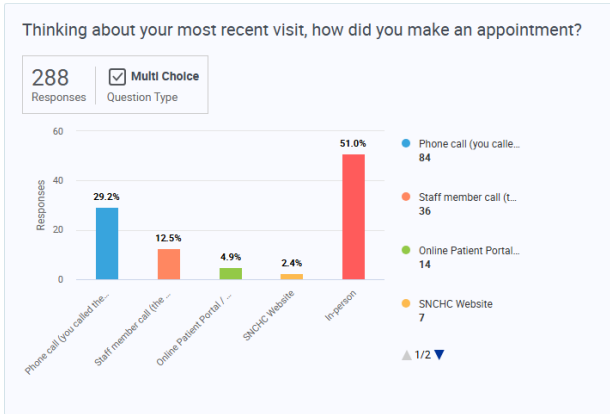
Gender



Service and Location

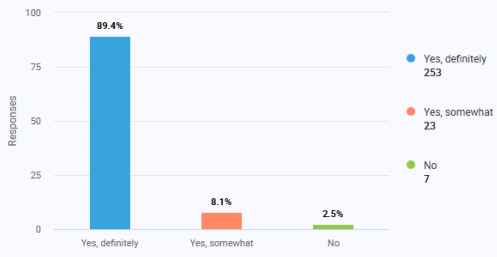


Provider, Staff, and Facility



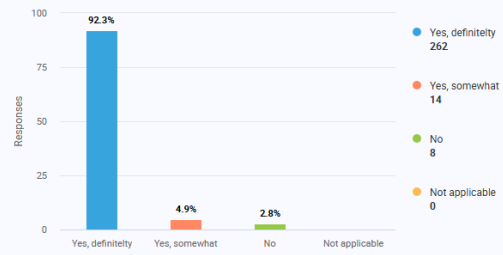
Did the provider spend enough time with you?

283 Responses Multi Choice Question Type



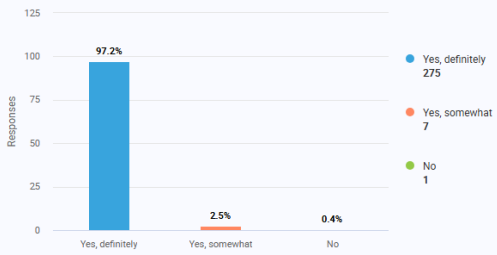
Were you satisfied with how the staff worked to address your healthcare needs (example: outstanding referrals, medications, labs, or diagnostics results)?

284 Responses Multi Choice Question Type



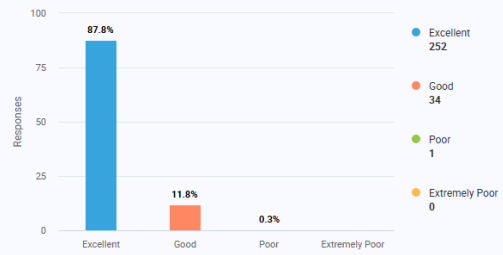
Did the staff treat you with courtesy and respect?

283 Responses Multi Choice Question Type



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

287 Responses Multi Choice Question Type



How would you rate the overall care you received from your provider, where 0 is the worst and 10 is the best?

284

Responses

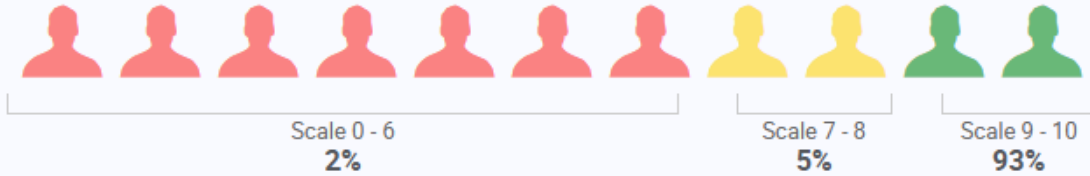
123

Numbers

Question Type

91

Net Promoter Score (NPS)



5

Scale 0 - 6

15

Scale 7 - 8

264

Scale 9 - 10

General Information

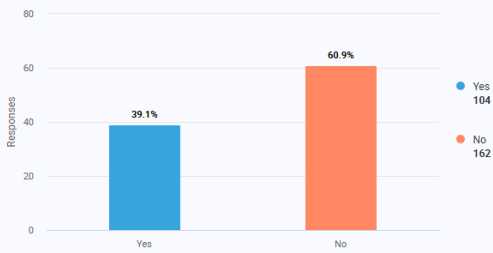
Do you have health insurance?

266

Responses

Multi Choice

Question Type



How did you hear about us?

287

Responses

Multi Choice

Question Type

