APPROVED BY THE SNCHC GOVERNING BOARD
FEBRUARY 18, 2025

MINUTES

SOUTHERN NEVADA COMMUNITY HEALTH CENTER GOVERNING BOARD MEETING
January 21, 2025 – 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 Scott Black Erin Breen Marie Dukes Blanca Macias-Villa Jose L. Melendrez
ABSENT:	Ashley Brown Luz Castro Brian Knudsen
ALSO PRESENT	Cade Grogan
LEGAL COUNSEL:	Edward Wyner, Associate General Counsel
CHIEF EXECUTIVE OFFICER:	Randy Smith
STAFF:	Chelle Alfaro, Emily Anelli, Tawana Bellamy, Todd Bleak, Donna Buss, Andria Cordovez Mulet, Brian Felgar, Tabitha Johnson, David Kahananui, Ryan Kelsch, Cassius Lockett, Cassondra Major, Anilkumar Mangla, Jonas Maratita, Kimberly Monahan, Desiree Petersen, Justin Tully, Kim Saner, Felicia Sgovio, Donnie Whitaker, Lourdes Yapjoco

I. CALL TO ORDER and ROLL CALL

The Chair called the Southern Nevada Community Health Center (SNCHC) Governing Board Meeting to order at 2:32 p.m. Tawana Bellamy, Senior Administrative Specialist, administered the roll call and confirmed a quorum. Ms. Bellamy provided clear and complete instructions for members of the general public to call in to the meeting to provide public comment, including a telephone number and access code.

II. PLEDGE OF ALLEGIANCE

III. RECOGNITION

1. **Southern Nevada Health District – 2024 Employee of the Year**
   - Desiree Petersen

The Chair recognized Desiree Petersen for being selected as the 2024 Southern Nevada Health District Employee of the Year. Ms. Petersen is a Community Health Worker, providing essential wrap around services in the Southern Nevada Community Health Center. On behalf of the Southern Nevada Community Health Center's Governing Board, the Chair congratulated Ms. Petersen on this well-deserved recognition.

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

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

V. **ADOPTION OF THE JANUARY 21, 2025, MEETING AGENDA** *(for possible action)*

Chair Feliz-Barrows called for questions or changed to the agenda. There were none.

A motion was made by Member Black, seconded by Member Breen, and carried unanimously to approve the January 21, 2025, 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**: December 10, 2024 *(for possible action)*

2. **Approve the Update to CHCA-001 Grants Management Policy;** direct staff accordingly or take other action as deemed necessary *(for possible action)*

3. **Approve the Update to CHCA-003 Patient Collections Policy;** direct staff accordingly or take other action as deemed necessary *(for possible action)*

4. **Approve the Update to CHCA-007 Legislative Mandate Review Policy;** direct staff accordingly or take other action as deemed necessary *(for possible action)*

~~5. **Approve the Update to CHCA-017 Ongoing Professional Evaluation - Peer Review Policy;** direct staff accordingly or take other action as deemed necessary *(for possible action)*~~

~~6. **Approve the CHCA-026 Non-Coercive Services Policy;** direct staff accordingly or take other action as deemed necessary *(for possible action)*~~

7. **Approve the CHCA-027 Durational Residency/Physician Referral Policy;** direct staff accordingly or take other action as deemed necessary *(for possible action)*

~~8. **Approve the Updated to CHCA-004 Procurement Policy;** direct staff accordingly or take other action as deemed necessary *(for possible action)*~~

9. **Approve the CHCA-028 Credentialing and Privileging Policy;** direct staff accordingly or take other action as deemed necessary *(for possible action)*

Chair Feliz-Barrows called for questions or changes to the Consent Agenda.

Items IV.5, VI.6 and VI.8 were removed from the Consent Agenda for further discussion.

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

VII. REPORT / DISCUSSION / ACTION

Member Melendrez joined the meeting at 2:42 p.m.

5. **Approve the Update to CHCA-017 Ongoing Professional Evaluation - Peer Review Policy**; direct staff accordingly or take other action as deemed necessary *(for possible action)*

Further to an inquiry from Member Hunt, Mr. Smith advised that Chief Medical Officer (CMO) and the Medical Director are included in the peer view process.

Further to an inquiry from Member Hunt, Mr. Smith advised there are policies in place to assist with the evaluation of the CMO and Medical Director.

A motion was made by Member Hunt, seconded by Member Black, and carried unanimously to Approve the Approve the Update to CHCA-017 Ongoing Professional Evaluation - Peer Review Policy, as presented.

6. **Approve the CHCA-026 Non-Coercive Services Policy**; direct staff accordingly or take other action as deemed necessary *(for possible action)*

Further to an inquiry from Member Hunt, Mr. Smith advised it is a new policy to prepare for a family planning site visit later this year.

Further to an inquiry from Member Hunt, Mr. Smith advised the language in the policy is being referenced from HRSA's Title X program documentation.

A motion was made by Member Hunt, seconded by Member Black, and carried unanimously to Approve the CHCA-026 Non-Coercive Services Policy, as presented.

8. **Approve the Updated to CHCA-004 Procurement Policy**; direct staff accordingly or take other action as deemed necessary *(for possible action)*

Randy Smith, Chief Executive Officer - FQHC provided an overview of the changes to the CHCA-004 Procurement Policy. Mr. Smith advised the new revisions changed the focus of the policy from a health district perspective to that of the health center. The job titles in the policy were updated to reflect this change.

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

A motion was made by Member Black, seconded by Member Breen, and carried unanimously to Approve the Updated to CHCA-004 Procurement Policy, as presented.

Recommendations from the January 14, 2025 Strategic Planning Committee Meeting

1. **Review, Discuss and Approve the Strategic Planning Committee Charter;** direct staff accordingly or take other action as deemed necessary *(for possible action)*

   Mr. Smith presented an overview of the Strategic Planning Committee Charter.

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

   A motion was made by Member Melendrez, seconded by Member Hunt, and carried unanimously to Approve the Strategic Planning Committee Charter, as presented.

2. **Receive, Discuss and Approve the Strategic Plan Directional Statement;** direct staff accordingly or take other action as deemed necessary *(for possible action)*

   David Kahananui, Administrative Manager – FQHC, provided an overview of the Strategic Plan Directional Statement and advised of the new and proposed mission, vision, and values.

   Proposed Mission: To provide patient-centered primary health care services to the underserved community with an emphasis on integrated, high-quality, and affordable care in a culturally respectful environment.

   Proposed Vision: Reducing health disparities in the community by empowering patients to achieve their best possible health through equitable access to comprehensive care.

   Proposed Values:
   - Commitment
   - Accountability
   - Respect
   - Excellence
   - Service

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

   A motion was made by Member Melendrez, seconded by Member Black, and carried unanimously to Approve the Strategic Plan Directional Statement, as presented.

3. **Receive, Discuss and Approve the Strategic Plan Goals for CY25 – CY27;** direct staff accordingly or take other action as deemed necessary *(for possible action)*

   Mr. Kahananui presented the Strategic Plan Goals for CY25 – CY27 and advised of the results of the Needs Assessment. Mr. Kahananui further advised of a recommendation from the Strategic Planning committee to add a goal about external marketing and promotional practices under increasing access to services.

   1) **Increase Access to services (# of unduplicated patients and visits) by 3%.**
      a) Increase # of patients seen per Provider per day by 3%.
         i) Remove barriers to integrated service provision.

ii) Optimize operational efficiencies.

b) Optimize and expand services at the Fremont location – SHC/RW/RH/Dental.
c) Grow and share cloud-based services (HIE, Healow, Virtual Visits).
d) Capital Outlay Strategies for expanding access in 2025 –
   i) Build a dental clinic at Fremont and develop an operational plan.
   ii) Open and optimize integrated care workflow at BH Center at Decatur.
e) Create and implement new external marketing and promotional practices.
   i) Collaborate with other like-minded individuals and organizations to explore and create opportunities to forge new external community partnerships.
   ii) Develop, implement, test, and launch new external marketing practices to bolster SNCHC's brand recognition in the community.

2) Improve Financial Sustainability
a) Increase Revenue.
   i) Improve the number of Medicaid visits by 5% YOY.
b) Improve accuracy of budgeting and revenue projections.

3) Improve Quality
a) Pursue Patient Centered Medical Home (PCMH) accreditation.
b) Maintain HRSA Compliance.
c) Ensure/enhance IT/Cyber-security.
d) Accelerate communication of current needs assessment, benchmark, and production data for timely decision-enhancing execution.

4) Strengthen Workforce
a) Improve Team OVS Survey Scores.
b) Sustain Employee Engagement Committee efforts to enhance workforce experience.
   i) Develop and Sustain Inclusive and Competent Workforce.

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

A motion was made by Member Melendrez, seconded by Member Black, and carried unanimously to Approve the Strategic Plan Goals for CY25 – CY27, as presented.

SNCHC Governing Board

4. Review, Discuss and Approve the Submission of HRSA Non-Competing Continuous Grant for Health Center Program - Title 10; direct staff accordingly or take other action as deemed necessary *(for possible action)*

Mr. Kahananui presented an overview of the Submission of HRSA Non-Competing Continuous Grant for Health Center Program - Title 10.

Further to an inquiry from Member Hunt, Mr. Kahananui advised that an increase in the amount HRSA awards is common, but he does not expect an increase in the third year.

A motion was made by Member Hunt, seconded by Member Melendrez, and carried unanimously to Approve the Submission of HRSA Non-Competing Continuous Grant for Health Center Program - Title 10, as presented.

Member Coca joined the meeting at 3:16 p.m.

5. **Receive, Discuss and Accept the November 2024 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 an unaudited November 2024 Year to Date Financial Report as of November 30, 2024, with the following highlights.

   Revenue
   - General Fund revenue (Charges for Services & Other) was $13.85M compared to a budget of $11.72M, a favorable variance of $2.13M.
   - Special Revenue Funds (Grants) were $2.69M compared to a budget of $3.28M, an unfavorable variance of $590K.
   - Total Revenue was $16.54M compared to a budget of $15.00M, a favorable variance of $1.54M.

   Expenses
   - Salary, Tax, and Benefits was $5.63M compared to a budget of $5.72M, a favorable variance of $90K.
   - Other Operating Expense was $11.59M compared to a budget of $10.10M, an unfavorable variance of $1.49M.
   - Indirect Cost/Cost Allocation was $3.27M compared to a budget of $3.20M, an unfavorable variance of $70K.
   - Total Expense was $20.50M compared to a budget of $19.01M, an unfavorable variance of $1.49M.

   Net Position: is ($3.96M) compared to a budget of ($4.01M), a favorable variance of $50K.

   Ms. Whitaker further advised of the following:
   - Revenue by Department
   - Expenses by Department
   - Patient Encounters by Department
   - Patient Encounters by Clinic

   The Chair called for questions and there were none.

   A motion was made by Member Melendrez, seconded by Member Coca, and carried unanimously to Accept the November 2024 Year to Date Financial Report, as presented.

6. **Review, Discuss and Approve the Quality Management Plan;** direct staff accordingly or take other action as deemed necessary *(for possible action)*

   Mr. Smith presented an overview of the Quality Management Plan.

   The Chair called for questions and there were none.

   A motion was made by Member Melendrez, seconded by Member Hunt, and carried unanimously to *Approve the Quality Management Plan Report,* as presented.

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

Member Hunt thanked Chair Feliz-Barrows for the invitation to deliver donuts to staff at the health centers. Member Hunt further shared she received a tour of the Fremont site. Member Hunt thanked staff for the invitation to behavioral health clinic open house.

Member Breen shared that through donation to her program, she has bright yellow, retro reflective jackets for anyone who works with the population who walk or bicycle out of necessity. Member Breen further shared the jackets help keep people warm and will help those who are most vulnerable at night. Member Breen asked if anyone is interested, they can contact her. Member Coca commented that Catholic Charities would be interested in those jackets.

Chair Feliz-Barrows thanked Mr. Smith and Ms. Bellamy for arranging the donuts and the visit with the staff at each health centers. Chair Feliz-Barrows commented that she would like to do it again this year and will ask the board for donations to be able to do more to show our appreciation to staff.

Mr. Smith commented that another opportunity to appreciate staff and acknowledge our accomplishments would be during the National Health Center week, which occurs in August.

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

- CEO Comments

Mr. Smith shared the following administrative updates.

- HRSA UDS annual report is due on February 15, 2024.
- HRSA FPAR 2.0 annual report is due on February 28, 2025.
- Dr. Robin Carter was hired as SNCHC's New Medical Director (Starts on February 3, 2025).
- Behavioral Health Clinic Open House at Decatur was on January 14, 2025.
- HRSA Behavioral Health Technical Assistance engagement in March 2025.
- HRSA Family Planning Title X site visit in September 2025.

Mr. Smith further shared an update on the HRSA Operational Site Visit.

- Three-day onsite visit: February 25 – 27, 2025.
- Pre-visit phone call with health center leadership on January 28, 2025.
- Documents uploaded by February 11, 2025
- Board participation opportunity.
  - Entrance Conference on February 25, 2025
  - Exit Conference on February 27, 2025
- Board member only session on February 26 at 12 p.m. – It is very important for all available Board members to attend and actively participate in the meeting.

Further to an inquiry Chair Feliz-Barrows, Mr. Smith advised that the entrance and exit conferences can be done on Zoom and are about one hour long.

Mr. Smith shared that Ms. Bellamy will send meeting invites to board members for the entrance and exit conference and the board only meeting.

X. INFORMATIONAL ITEMS

- Community Health Center (FQHC) Monthly Reports (Nov 2024 / Dec 2024)

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 Chair adjourned the meeting at 3:52 p.m.

Randy Smith
Chief Executive Officer - FQHC

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AGENDA

SOUTHERN NEVADA COMMUNITY HEALTH CENTER
GOVERNING BOARD MEETING
January 21, 2025 – 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/c2fd9923-5e32-4e97-a197-b0aeba8384bd@1f318e99-9fb1-41b3-8c10-d0cab0e9f859

To call into the meeting, dial (702) 907-7151 and enter Phone Conference ID: 894 895 92#

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

I. CALL TO ORDER & ROLL CALL

II. PLEDGE OF ALLEGIANCE

III. RECOGNITION

1. **Southern Nevada Health District – 2024 Employee of the Year**
   - Desiree Petersen

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 and spell your name for the record. If any member of the Board wishes to extend the length of a presentation, this may be done by the Chair or the Board by majority vote. There will be two public comment periods. To submit public comment on either public comment period on individual agenda items or for general public comments:
   - **By Teams:** Use the Teams link above. You will be able to provide real-time chatroom messaging, which can be read into the record or by raising your hand. Unmute your microphone prior to speaking.
   - **By telephone:** Call (702) 907-7151 and when prompted to provide the Meeting ID, enter 894 895 92#. To provide public comment over the telephone, please press *5 during the comment period and wait to be called on.

- **By email:** public-comment@snhd.org. For comments submitted prior to and during the live meeting, include your name, zip code, the agenda item number on which you are commenting, and your comment. Please indicate whether you wish your email comment to be read into the record during the meeting or added to the backup materials for the record. If not specified, comments will be added to the backup materials.

V. ADOPTION OF JANUARY 21, 2025 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**: December 10, 2024 *(for possible action)*

2. **Approve the Update to CHCA-001 Grants Management Policy** (Finance updated but Yin Jie verifying reference dates one more time)**;** direct staff accordingly or take other action as deemed necessary *(for possible action)*

3. **Approve the Update to CHCA-003 Patient Collections Policy;** direct staff accordingly or take other action as deemed necessary *(for possible action)*

4. **Approve the Update to CHCA-007 Legislative Mandate Review Policy;** direct staff accordingly or take other action as deemed necessary *(for possible action)*

5. **Approve the Update to CHCA-017 Ongoing Professional Evaluation - Peer Review Policy;** direct staff accordingly or take other action as deemed necessary *(for possible action)*

6. **Approve the CHCA-026 Non-Coercive Services Policy;** direct staff accordingly or take other action as deemed necessary *(for possible action)*

7. **Approve the CHCA-027 Durational Residency/Physician Referral Policy;** direct staff accordingly or take other action as deemed necessary *(for possible action)*

8. **Approve the Updated CHCA-004 Procurement Policy;** direct staff accordingly or take other action as deemed necessary *(for possible action)*

9. **Approve the CHCA-028 Credentialing and Privileging Policy;** direct staff accordingly or take other action as deemed necessary *(for possible action)*

VII. REPORT / DISCUSSION / ACTION

Recommendations from the January 14, 2025 Strategic Planning Committee Meeting

1. **Review, Discuss and Approve the Strategic Planning Committee Charter;** direct staff accordingly or take other action as deemed necessary *(for possible action)*

2. **Receive, Discuss and Approve the Strategic Plan Directional Statement;** direct staff accordingly or take other action as deemed necessary *(for possible action)*

3. **Receive, Discuss and Approve the Strategic Plan Goals for CY25 – CY27;** direct staff accordingly or take other action as deemed necessary *(for possible action)*

SNCHC Governing Board

4. **Review, Discuss and Approve the Submission of HRSA Non-Competing Continuous Grant for Health Center Program - Title 10;** direct staff accordingly or take other action as deemed necessary *(for possible action*

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

6. **Review, Discuss and Approve the Quality Management Plan;** 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 *(Informational Only)***

- CEO Comments

X. **INFORMATIONAL ITEMS**

- Community Health Cener (FQHC) Monthly Reports (Nov 2024 / Dec 2024)

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. **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.

MINUTES

SOUTHERN NEVADA COMMUNITY HEALTH CENTER
GOVERNING BOARD MEETING
December 10, 2024, 2024 – 2:30 p.m.

Meeting was conducted via Microsoft Teams

MEMBERS PRESENT:	Donna Feliz-Barrows, Chair Jasmine Coca, First Vice Chair Sara Hunt, Second Vice Chair Scott Black Erin Breen Ashley Brown Marie Dukes Blanca Macias-Villa Jose L. Melendrez
ABSENT:	Luz Castro Brian Knudsen
ALSO PRESENT:	Josh Findlay
LEGAL COUNSEL:	Edward Wyner, Associate General Counsel
CHIEF EXECUTIVE OFFICER:	Randy Smith
STAFF:	Emily Anelli, Tawana Bellamy, Todd Bleak, Andria Cordovez Mulet, Jacques Graham, Ryan Kelsch, Fermin Leguen, Cassius Lockett, Jonas Maratita, Kyle Parkson, Luann Province, Kim Saner, Justin Tully, Donnie Whitaker

I. CALL TO ORDER and ROLL CALL

The Chair called the Southern Nevada Community Health Center (SNCHC) Governing Board Meeting to order at 2:36 p.m. Tawana Bellamy, Senior Administrative Specialist, administered the roll call and confirmed a quorum.

II. PLEDGE OF ALLEGIANCE

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

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

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

IV. ADOPTION OF THE DECEMBER 10, 2024, MEETING AGENDA *(for possible action)*

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

A motion was made by Member Breen, seconded by Member Hunt, and carried unanimously to approve the December 10, 2024, agenda, as presented.

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

1. **APPROVE MINUTES – SNCHC GOVERNING BOARD MEETING**: November 19, 2024 *(for possible action)*

   Chair Feliz-Barrows called for any action and there were none.

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

VI. REPORT / DISCUSSION / ACTION

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

   Josh Findlay, Audit Director, of FORVIS MAZARS LLP attended the meeting to present the Annual Comprehensive Financial Audit Report and Single Audit Report.

   Mr. Findlay advised that they issued an unmodified audit with no reportable findings.

   Mr. Findlay outlined that the following five (5) major programs were audited.
   - 21.027 - COVID-19 — Coronavirus State and Local Fiscal Recovery Funds
   - 93.217 - Family Planning Services
   - 93.323 - COVID-19 — Epidemiology and Laboratory Capacity for Infectious Diseases (ELC)
   - 93.391 - COVID-19 — Activities to Support State, Tribal, Local and Territorial (STLT) Health Department Response to Public Health or Healthcare Crises
   - 93.967 - Centers for Disease Control and Prevention Collaboration with Academia to Strengthen Public Health

   Mr. Findlay further outlined the required communications related to accounting policies and practices, GASB 101, GASB 102, GASB 103, and GASB 104.

   Further to an inquiry from Mr. Smith, Mr. Findlay shared that the single audit is conducted on a risk-based approach, based on a checklist, and federal guidelines are followed to determine which programs are audited.

The Chair called for questions and there were none.

A motion was made by Member Breen, seconded by Member Melendrez, and carried unanimously to accept the Annual Comprehensive Financial Audit Report and Single Audit Report from FORVIS MAZARS LLP, as presented.

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

There were no board reports.

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

- CEO Comments

Mr. Smith advised of the unduplicated patient and visit counts for November 2024 and shared that the health center has already exceeded its CY24 goal for the unduplicated patient count and will likely exceed its goal for the visit count.

Mr. Smith advised the board member of reminders to complete their conflict of interest forms, as it is a HRSA requirement and also to provide the required information for the Nevada Medicaid Re-validation application request.

Mr. Smith further shared updates on SNCHC's HRSA On Site Visit (OSV). Mr. Smith advised of the following:

- The last OSV was conducted virtually in June 2022 and occurs every three years.
- The upcoming OSV is a three-day on-site visit: February 25th – Thursday, February 27th.
- Pre-visit phone call six weeks prior to the visit.
- All documents submitted two weeks prior to the visit.
- The last opportunity to submit documents is February 25, 2025.
- Opportunities for board involvement:
  - Day 1 – Entrance Meeting (morning), Day 2 – Meeting with Board (lunch time), Day 3 – Exit Meeting (late morning/early afternoon).
- Compliance Resolution Opportunity (CRO) – 14 calendars from receipt of EHB task to submit a response to HRSA addressing areas of non-compliance.
  - Depending on timing, an additional off schedule board meeting may be needed to approve submission items (e.g., a new/revised policy)

Mr. Smith shared that Chair Feliz-Barrows will connect with the managers at Decatur and Fremont the week of December 23, 2024, to thank staff and say happy holidays. Mr. Smith further advised if other board members are interested in participating to let Ms. Bellamy know.

Chair Feliz-Barrows commented that it would be great if a couple of board members would participate to show the board's appreciation for everything staff has done in the last year.

Further to an inquiry from First Chair Coca, Mr. Smith shared that Ms. Bellamy would send information to board members with an invitation to participate.

X. INFORMATIONAL ITEMS

Nothing to 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 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 Chair adjourned the meeting at 3:11 p.m.

Randy Smith
Chief Executive Officer - FQHC

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SOUTHERN NEVADA COMMUNITY HEALTH CENTER
POLICY AND PROCEDURE

DIVISION:	Administration	**NUMBER(s):**	CHCA-001
		VERSION:	1.01~~0~~
PROGRAM:	Finance	**Page:**	1 of 6
TITLE:	Grants Management	**EFFECTIVE DATE:**	January XX, 2025
DESCRIPTION:	Managing Grants	**ORIGINATION DATE:**	~~New~~May 11, 2022
APPROVED BY: ~~**DISTRICT HEALTH**~~**CHIEF EXECUTIVE OFFICER - FQHC:**		**Replaces:** ~~New~~ May 11, 2022	
Randy Smith, MPA	Date		

I. PURPOSE

The Southern Nevada Community Health Center (SNCHC) is committed to ensuring federal cash draws are made and administered in a manner consistent with payment standards required by ~~the U.S. Department of Health and Human Services found at 45 CFR Part 75 Subpart E, 2 CRF 200, state and local statutes~~federal law and regulations, HRSA policies, and executive orders, as applicable. Revisions to Uniform Grant Guidance are automatically included in the Center's policy. See references at the end of this policy/procedure.

II. SCOPE

This policy applies to payments received for direct ~~or pass-through~~ federal grant funds awarded to SNCHC.

III. POLICY

The documentation maintained for each federal grant payment will account for the receipt, obligation, and expenditure of funds. SNCHC draws as a reimbursement for expenditures that have already been incurred.

IV. PROCEDURE

A. Documentation

The following documentation is kept for each draw~~ or request for reimbursement~~:

1. A general ledger listing of the expenditures that are being reimbursed in sufficient detail to satisfy the documentation requirements of Uniform Grant Guidance.
2. Information regarding the date of federal grant payment receipt and the timing of expenditures relative to the receipt of the federal funds.
3. Federal expenditures are tracked using a grant code in the general ledger. A report is run from the general ledger to determine the amount of the drawdown. An electronic copy of this report is attached to the draw down request by the accountant. This request is approved by ~~accountant~~an accountant, accounting supervisor, and controller ~~,~~ and/or CFO electronically through accounting software. After the appropriate approvals the accountant will make the draw through the Payment Management System (PMS) or other applicable system.
4. The health center's financial management system can account for all Federal awards (including the Federal award made under the health center program) to identify the receipt and expenditure of funds for federally funded activities in whole or in part. Specifically, the health center's financial records contain information and related source documentation pertaining to authorizations, obligations, unobligated balance, assets, expenditures, income, and interest under the Federal award as applicable.
5. The accountant will assure expenditures of Federal award funds are allowable in accordance with the terms and conditions of the Federal award including those that limit the use of Federal funds, and with the Federal Cost Principles in 45 CFR Part 75 Subpart E and/or 2 Code of Federal Regulations (CFR) Part 200 (Subparts A–F). ~~The a~~An accountant, accounting supervisor and controller and/or CFO are~~is~~ responsible to ensure that no Federal funds are used for mandated limitations/restrictions.

B. Timing

While cash advances are permitted, federal regulations require the timing and amount of cash advances shall be as close as is administratively feasible to the actual disbursements. SNCHC uses the reimbursement method for all grant draws. However, in the case of request as a cash advance, it is the SNHD's policy to ensure the following prior to requesting a cash advance:

1. The draw is the minimum amount needed.
2. The draw is timed in accordance with actual, immediate cash requirements.
3. That the draw is not done any earlier than necessary to make the payment thus minimizing the time between the draw and expenditure. The distinction is also that timing is based on when expenditures will be paid and not when the expenditure is accrued.
4. The draws will not be made to alleviate cash flow problems within SNHD.

C. Method

The preferred method of reimbursement is through electronic fund transfer if available. Requests for draws through the federal payment management system (PMS) will follow the steps and processes outlined with the system. If the draw is not through the federal payment management system, then the draw should be done consistent with the terms of the grant and the processes required by the awarding agency.

D. Oversight and Monitoring

Appropriate fiscal oversight will be maintained for all grants and awards. With respect to Federal funding and the requirements on restrictions to limitations ~~on use of Federal funds as mandated by the Department of Defense and L~~labor, Health and Human ~~Services, and Education Appropriations Act, 2019 and Continuing Appropriations Act, 2019, Division B, Pub. L. 115-245,~~ the health center assures oversight and monitoring of changes to legislative mandates and other federal changes for compliance via SNHD grants management. The initial grant draw request and support for expenditures will be prepared by ~~the~~ an accountant.

~~The~~ An accountant, accounting supervisor, and ~~C~~controller and/or CFO ensures that there is effective control over, and accountability for, all funds, property, and other assets associated with SNCHC projects. The Controller ensures the safeguarding of all assets to assure they are used solely for authorized purposes in accordance with the terms and conditions of the Health Center Program award/designation. SNCHC has the capacity to track the financial performance of the health center, including identification of trends or conditions that may warrant action by the organization to maintain financial stability.

E. Reporting

The standard financial reporting form SF-425 Federal Financial Report (FFR) is filed ~~quarterly~~ in accordance with HRSA guidelines. An annual FFR is compiled with any carryforward requested amounts noted on the form and followed through for HRSA approval. The ~~quarterly~~ PMS FFR reports are filed by the accountant after receiving the appropriate approvals. See references listed below.

1. The submission of quarterly and semi-annual interim FFRs, annual reports and/or final reports will be ~~on a quarterly, semi-annual, or annual basis,~~ as directed by the Federal agency or funder. A final FFR shall be submitted at the completion of the award agreement. ~~The following reporting period end dates shall be used for interim reports: 3/31, 6/30, 9/30, or 12/31.~~ For final FFRs, the reporting period end date shall be the end date of the project or grant period.

~~F. Quarterly and semi-annual interim reports shall be submitted no later than 30 days after the end of each reporting period. Annual reports shall be submitted no later than 90 days after the end of each reporting period. Final reports shall be submitted no later than 90 days after the project or grant period end date or as directed by the funder.~~

~~G.~~F. Mandatory Disclosures

Any violation of federal criminal law involving fraud, bribery and gratuity violations potentially affecting the award will be disclosed in writing to HHS within 14 days of discovery. This notification will be the responsibility of the DHO and the Board Chair.

~~H.~~G. Other Audit Objectives

Obtain an understanding of internal control, assess risk, and test internal control as required by 2 CFR section 200.514(c). Compliance Supplement 2024~~1~~ 3-L-4 ~~July 2021~~May 2024 Compliance Requirements – Reserved.

Determine whether required reports for federal awards include all activity of the reporting period, are supported by applicable accounting or performance records, and are fairly presented in accordance with governing requirements.

SNCHC shall not use federal grant funds to pay the salary or expenses of any employee or agent of SNCHC for activities designed to influence the enactment of legislation, appropriations, regulation, administrative action, or Executive order proposed or pending before the Congress or any State government, State legislature or local legislature or legislative body, other than for normal and recognized executive-legislative relationships or participation by an agency or officer of a State, local or tribal entity/government.

V. REFERENCES

~~1. Department of Defense and Labor, Health and Human Services, and Education Appropriations Act, 2019 and Continuing Appropriations Act, 2019, Division B, Pub. L. 115-245~~

~~2. HHealth Resources and Services Administration. (2019). *Grants policy bulletin: Changes to HRSA grants policy statement* (No. 2019-02E). U.S. Department of Health and Human Services. https://www.hrsa.gov/sites/default/files/hrsa/grants/manage/grants-policy-bulletin-2019-02.pdfRSA Grants Bulletin: 2019-02~~

~~3. 45 CFR 46.204(b) and section 498(b) of the Public Health Service Act (42 U.S.C. 289g(b))~~

~~4. HS.142 - 113th Congress (2013-2014): Hyde Amendment Codification Act. (2013, January 24). https://www.congress.gov/bill/113th-congress/senate-bill/142/text yde Amendment~~

~~5. Consolidated Appropriations Act, 2019 https://www.congress.gov/resources/display/content/Appropriations+for+Fiscal+Year+2019~~

~~6. Controlled Substances Act, Section 202 https://www.deadiversion.usdoj.gov/21cfr/21usc/812.htm~~

~~7. 45 CFR Part 75 Subpart E: Cost Principles https://www.govinfo.gov/content/pkg/CFR-2017-title45-vol1/xml/CFR-2017-title45-vol1-part75.xml~~

~~a. 2 Code of Federal Regulations (CFR) Part 200 (Subparts A–F) https://www.govinfo.gov/app/details/CFR-2014-title2-vol1/CFR-2014-title2-vol1-part200~~

~~b. 2 CFR Part 200 https://www.whitehouse.gov/wp-content/uploads/2021/08/OMB-2021-Compliance-Supplement_Final_V2.pdf):~~

~~c. Financial reporting, 2 CFR section 200.328.~~

~~d. Monitoring and reporting program performance, 2 CFR section 200.329.~~

~~e. Transparency Act, implementing requirements in 2 CFR Part 170 and the FAR~~

~~8. The legislative statutes that establish, authorize, and govern specific programs, providing the legal framework and requirements for its implementation and funding. Program legislation~~

~~9. FRegulations issued by the federal agency responsible for awarding and overseeing grants, as outlined in applicable federal statutes and guidelines, such as those in the Code of Federal Regulations (e.g., 2 CFR Part 200).ederal awarding agency regulations~~

~~The specific terms and conditions outlined in the grant award documentation that defines the requirements, responsibilities, and compliance expectations, as established by the awarding agency~~

~~10. The terms and conditions of the award~~

1. 45 CFR Part 75 (available at https://www.ecfr.gov/current/title-45/subtitle-A/subchapter-A/part-75?toc=1).
2. 2 CFR Part 200 (available at https://www.ecfr.gov/current/title-2/subtitle-A/chapter-II/part-200?toc=1).
3. HRSA Financial Management page (available at https://www.hrsa.gov/grants/manage-your-grant/financial-management).
4. HRSA Reporting Requirements page (available at https://www.hrsa.gov/grants/manage-your-grant/reporting-requirements).
~~5.~~ HRSA Policies, Regulations, & Guidance page (available at https://www.hrsa.gov/grants/manage-your-grant/policies-regulations-guidance).

HISTORY TABLE

Table 1: History

Version/Section	Effective Date	Change Made
Version 1		Formatted to current template, periodic review, updated references
Version 0	05/11/2022	First issuance

VI. ATTACHMENTS

Not Applicable

DIVISION:	Federally Qualified Health Center	**NUMBER(s):** CHCA-003 **VERSION:** 1.0~~1~~2
PROGRAM:	Finance	**Page:** 1 of 3
TITLE:	Patient Collections Policy	**EFFECTIVE DATE:**
DESCRIPTION:	To establish guidelines for billing and collection for patients receiving medical, behavioral health, and dental services.	**ORIGINATION DATE:** June 14, 2022
APPROVED BY: **CHIEF EXECUTIVE OFFICER:** Randy Smith	Date	**Replaces:** ~~CHCA-003, Effective 06/14/2022~~April 16, 2024

I. PURPOSE

To establish consistent guidelines for billing and collection practices for all patients receiving medical, behavioral health, and dental services in the Southern Nevada Community Health Center (SNCHC). The Health District employs ethical, legally compliant, and appropriate billing practices and ensures BPHC guidelines for patient billing and discounts related to Section 330 funding and other governmental regulations are implemented. Additionally, to ensure that all appropriate government and state regulations are adhered to in the creation and submission of charges.

II. SCOPE

This policy applies to all Workforce members responsible for, or otherwise involved with billing and collection activities.

It is the responsibility of the FQHC Chief Executive Officer, Chief Financial Officer, and Revenue Cycle Manager to adhere and/or enforce this policy.

III. POLICY

It is the Health District's policy to provide quality healthcare to clients regardless of their ability to pay. The Health District is committed to designing and implementing patient-focused billing and collection practices that seek to minimize financial barriers patients may face in paying for services. Services will never be denied based upon the inability of patients to pay.

IV. PROCEDURE

A. All Southern Nevada Community Health Center (SNCHC) patients are eligible to apply for a sliding fee discount. Uninsured or under-insured patients who are not willing to apply for discounts or who are not income eligible for discounts are assessed the full charge for services.

1. Patients with incomes above 200% of the Federal Poverty Guidelines (FPG) who are not eligible for a sliding fee discount may receive a Point of Care Discount of 50% if they make their payment at the time of their appointment.

B. Collection of fees is the responsibility of Health District staff at the point of care. If a patient leaves the Health District site without paying for services, reasonable attempts to secure payment will be made according to the following guidelines:

1. Fees may be waived at the Health District's discretion, based on a hardship. Hardships are defined as an inability to pay for services rendered due to negative life experience(s). Examples may include, but are not limited to the following:
   a. Financial crisis
   b. A medical condition, mental health disorder, or substance use disorder resulting in multiple visits
   c. Homelessness
   d. A catastrophic life events
   e. Domestic Violence; or
   f. If a patient present to clinic sites for services and their record indicates an outstanding balance is owed, clinic staff will attempt to secure payment for the outstanding balance in accordance with applicable regulations regarding fee collection/billing guidelines.

   g. Patients with balances receive statements showing the outstanding amount due and payment options.

      a. Patients are provided the contact information to the billing department for assistance with any questions or concerns they may have about their statements.

2. If a patient does not present for services and/or a patient's record reflects an outstanding balance due that has aged 12 months or greater from the date of service, the Health District will write-off the debt as part of its on-going commitment to ensure access to health care for low-income clients. If the Health District is provided written notification that a patient has moved, filed for bankruptcy, or is deceased, then that patient's account can be written off in full at that time.

C. The Health District makes every reasonable effort to secure payment for services from patients, in accordance with Health District fee schedules and any corresponding schedule of discounts. Patients who refuse to pay will not be denied services.

D. The Health District maintains a schedule of fees for the provision of its services that is consistent with locally prevailing rates and is designed to cover reasonable costs of operation.

E. Southern Nevada Community Health Center is recognized by CMS as a Federally Qualified Health Center entitled to cost base reimbursement for Medicare and Medicaid services. Separate site-specific ID numbers are maintained as required.

F. The Health District adheres to all requirements and guidelines for Medicare and Medicaid practice as determined by the Centers for Medicare and Medicaid Services (CMS) and the State Medicaid authority Nevada Medicaid.

G. Billing for services rendered will occur at appropriate intervals. This will be no less than weekly for third party activity and monthly for patient pay amounts. Denials will be worked no less than weekly.

H. Patients will be notified in writing ahead of time of~~to~~ any additional costs for supplies and equipment related to but not included in the service when applicable.

I. The Health District establishes systems for insurance eligibility determination and for billing/collections with respect to third party payors. The Health District makes every reasonable effort to enter contractual or other arrangements to collect reimbursement of its costs with the appropriate agency(s) of the state which administers or supervises the administration of:

1. A state Medicaid plan approved under Title XIX of the Social Security Act for the payment of all or a part of the center's costs in providing health services to persons who are eligible for such assistance; or

2. CHIP under Title XXI of the Social Security Act with respect to individuals who are state CHIP beneficiaries.

V. REFERENCES

42 USC §§ 1395, 1396 & 1397 & 425.314, & 1320a-7b(b)

HISTORY TABLE

Table 1: History

Version/Section	Effective Date	Change Made
Version 2		1. Review and correction a word in section H.
Version 1	04/16/2024	~~1.~~2. Revisions for clarity only. ~~2.~~3. Updated procedures.
Version 0	06/14/2022	First issuance, origination date June 14, 2022

VI. ATTACHMENTS

Not Applicable

SOUTHERN NEVADA COMMUNITY HEALTH CENTER
POLICY AND PROCEDURE

DIVISION:	Administration	**NUMBER(s):**	CHCA-007
PROGRAM:	FQHC	**VERSION:**	~~1.00~~1.01
TITLE:	Legislative Mandate Review Policy	**PAGE:**	1 of 12
		EFFECTIVE DATE: 01/XX/2025	
DESCRIPTION: To establish procedures for ensuring compliance with legislative mandates.		**ORIGINATION DATE:** ~~New~~August 25, 2025	
APPROVED BY: **FQHC OPERATIONS OFFICER:** Click or tap here to enter text. Randy Smith, MPA Date		**REPLACES:** ~~New~~August 25, 2022	

I. PURPOSE

To establish procedures for ensuring compliance with legislative mandates, including mandates in Department of Health and Human Services appropriations acts, and applicable Health Resources and Services Administration guidance.

II. SCOPE

This policy applies to all Southern Nevada Community Health Center herein referred to as Health Center operations.

III. POLICY

A. Procurement Standards for Federal Awards

1. 2 CFR Part 200; 45 CFR Part 75. Code of Federal Regulations (CFR) Title 2 Part 200 and Title 45 Part 75 contain the uniform administrative requirements, cost principles and audit requirements for federal awards. Any procurement awarded with federal (grant) funds will comply with 2 CFR 200 or 45 CFR 75 as applicable.
2. 2 CFR 200, Sections 317-326, Procurement Standards. Sections 200.317 through 200.326 contain the procurement standards. The following procurement standards apply to federally funded procurements.

a. 200.317, Procurements by states

b. 200.318, General procurement standards

c. 200.319, Competition

d. 200.320, Methods of procurement to be followed

e. 200.321, Contracting with small and minority businesses, women's business enterprises and labor surplus area firms

f. 200.322, Procurement of recovered materials

g. 200.323, Contract cost and price

h. 200.324, Federal awarding agency or pass-through entity review

i. 200.325, Bonding requirements

j. 200.326, Contract provisions

3. 2 CFR 200 Section 330, Subrecipient and Contractor Determination. Every contract awarded will have a subrecipient determination on file. A purchase order will be awarded to a supplier, and not a subrecipient.

4. 2 CFR 200, Sections 420-475; 45 CFR 75, Sections 420-475, General Provisions for Selected Items of Cost. These sections provide principles to be applied in establishing the allowability of certain items involved in determining cost. These principles apply whether or not a particular item of cost is properly treated as direct cost or indirect (F&A) cost.

5. 2 CFR 200, Appendix II, Contract Provisions for Non-Federal Entity Contracts under Federal Awards. The following clauses covered under this section will be included with any procurement using federal funding, including purchase orders.

   a. Remedies. Contracts for more than the simplified acquisition threshold currently set at $250,000, which is the inflation-adjusted amount determined by the Civilian Agency Acquisition Council and the Defense Acquisition Regulations Council (Councils) as authorized by 41 U.S.C. 1908, must address administrative, contractual, or legal remedies in instances where contractors violate or breach contract terms, and provide for such sanctions and penalties as appropriate.

   b. Termination. All federally funded contracts $10,000 or more must address termination for cause and for convenience by the non-federal entity including the manner by which it will be affected and the basis for settlement.

   c. Equal Employment Opportunity. Except as otherwise provided under 41 CFR Part 60, all contracts that meet the definition of "federally assisted construction contract" in 41 CFR Part 60-1.3 must include the equal opportunity clause provided under 41 CFR 60-1.4(b), in accordance with Executive Order 11246, "Equal Employment Opportunity" (30 FR 12319, 12935, 3 CFR Part, 1964-1965 Comp., p. 339), as amended by Executive Order 11375, "Amending Executive Order 11246 Relating to Equal Employment Opportunity," and implementing regulations at 41 CFR part 60, "Office of Federal Contract Compliance Programs, Equal Employment Opportunity, Department of Labor."

   d. Davis-Bacon Act. As amended (40 U.S.C. 3141-3148). When required by federal program legislation, all prime construction contracts equal to or in excess of $2,000 awarded by non- federal entities must include a provision for compliance with the Davis-Bacon Act (40 U.S.C. 3141-3144, and 3146-3148) as supplemented by Department of Labor regulations (29 CFR Part 5, "Labor Standards Provisions Applicable to Contracts Covering Federally Financed and Assisted Construction"). In accordance with the statute, contractors must be required to pay wages to laborers and mechanics at a rate not less than the prevailing wages specified in a wage determination made by the Secretary of Labor. In addition, contractors must be required to pay wages not less than once a week. The non-Federal entity must place a copy of the current prevailing wage determination issued by the Department of Labor in each solicitation. The decision to award a contract or subcontract must be

conditioned upon the acceptance of the wage determination. The non-federal entity must report all suspected or reported violations to the federal awarding agency. The contracts must also include a provision for compliance with the Copeland "Anti- Kickback" Act (40 U.S.C. 3145), as supplemented by Department of Labor regulations (29 CFR Part 3, "Contractors and Subcontractors on Public Building or Public Work Financed in Whole or in Part by Loans or Grants from the United States"). The Act provides that each contractor or subrecipient must be prohibited from inducing, by any means, any person employed in the construction, completion, or repair of public work, to give up any part of the compensation to which he or she is otherwise entitled. The non- federal entity must report all suspected or reported violations to the federal awarding agency.

e. Contract Work Hours and Safety Standards Act (40 U.S.C. 3701-3708). Where applicable, all contracts awarded by a non-federal entity in excess of $100,000 that involve the employment of mechanics or laborers must include a provision for compliance with 40 U.S.C. 3702 and 3704, as supplemented by Department of Labor regulations (29 CFR Part 5). Under 40 U.S.C. 3702 of the Act, each contractor must be required to compute the wages of every mechanic and laborer based on a standard work week of 40 hours. Work in excess of the standard work week is permissible provided that the worker is compensated at a rate of not less than one and a half times the basic rate of pay for all hours worked in excess of 40 hours in the work week. The requirements of 40 U.S.C. 3704 are applicable to construction work and provide that no laborer or mechanic must be required to work in surroundings or under working conditions which are unsanitary, hazardous or dangerous. These requirements do not apply to the purchases of supplies or materials or articles ordinarily available on the open market, or contracts for transportation or transmission of intelligence.

f. ~~Federal~~ If the Federal award meets the definition of "funding agreement" under 37 CFR § 401.2 (a) and the recipient or subrecipient wishes to enter into a contract with a small business firm or nonprofit organization regarding the substitution of parties, assignment or performance of experimental, developmental, or research work under that "funding agreement," the recipient or subrecipient must comply with the requirements of 37 CFR Part 401, "Rights to Inventions Made by Nonprofit Organizations and Small Business Firms Under Government Grants, Contracts and Cooperative Agreements," and any implementing regulations issued by the awarding agency.

g. Clean Air Act (42 U.S.C. 7401-7671q.) and the Federal Water Pollution Control Act (33 U.S.C. 1251-1387), as amended—Contracts and subgrants of amounts in excess of $150,000 must contain a provision that requires the non-federal award to agree to comply with all applicable standards, orders or regulations issued pursuant to the Clean Air Act (42 U.S.C. 7401-7671q) and the Federal Water Pollution Control Act as amended (33 U.S.C. 1251-1387). Violations must be reported to the federal awarding agency and the Regional Office of the Environmental Protection Agency (EPA).

h. Energy Efficiency. Contractor will comply with mandatory standards and policies relating to energy efficiency, which are contained in the state energy conservation plan issued in compliance with the Energy Policy and Conservation Act (42 U.S.C. 6201).

i. Debarment and Suspension. (Executive Orders 12549 and 12689)—A contract award (see 2 CFR 180.220) must not be made to parties listed on the governmentwide Excluded Parties List System in the System for Award Management (SAM), in accordance with the OMB guidelines at 2 CFR 180 that implement Executive Orders 12549 (3 CFR Part 1986 Comp., p. 189) and 12689 (3 CFR Part 1989 Comp., p. 235),

j. Debarment and Suspension. The Excluded Parties List System in SAM contains the names of parties debarred, suspended, or otherwise excluded by agencies, as well as parties declared ineligible under statutory or regulatory authority other than Executive Order 12549. Furthermore, each of contractor's vendors and sub-contractors will certify that to the best of its respective knowledge and belief, that it and its principals are not presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from covered transactions by any federal department or agency.

k. Byrd anti-Lobbying Amendment (31 U.S.C. 1352)—Contractors that apply or bid for an award of $100,000 or more must file the required certification. Each tier certifies to the tier above that it will not and has not used federal appropriated funds to pay any person or organization for influencing or attempting to influence an officer or employee of any agency, a member of Congress, officer or employee of Congress, or an employee of a member of Congress in connection with obtaining any federal contract, grant or any other award covered by 31 U.S.C. 1352. Each tier must also disclose any lobbying with non-federal funds that takes place in connection with

obtaining any federal award. Such disclosures are forwarded from tier to tier up to the non-federal award.

~~k.~~1. PROCUREMENT OF RECOVERED MATERIALS. A non-Federal entity that is a state agency or agency of a political subdivision of a state and its contractors must comply with section 6002 of the Solid Waste Disposal Act, as amended by the Resource Conservation and Recovery Act. The requirements of Section 6002 include procuring only items designated in guidelines of the Environmental Protection Agency (EPA) at 40 CFR part 247 that contain the highest percentage of recovered materials practicable, consistent with maintaining a satisfactory level of competition, where the purchase price of the item exceeds $10,000 or the value of the quantity acquired by the preceding fiscal year exceeded $10,000; procuring solid waste management services in a manner that maximizes energy and resource recovery; and establishing an affirmative procurement program for procurement of recovered materials identified in the EPA guidelines.

IV. PROCEDURE

A. Statement

1. ~~Southern Nevada Community~~ The Health Center ~~herein referred as Health Center,~~ recognizes that as a recipient of Federal funds, they are responsible for compliance with all applicable laws, regulations, and provisions of contracts and grants. This includes understanding and adhering to allowances and/or restrictions to use of Federal funds.

2. Appropriate fiscal oversight will be maintained for all Grants and awards. With respect to Federal funding and the requirements on restrictions to limitations on use of Federal funds as mandated by the Department of Defense and Labor, Health and Human Services, and Education Appropriations Act, ~~2019~~ and Continuing Appropriations Act, ~~2019, Division B, Pub. L. 115-245~~ the ~~health~~ Health ~~center~~ Center assures oversight and monitoring for compliance via grants management. The health center will comply with all requirements under the program compliance manual. The ~~health~~ Health ~~center~~ Center will also comply with all requirements under 45 CFR Part 75 Subpart E: Cost Principles and/or 2 Code of Federal Regulations (CFR) Part 200 (Subparts A – F). In addition, the ~~health~~ Health ~~center~~ Center will monitor HRSA Grants Policy Bulletins and ensure compliance~~comply with all requirements under HRSA Grants Policy Bulletin 2020-04~~.

B. Responsibility

The grant accountant, accounting supervisor and controller are responsible to ensure that no Federal funds are used for mandated limitations/restrictions.

C. Implementation

1. Mandatory Disclosures

   Any violation of federal criminal law involving fraud, bribery and gratuity violations potentially affecting the award will be disclosed in writing to HHS within 14 days of discovery. This notification will be the responsibility of the CEO~~ED~~ and the Health Center Board Chair.

2. Salary Limitation (Section 202)

   None of the funds appropriated in this title shall be used to pay the salary of an individual, through a grant or other extramural mechanism, at a rate in excess of Executive Level II. The Executive Level II salary is currently set at $2210~~03~~,970~~0~~0, as of January 2024~~2~~.

3. Gun Control (Section 210)

   None of the funds made available in this title may be used, in whole or in part, to advocate or promote gun control.

4. Anti-Lobbying (Section 503)

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

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

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

5. Health Center shall not use federal grant funds, other than for normal and recognized executive legislative relationships, for the following:

   a. For publicity or propaganda purposes

   b. For the preparation, distribution, or use of any kit, pamphlet, booklet, publication, electronic communication, radio, television, or video presentation designed to support or defeat the enactment of legislation before the Congress or any State or local legislature or legislative body, except in presentation to the Congress or any State or local legislature itself, or designed to support or defeat any proposed or pending regulation, administrative action, or order issued by the executive branch of any State or local government, except in presentation to the executive branch of any State or local government itself.

   c. Health Center shall not use federal grant funds to pay the salary or expenses of any employee or agent of Health Center for activities designed to influence the enactment of legislation, appropriations, regulation, administrative action, or Executive order proposed or pending before the Congress or any State government, State legislature or local legislature or legislative body, other than for normal and recognized executive- legislative relationships or participation by an agency or officer of a State, local or tribal government in policymaking and administrative processes within the executive branch of that government.

   d. The prohibitions in subsections A and B include any activity to advocate or promote any proposed, pending or future Federal, State or local tax increase, or any proposed, pending, or future requirement or restriction on any legal consumer product.

6. Acknowledgement of Federal Funding

   When issuing statements, press releases, requests for proposals, bid solicitations and other documents describing projects or programs funded in whole or in part with federal money, Health Center shall clearly state:

   a. The percentage of the total costs of the program or project which will be financed with Federal money.

   b. The dollar amount of Federal funds for the project or program.

   c. Percentage and dollar amount of the total costs of the project or program that will be financed by nongovernmental sources.

7. Restrictions on Abortions, and Exceptions to these Restrictions

   a. Health Center shall not use federal grant funds for any abortion or for health benefits coverage that includes coverage of abortion. These restrictions shall not apply to abortions (or coverage of abortions) that fall within the Hyde amendment exceptions.

   b. The Hyde Amendment is a statutory provision included as part of the annual Appropriations Act, which prohibits health centers from using federal funds to provide abortions (except in cases of rape or incest, or where a woman suffers from a physical disorder, physical injury, or physical illness, including a life endangering physical condition caused by or arising from the pregnancy itself, that would, as certified by a physician, place the woman in danger of death unless an abortion is performed).

8. Ban on Funding Human Embryo Research - Health Center shall not use federal grant funds for:

   a. The creation of human embryos for research purposes.

   b. Research in which a human embryo or embryos are destroyed, discarded, or knowingly subjected to risk of injury or death greater than that allowed for research on fetuses in utero under 45 CFR 46.204(b) and section 498(b) of the Public Health Service Act (42 U.S.C. 289g(b)).

9. Limitations on the Use of Grant Funds for the Promotion of Legalization of Controlled Substances

   a. Health Center shall not use federal grant funds to promote the legalization of any drug or other substance included in schedule I of the schedules of controlled substances established under section 202 of the Controlled Substances Act.

   b. Restriction on Distribution of Sterile Needles (Section 526) Notwithstanding any other provision of this Act, no funds appropriated in this Act shall be used to purchase sterile needles or syringes for the hypodermic injection of any illegal drug: Provided, That such limitation does not apply to the use of funds for elements of a program other than making such purchases if the relevant State or local health department, in consultation with the Centers for Disease Control and Prevention, determines that the State or local jurisdiction, as applicable, is experiencing, or is at risk for, a significant increase in hepatitis infections or an HIV outbreak due to injection drug use, and such program is operating in accordance with State and local law.

10. Restriction of Pornography on Computer Networks

Health Center shall not use federal grant funds to maintain or establish a computer network unless such network blocks the viewing, downloading, and exchanging of pornography.

11. Confidentiality Agreements

Health Center shall not require its employees or contractors seeking to report fraud, waste, or abuse to sign internal confidentiality agreements or statements prohibiting or otherwise restricting such employees or contractors from lawfully reporting such waste, fraud, or abuse to a designated investigative or law enforcement representative of a Federal department or agency authorized to receive such information.

12. Procedure

~~SNHD,~~Health Center will review HRSA's Legislative Mandates annually for the passage of a new HHS Appropriations Act or issuance of HRSA guidance regarding the Legislative Mandates and ensure ~~SNHD's~~ Health Center's policies and procedures are updated as necessary. Any modifications to ~~SNHD's legislative mandates policies and procedures~~this policy will require review and approval by the ~~Board of Directors~~Health Center Board.

V. REFERENCES

1. Department of Defense and labor, Health and Human Services, and Education Appropriations Act, ~~2019~~ and Continuing Appropriations Act, ~~2019~~, ~~Division B, Pub. L. 115- 245~~
~~1.~~2. HRSA Policies, Regulations, & Guidance page accessible at https://www.hrsa.gov/grants/manage-your-grant/policies-regulations-guidance
~~2.~~3. HRSA Grants Bulletins~~: 2022-05E, April 14, 2022~~
~~3.~~4. 45 CFR 46.204(b) and section 498(b) of the Public Health Service Act (42 U.S.C. 289g(b)).
~~4.~~5. Hyde Amendment
~~5.~~6. Consolidated Appropriations Act, ~~2019~~ https://www.congress.gov/resources/display/content/Appropriations+for+Fiscal+Year+2019
~~6.~~7. Controlled Substances Act, Section 202 https://www.deadiversion.usdoj.gov/21cfr/21usc/812.htm
~~7.~~8. 45 CFR Part 75 Subpart E: Cost Principles https://www.govinfo.gov/content/pkg/CFR- 2017-title45-vol1/xml/CFR-2017-title45-vol1-part75.xml
~~8.~~9. 2 Code of Federal Regulations (CFR) Part 200 (Subparts A – F) https://www.govinfo.gov/app/details/CFR-2014-title2-vol1/CFR-2014-title2-vol1-part200
~~9.~~10. HRSA Grants Policy Bulletin 2020-04. https://protect- us.mimecast.com/s/n_JSCmZ6L0Fz60KCGLwwD?domain=hrsa.gov

VI. DIRECT RELATED INQUIRIES TO

~~FQHC Operations Officer~~Chief Executive Officer - FQHC

HISTORY TABLE

Table 1: History

Version/Section	Effective Date	Change Made
Version 1		1. Policy review
Version 0	08/25/2022	First issuance

VII. ATTACHMENTS

Not Applicable

SOUTHERN NEVADA COMMUNITY HEALTH CENTER
POLICY AND PROCEDURE

DIVISION:	FQHC	**NUMBER(s):**	CHCA-017
PROGRAM:	Division Wide	**VERSION:**	1.02
TITLE:	Ongoing Professional Practice Evaluation – Peer Review	**PAGE:**	1 of 6
		EFFECTIVE DATE: ~~May 25, 2023~~January XX, 2025	
DESCRIPTION:	Professional Practice Evaluation Process	**ORIGINATION DATE:** 2/11/2020	
APPROVED BY: **FQHC CHIEF EXECUTIVE OFFICER:** Click or tap here to enter text. Randy Smith, MPA Date		**REPLACES:** May 25, 2023~~FQHC-ADM-OOO-C~~	

I. PURPOSE

To establish an ongoing professional practice evaluation (OPPE) program to measure the performance of licensed independent practitioners (LIPs) and other licensed or certified practitioners (OLCPs) to support decision making for the granting, renewal, modification, and removal of privileges.

II. SCOPE

This policy applies to all employed, contracted, and volunteer LIPs and OLCPs providing clinical care services at Southern Nevada Community Health Center (SNCHC).

III. POLICY

SNCHC is committed to ensuring patient safety and delivering high quality clinical care services. To achieve these objectives, the health center engages in an ongoing professional practice evaluation using standardized tools and metrics to assess clinical proficiency, professional behavior, and patient satisfaction.

IV. PROCEDURE

A. The evaluation process uses standardized tools to support the professional practice evaluation through:

1. The use of clearly defined criteria approved by the CMO.
2. A clearly defined process for collecting, assessing, and addressing clinical practice performance, concerns and for identifying best practices.
3. Utilization of trend analysis to capture clinical quality and patient safety performance over time.
4. A process that ensures that identified concerns regarding a LIP's or OLCP's professional practice are uniformly investigated and addressed as defined by policies and applicable law.
5. A process that gives individual LIPs and OLCPs access to their performance reports and relevant internal and external benchmarks.
6. Requires LIP and OLCP participate in peer review activities.
7. Utilizes clinical performance measure, patient satisfaction, access, and employee evaluation data.

B. The health center will establish a Professional Practice Evaluation Committee to conduct assessment activities using information acquired through the following:

1. Targeted and Program Specific Chart Audits
2. Peer Review Chart Audits (Internal and/or External)
    a. Medical Director or designee will select charts. A calendar of what charts will be audited will be published.
        i. Random Selection
        ii. Selection based on Quality Measure or General Area
    b. Chart audits will be performed quarterly
    c. Five (5) charts per quarter
3. Direct Observations
    a. Clinical Practice Techniques/Patterns
    b. Diagnostic and Treatment Techniques
    c. Workflows and Access
4. Proctoring
5. Patient Complaints/Grievances
6. Patient Satisfaction Survey

C. The professional practice evaluation provides a mechanism to validate that patient care is based on current clinical standards of care utilizing six areas of general competencies:

1. Clinical/Medical Knowledge
2. Interpersonal and Communication Skills
3. Patient Care
4. Practice Based Learning and Improvements
5. Professionalism
6. System-based Practice.

D. On a quarterly basis the Quality Improvement Work Group will review summary reports of LIP and OLCP performance for the purpose of conducting and evaluating process improvement activities.

E. Ongoing professional practice evaluation and any corrective actions shall be conducted pursuant to the criteria established in this policy.

F. Relevant information from LIP and OLCP performance reviews will be integrated into performance improvement activities and will be utilized to determine whether to continue, modify or remove existing privileges. Based on the findings of the ongoing professional practice review, interventions may be implemented. The criteria utilized to determine the type of intervention includes an assessment of severity/risk and/or frequency of occurrence. Interventions include, but may not be limited to, proctoring, education, focused review, and corrective actions. Types of interventions include:

1. Benchmarking, identifying indicators to use for comparative analysis for LIP and OLCP performance.
2. Collecting and comparing aggregate data for these indicators.
3. Developing thresholds to identify standard performance for focused review.
    a. For peer reviews below threshold, the FQHC Quality Management Coordinator, or designee, will reassess to confirm scoring accuracy.
4. All peer reviews will be presented to the Professional Practice Evaluation Committee. An action plan for LIP's and OLCP's that score below the threshold will be implemented.
    a. First Occurrence: LIPs and OLCPs will meet with the medical director for an information discussion, review of clinical standards, and training as needed. A follow up peer review in the same focus areas will occur at (90) days. If the practitioner successfully meets the threshold of the peer review, no additional action is taken. Those practitioners who score below the threshold are required to advance to the second occurrence phase.

b. Second Occurrence: LIPs and OLCPs will meet with the medical director for a formal discussion. Additional support, review of clinical standards, direct observations, and training will be implemented via a formal (60) performance improvement plan. A second follow up peer review in the same focus areas will occur at (60) days. If the practitioner successfully meets the threshold of the peer review, no additional action is taken. Those practitioners who score below the threshold are required to advance to the third occurrence phase.

c. Third Occurrence: LIPs and OLCPs will meet the medical director and chief medical officer for a formal discussion clinical performance. Additional support, review of clinical standards, direct observations, and training will be implemented via a formal (30) performance improvement plan. A third follow up peer review in the same focus areas will occur at (30) days. If the practitioner successfully meets the threshold of the peer review, no additional action is taken. Those practitioners who score below will be subject to formal disciplinary action, up to and including modification or removal of privileges and/or termination from the practice.

G. Practitioners who had their privileges modified or removed may appeal the decision in writing to the District Health Officer (DHO). The DHO will review the findings and supporting documentation. The DHO will speak with the relevant parties as needed. The DHO will have the final decision-making authority. The DHO's decision will be communicated in writing to the appealing practitioner.

H. The Professional Practice Evaluation Committee will be comprised of the following positions:

1. Chief Medical Officer
2. FQHC Chief Executive Officer
3. Medical Director
4. FQHC Quality Management Coordinator
5. Human Resources Business Partner
6. Other members may be added to the committee at the request of the chief medical officer.

I. The committee will meet no less than quarterly and as necessary to support activities of the Ongoing Professional Practice Evaluation.

J. The committee will engage with Human Resources as needed to discuss and receive guidance around employee performance related issues that may arise through the evaluation process.

Acronyms/Definitions

Acronym	Definition
Licensed Independent Practitioners (LIPs)	Medical Doctor (MD) Doctor of Osteopathic Medicine (DO) Physician Assistants (PA) Advance Practice Registered Nurse (APRN) Psychologist (PhD/PsyD) Licensed Clinical Social Worker (LCSW) Dentists (DDS) Pharmacist (PharmD)
Other Licensed and Certified Practitioners (OLCPs)	Registered Nurses (RNs) Licensed Practical Nurses (LPNs) Registered Dieticians (RDs)
External Review	A review conducted by an unbiased physician or other practitioner in an appropriate specialty or subspecialty who is actively in practice or has recently retired, but who is not a member of the Medical Staff.
On-going Professional Practice Evaluation (OPPE)	A process to identify professional practice trends and provide on-going evaluation of performance impacting clinical care and patient safety.
Peer Review	The objective measurement, assessment, and evaluation by Peer Reviewers or Peer Review Committees, of the quality of care provided by individual LIPs and OLCPs as well as the identification of opportunities to improve care.

V. REFERENCES

Quality Management Plan

Quality Management Program Policy

VI. DIRECT RELATED INQUIRIES TO

Medical Director

HISTORY TABLE

Table 1: History

Version/Section	Effective Date	Change Made
Version 2		1. Corrected acronym in section D ~~1.~~2.Updated section F ~~2.~~3.Updated position titles in section H
Version 1	5/25/2023	1. Reformatted 2. Added history table
Version 0	2/11/2020	Origination Date 2/11/2020

VII. ATTACHMENTS

Not Applicable

SOUTHERN NEVADA COMMUNITY HEALTH CENTER
POLICY AND PROCEDURE

DIVISION:	FQHC	**NUMBER(s):**	CHCA-026
PROGRAM:	Family Planning	**VERSION:**	1.00
TITLE:	Non-Coercive Services	**PAGE:**	1 of 4
		EFFECTIVE DATE: January XX, 2025	
DESCRIPTION: Process to ensure compliance with Title X for services provided in Family Planning.		**ORIGINATION DATE:** January XX, 2025	
APPROVED BY: **FQHC CHIEF EXECUTIVE OFFICER:** Click or tap here to enter text. Randy Smith, MPA Date		**REPLACES:** New	

I. PURPOSE

The purpose of this policy is to describe Southern Nevada Community Health Center's (SNCHC) process for ensuring compliance (including the recipient and service sites, as appropriate) with the expectation that projects provide services without subjecting individuals to any coercion to accept services or to employ or not to employ any particular methods of family planning (42 CFR § 59.5(a)(2)); ensure that acceptance of services is solely on a voluntary basis and may not be made a prerequisite to eligibility for, or receipt of, any other services, assistance from or participation in any other program of the recipient (Sections 1001 and 1007, PHS Act; 42 CFR § 59.5(a)(2)); and ensure that staff are informed that any officer or employee of the United States, officer or employee of any State, political subdivision of a State, or another entity, which administers or supervises the administration of any program receiving federal financial assistance, or person who receives, under any program receiving federal assistance, compensation for services, who coerces or endeavors to coerce any person to undergo an abortion or sterilization procedure by threatening such person with the loss of, or disqualification for the receipt of, any benefit or service under a program receiving federal financial assistance shall be fined not more than $1,000 or imprisoned for not more than one year, or both. (42 U.S.C. § 300a-8, as set out in 42 CFR § 59.5(a)(2) footnote 1)

II. SCOPE

Applies to all workforce members involved in the delivery of Family Planning services.

III. POLICY

- Services are provided without subjecting individuals to any coercion to accept services or to employ, or not to employ, any particular methods of family planning.
- A general consent form provided to clients states that receipt of family planning services is not a prerequisite to receipt of any other services offered by SNCHC (Attachment A – Informed General Consent for Family Planning Services).
- Services are not made a prerequisite to eligibility for, or receipt of, any other services, assistance from or participation in any other program of the recipient.
- Staff are informed that any officer or employee of the United States, officer or employee of any state, political subdivision of a state, or any other entity, which administers or supervises the administration of any program receiving federal financial assistance, or person who receives, under any program receiving federal assistance, compensation for services, who coerces or endeavors to coerce any person to undergo an abortion or sterilization procedure by threatening such person with the loss of, or disqualification for the receipt of, any benefit or service under a program receiving federal financial assistance shall be fined not more than $1,000 or imprisoned for not more than one year, or both (Attachment B – Title X Requirements Acknowledgement Form).

IV. PROCEDURE

A. Initial Visit: During the client's first visit, provide the Informed General Consent Form that includes the following key points:

1. Services are provided without subjecting individuals to any coercion to accept services, or to employ, or not to employ, any particular method. Certain methods such as Long-Acting Reversible Contraceptives, Intra Uterine Contraception (IUC), or Implants will require additional consent.
2. All services offered at the Southern Nevada Community Health Center are to be provided on a voluntary basis.
3. Acceptance of Reproductive and Sexual Health Services is not a prerequisite to receive other health services.
4. Review the form with the client to ensure understanding. Address any questions or concerns.
5. Obtain the client signature on the form as acknowledgment.

6. Scan the signed form into the client's electronic health record (EHR).

B. Annual Updates:

1. During subsequent annual visits, provide the client with the same consent form to reinforce the information, and to account for any changes in their understanding or preferences.

2. Repeat section A, steps 4-6.

C. Documentation:

1. Maintain an up-to-date record of the client's signed consent form in the EHR.

D. Ongoing Communication:

1. Ensure all staff are trained to communicate the voluntary nature of Title X Family Planning services when discussing services.

2. Reinforce to clients during visits or consultations that they are free to decline any services without impacting their ability to receive other care.

E. Training Requirements for Staff: New Hire Orientation and Annual Training

1. All new hires must complete Federal Title X Training Requirements as part of their onboarding process and annually. All staff are required to complete annual refresher training on Title X Family Planning services to ensure ongoing compliance and understanding.

2. Training resources are available on the Reproductive Health National Training Center (RHNTC) website.

3. New hires must complete and sign the Title X Requirements Acknowledgement form as proof of understanding and compliance with Title X policies. Staff must renew and sign above form to confirm their understanding of the updated policy and Title X requirements. The form is maintained in the staff training binder.

4. As part of the orientation, new hires are required to review this policy to ensure they fully understand their responsibilities under Title X regulations. During the annual training, staff must review this policy to stay informed about any updates or changes.

F. Access to Policy:

1. Staff can access this policy through the following methods:

a. Onsite Binders: Physical copies of this policy are stored in designated binders available onsite at each clinic location. Staff should refer to the binder labeled Policies and Procedures for the

most recent binders

b. A digital version of this policy is available on the Neogov Policy Portal. Staff can log into their account to search for this policy.

G. Review Schedule: This procedure will be reviewed as needed to ensure compliance with Title X regulations and updated as needed based on changes to laws, training requirements, or clinic practices.

V. REFERENCES

Title X Program Handbook, Section 3, Program Administration #1, #2, and #3 (https://opa.hhs.gov/sites/default/files/2022-08/title-x-program-handbook-july-2022-508-updated.pdf#page=16)

Sections 1001 and 1007, Public Health Service (PHS) Act (https://opa.hhs.gov/sites/default/files/2020-07/title-x-statute-attachment-a_0.pdf)

2021 Title X Final Rule (42 CFR § 59.5(a)(2)) (https://www.ecfr.gov/current/title-42/chapter-I/subchapter-D/part-59#59.5)

VI. DIRECT RELATED INQUIRIES TO

Community Health Nurse Manager (FQHC)

HISTORY TABLE

Table 1: History

Version/Section	Effective Date	Change Made
Version 0		First issuance

VII. ATTACHMENTS

Attachment A – Informed General Consent for Family Planning Services

Attachment B – Title X Requirements Acknowledgement Form

SOUTHERN NEVADA COMMUNITY HEALTH CENTER
POLICY AND PROCEDURE

DIVISION:	FQHC	**NUMBER(s):**	CHCA-027
PROGRAM:	Family Planning	**VERSION:**	1.00
TITLE:	Durational Residency/Physician Referral	**PAGE:**	1 of 4
		EFFECTIVE DATE: January XX, 2025	
DESCRIPTION: Process to ensure compliance with Title X for services provided in Family Planning.		**ORIGINATION DATE:** January XX, 2025	
APPROVED BY: **FQHC CHIEF EXECUTIVE OFFICER:** Click or tap here to enter text. Randy Smith, MPA Date		**REPLACES:** New	

I. PURPOSE

The purpose of this policy is to describe Southern Nevada Community Health Center's process for ensuring compliance with the expectation that services are provided without the imposition of any durational residency requirement or that the client be referred by a physician. (42 CFR § 59.5(b)(5))

II. SCOPE

Applies to all workforce members involved in the delivery of Family Planning services.

III. POLICY

- Services are provided without the imposition of any durational residency requirement.
- Services are provided without the imposition of a requirement that the client be referred by a physician.

IV. PROCEDURE

A. Staff are made aware that the Title X-funded project does not impose durational residency or physician referral requirements for the receipt of services through policy review, training and by signing the Title X acknowledgement form during initial hire training and annually (Attachment A – Title X Requirements Acknowledgement Form).

B. The SNHD Policies and Attachments Portal in NEOGOV tracks the review of policies including updates.

C. Policies are made available to staff online through the portal and in clinic binders.

D. Trained staff will communicate to clients that the Title X-funded project does not impose durational residency or physician referral requirement for the receipt of services when applicable.

E. Patients are provided with Informed General consent which outlines that services are provided without imposition of any durational residency requirement or that the client be referred by a physician.

V. REFERENCES

Title X Program Handbook, Section 3, #4
(https://opa.hhs.gov/sites/default/files/2022-08/title-x-program-handbook-july-2022-508-updated.pdf#page=16)

2021 Title X Final Rule 42 CFR § 59.5(a)(4)
(https://www.ecfr.gov/current/title-42/chapter-I/subchapter-D/part-59#59.5)

VI. DIRECT RELATED INQUIRIES TO

Community Health Nurse Manager (FQHC)

HISTORY TABLE

Table 1: History

Version/Section	Effective Date	Change Made
Version 0		First issuance

VII. ATTACHMENTS

Attachment A - Title X Requirements Acknowledgement Form

SOUTHERN NEVADA COMMUNITY HEALTH CENTER
POLICY AND PROCEDURE

DIVISION:	FQHC	**NUMBER(s):**	CHCA-004
PROGRAM:	Division Wide	**VERSION:**	1.00
TITLE:	Procurement Policy	**PAGE:**	1 of 5
		EFFECTIVE DATE: January XX, 2025	
DESCRIPTION: To establish procedures for ensuring all sourcing and purchasing activities are in compliance with applicable law.		**ORIGINATION DATE:** 1/6/2025	
APPROVED BY: **CHIEF EXECUTIVE OFFICER - FQHC** Randy Smith, MPA Date		**REPLACES:** NEW	

I. PURPOSE

To establish procedures for ensuring that all sourcing and purchasing activities for the Health District are in compliance with applicable law including but not limited to, 45 CFR, Part 75, Subpart E and 2 CRF part 200.

II. SCOPE

This policy applies to all Workforce Members.

III. POLICY

Workforce Members will make every effort to ensure the acquisition of quality goods and services at competitive costs while adhering to professional standards and practices. The Financial Services Department is responsible for all purchase orders, solicitations, and related contract encumbrances. The Health District has elected to follow OMB M-18-18, which outlines the purchasing thresholds.

IV. PROCEDURE

The Health District will only award purchases to responsible suppliers possessing the ability to perform successfully under the terms and conditions of a proposed procurement.

Consideration will be given to such matters as supplier integrity, compliance with public policy, record of past performance, suspension and debarment, and financial and technical resources.

A. Purchase Order Approval Authority

1. The Chief Financial Officer (CFO) or designee is responsible for reviewing and approving all purchase requisitions. Purchase requisitions valued above the applicable purchase threshold will be approved based on the following factors:
   a. Sufficiency of departmental appropriations
   b. Compliance with budgetary and fiscal policies
   c. Compliance with accounting principles and standards
   d. Reasonableness of the request
2. All purchase ~~orders~~ requisitions valued at under $50,000 will be reviewed for final approval by the CFO, or designee. All purchase ~~orders~~ requisitions valued at over $50,000 will be reviewed for final approval by the District/Chief Health Officer or designee.
3. No Workforce Member will make a purchase without an approved purchasing agreement. Exceptions require pre-approval by the CFO in consultation with the District Health Officer. The Workforce Member may be held liable for unauthorized purchases.

B. General Purchasing Requirements

1. Purchase Orders and P-Cards - Purchase orders are used for the one-time purchase of specific goods or services and for repetitive purchases of goods and services provided as needed on an on-going basis during the Health District's fiscal year. Generally, all individual purchases valued at $5,000 and over must be made with a purchase order or a contract. Purchases below $5,000 made with a P-Card must adhere to the P-Card policy. Certain categories of obligations can be paid without a purchase order (see Procurement Manual). Division Directors, Managers, and Supervisors are responsible for ensuring the appropriateness of purchases made with purchase orders. Emergency Purchase Order changes will be executed by the Purchasing Agent or designee.

2. Sole Source - All exceptions for purchase requests greater than the micro purchase threshold that are not competitively awarded will be documented and approved using the Sole Source Justification Form.

3. Goods and Nonprofessional Services - The process and documentation associated with the purchase of goods and nonprofessional services are based on the dollar value of the specific purchase request. Dividing (splitting) purchasing transactions to avoid the purchasing and approval requirement is prohibited. Goods and nonprofessional service transactions valued over $50,000 per fiscal year for the same product or service and to the same supplier requires a formal solicitation unless the purchase occurs under a purchasing agreement or program or is a valid sole/single source.

   a. All purchase requests valued at $50,000 or over ($100,000 for construction) requires a formal Request for Proposals (RFP) (unless purchase is a valid sole source).

   b. All purchases of software, hardware and/or implementation will be requested by the IT Department.

4. Any federally funded procurement activity will be in accordance with the federal procurement requirements or grant requirements. Staff will ensure all procurement costs directly attributable to the Health Resources Services Administration (HRSA), federal awards are allowable, consistent with federal cost principles.

   a. The Health District has records for procurement actions paid for in whole or in part under the HRSA's federal award that include the rationale for method of procurement, selection of contract type, contractor selection or rejection, and the basis for the contract price.

   b. The health center's contracts that support the HRSA-approved scope of project include provisions that address the following:

      The specific activities or services to be performed or goods to be provided;

      Mechanisms for the health center to monitor contractor performance; and

      Requirements for the contractor to provide data necessary to meet the recipient's applicable federal financial and programmatic reporting requirements, as well as provisions addressing record retention and access, audit, and property management.

5. Competition - All procurement transactions must be conducted in a manner providing full and open competition and will only include costs allowable, consistent with federal cost principles, and meets grant guidelines, as applicable. Contractors who develop or draft specifications, requirements, statements of work, or invitations for bids/requests for proposals must be excluded from competing for such procurements. The solicitation may not include geographical preferences in the evaluation of bids or proposals. State licensing laws may be a requirement for a firm to bid. Architectural and engineering services may be limited to a geographic location if there are sufficient firms to compete for the contract. The solicitation must identify evaluation factors and their relative importance. Any response to publicized requests for proposal must be considered to the maximum extent practical.

C. Emergency Purchases

An emergency is defined as a disaster or a situation that may lead to the impairment of health, safety, or welfare of the public if not immediately addressed. The purchasing process for emergencies depends on the severity and resources required to manage the incident. P-Card purchases may be utilized during emergencies. Such purchases will not require prior written approvals.

Department approved invoices for goods or services purchased without a P-Card must be forwarded to Finance for review, approval and payment.

D. Entering into state and local intergovernmental agreements or inter-entity agreements (i.e., NASPO, GPO, GSA) are encouraged. Prior to entering into these agreements, mandatory federal flow down clauses will be included (2 CFR 200, Appendix II), as applicable.

E. Conflict of Interest

Any Workforce Member directly associated with and/or responsible for the procurement of goods, services and/or contracting activities, including Board of Directors, officers, employees and agents, are prohibited from having any direct or indirect interest, or any real or apparent conflict of interest, in or with any entity with which the Health District does business. Workforce members violating this standard may be subject to disciplinary action up to and including termination.

Any Workforce Member participating in the procurement process must disclose any real or apparent conflict of interest. Disclosure must be made on the Conflict of Interest Disclosure Form (see Reference No. 10).

V. REFERENCES

1. Procurement Manual
2. P-Card Policy
3. Sole Source Justification Form (FIN-101)
4. RFP Request Form (FIN-106)
5. OMB M-18-18
6. 2 CFR §200.317-326, Procurement Standards
7. 2 CFR 200 Appendix II, Contract Provisions for Non-Federal Entity Contracts Under Federal Awards
8. 45 CFR Part 75, subpart E
9. NRS 332 Purchasing Local Governments
10. Form No. CHCA-004-FRM-004-1, Conflict of Interest Disclosure Form

HISTORY TABLE

Table 1: History

Version/Section	Effective Date	Change Made
Version 0	01/XX/2025	First issuance

VI. ATTACHMENTS

Not Applicable

SOUTHERN NEVADA COMMUNITY HEALTH CENTER
POLICY AND PROCEDURE

DIVISION:	FQHC	**NUMBER(s):**	CHCA-028
PROGRAM:	Division Wide	**VERSION:**	1.00
TITLE:	Credentialing and Privileging Policy	**PAGE:**	1 of 5
		EFFECTIVE DATE: January XX, 2025	
DESCRIPTION: Requirements and processes for initial and reoccurring credentialing and privileging of clinical personnel providing services in the Southern Nevada Community Health Center.		**ORIGINATION DATE:** January XX, 2025	
APPROVED BY: **CHIEF EXECUTIVE OFFICER - FQHC** Randy Smith, MPA Date		**REPLACES:** New	

I. PURPOSE

To ensure all employees, contractors, and volunteers providing clinical services on behalf of the Southern Nevada Community Health Center are credentialed and privileged in accordance with the Heath Center program requirements put forth by the Health Resources and Services Administration.

II. SCOPE

All Southern Nevada Health District employees, contractors, and volunteers designated as a LIP, OLCP, or OCS providing services in the Southern Nevada Community Health Center.

III. POLICY

All licensed independent practitioners (LIPs), other licensed or certified practitioners (OLCPs), and other clinical staff (OCS) providing services on behalf of the health center will complete initial credentialing and privileging upon hire or acceptance of a position classified as a LIP, OLCP, or OCS and will also complete recredentialing and renewal of privileges on a two-year reoccurring basis. All credentialing and privileging packets for LIPs will go before the Southern Nevada Community Health Center Governing Board for approval.

IV. PROCEDURE

A. At the time of the offer, Human Resources (HR) will discuss the credentialing and privileging process with the new hire. Human Resources will also reach out to internal teams within the FQHC, Finance, and Legal departments to communicate the start date and job title of the incoming candidate.

B. For Licensed Independent Practitioners (LIPs), HR will send the credentialing checklist to the selected candidate requesting the following documents:

1. Best Contact Methods form
2. Fitness for Duty Attestation
    a. To be reviewed and completed by the District Health Officer or Designee during file review
3. Provider Information Form
4. Delineation of Privileges
    a. To be reviewed and completed by the District Health Officer or Designee, Chief Executive Officer or Designee of the FQHC, and the Chief Human Resources Officer during file review
5. State Identification Card or Driver's License
6. Copy of current licensure, board certification for medical, nursing, and other applicable license(s)
7. Copy of DEA or Controlled Substance license as applicable
8. Basic Life Support certification and any additional Life Support certifications
9. A copy of the provider's Curriculum Vitae
10. Copies of all diplomas and other relevant medical certifications, including Fellowship, Residency, and any other post-graduate credentials
    a. Primary Source Verification is carried out as part of the employment background check process.
11. Medical malpractice history (if applicable)
12. Current malpractice insurance (if applicable)

C. For Other Licensed Clinical Professionals (OLCPs) and Other Clinical Staff (OCS), Human Resources will request the following documentation:

1. State Identification Card or Driver's License.
2. Copy of current licensure, board certification for medical, nursing, and other applicable license(s).
3. Copy of DEA or Controlled Substance license as applicable.

4. Basic Life Support certification and any additional Life Support certifications as applicable.

D. Human Resources will complete Primary Source Verification of LIP, OLCP, and OCS credentials:

1. Relevant education, training, or experience (Primary Source Verified).
2. License, board certification, and other applicable registrations (Primary Source Verified).

E. Received documents will be saved by HR into a digital credentialing file accessible only to Human Resources. Necessary documentation will be forwarded as needed to appropriate departments.

1. HR will provide the start date, NPI number, FTE, and any other necessary legal information to the SNHD's Legal department for malpractice insurance purposes.

F. Human Resources will enroll the new staff member in the National Practitioner Data Bank (NPDB) for continuous query.

G. HR will verify that all information requested for the FQHC credentialing process has been provided and will follow up with the provider if anything is missing. HR will address any issues, discrepancies, or missing documentation throughout the process.

H. If the inquiries of the District Health Officer, or designee, are not answered sufficiently, or the candidate fails to provide appropriate documentation by the required deadline, the job offer will be rescinded and/or an existing employee will be placed on administrative leave until the credentialing concern is corrected.

I. The new staff member will meet with the Employee Health Nurse or Designee on their first day to review the Hep B vaccination form, necessary immunization records, and Tuberculosis testing records. If necessary, the Employee Health Nurse will have the new staff member tested annually for Tuberculosis.

J. Upon receipt of the Tuberculosis/Immunizations form from the Employee Health Nurse, Human Resources will ensure the candidate's credentialing file is complete. For LIPs, Human Resources will then send the file for review by the DHO or Designee, the CEO of the FQHC or Designee, and the CHRO for completion and accuracy.

K. Once all signatures are obtained to show the file has been reviewed, the packet is complete. Human Resources will ensure the CEO of the FQHC has a copy of the complete file.

L. Credentialing and recredentialing packets for health center Licensed Independent Practitioners are presented to the board for approval.

M. Human Resources will track all required documentation (e.g., licenses and certifications) on an ongoing basis. Human Resources will work with employees and contractors to ensure the required documentation is always maintained current. As needed, Human Resources will work with program supervisors for support in obtaining the required information and documentation. Employees and contractors with missing or expired documentation will be placed on administrative leave until all required information is received by Human Resources.

N. At the time of recredentialing, Human Resources will initiate contact with health center LIPs, OLCPs, and OCS to commence the process for completing the activity with a goal of ensuring a complete packet is approved within the two-year timeframe.

V. PRIVILEGING

A. Upon hire and on a two-year reoccurring basis, all LIPs will complete initial requesting of privileges and renewal of privileges.

B. The health center uses the following information for LIPs when granting initial privileges and for the renewal of privileges every two years:

a. Fitness for duty
b. Immunizations
c. Communicable disease status
d. Verification of current clinical competence via training, education, and as available, reference reviews (initial privileging only)
e. Verification of clinical competence via peer review and performance reviews (renewal of privileges only)
f. Results of Ongoing Professional Evaluation regarding the denial, modification, and or removal of privileges based on clinical competence and fitness for duty

C. Health center LIPs request initial granting of clinical privileges and the renewal of privileges using SNHDs Delineation of Privileges form.

D. Human Resources will forward a complete request to the health center's CEO or their Designee to review and approve or decline the privileging requests.

a. As needed, the CEO or their Designee will consult employee supervisors and/or the Ongoing Professional Evaluation Committee for additional information to assist with a decision.

E. Requests for initial privileges and renewal of privileges are presented to the health center's Governing Board for final approval.

F. Initial privileging for OLCPs and OCS occurs upon hire and renewal of privileges take place at least every two years on an going basis.

G. The scope of privileges available to OLCPs and OCSs is outlined in their position job description.

H. The health center uses the following information for OLCPs and OCS when granting initial privileges and for the renewal of privileges every two years:

a. Immunizations
b. Communicable disease status
c. Signed job description
d. Performance Evaluations (renewal of privileges only)

I. In the event an OLCP or OCS should perform below satisfactorily as determined by their annual performance evaluation and/or the presence of formal progressive discipline, supervisors may deny, modify, or remove privileges. Such action will be taken in consultation with the CEO and Human Resources.

VI. THIRD PARTY PAYER CREDENTIALING

A. Human Resources will provide credentialing documents to the Finance Department Revenue Cycle Manager for all newly hired LIPs. Every effort is made by the Billing Department team to initiate the LIP credentialing process with contracted third-party payers as early as possible to account for the long processing time by insurance plans. The Billing Department will work with each contracted insurance company to ensure LIPs are properly enrolled with each eligible insurance plan. The Revenue Cycle Manager will communicate the status of LIP credentialing via an ongoing Revenue Cycle meeting and the credentialing spreadsheet. The Billing Department will work with LIPs and their supervisors to ensure credentialing remains current and any required revalidations are completed.

VII. REFERENCES

HRSA Health Center Program Compliance Manual

VIII. DIRECT RELATED INQUIRIES TO

Medical Director
Chief Executive Officer – FQHC
Human Resources Assistant

HISTORY TABLE

Table 1: History

Version/Section	Effective Date	Change Made
Version 0		First issuance

IX. ATTACHMENTS

Not Applicable

1. **Review, Discuss and Approve the Strategic Planning Committee Charter;** direct staff accordingly or take other action as deemed necessary *(for possible action)*

SOUTHERN NEVADA Community HEALTH CENTER
AT THE SOUTHERN NEVADA HEALTH DISTRICT

SNCHC Strategic Planning Committee Charter

(Proposed)

Committee Purpose:

The Strategic Planning Committee assists the board with its responsibilities for Southern Nevada Community Health Center's (SNCHC) mission, vision, values and strategic direction.

Scope of Duties and Responsibilities:

The specific responsibilities of the Strategic Planning Committee include:

1. Making recommendations to the full board related to the organization's mission, vision, values, strategic initiatives, major programs and services.
2. Helping management identify critical community needs and strategic issues facing the organization, assisting in analysis of strategic options.
3. Ensuring management has established an effective strategic planning process, including the development of a three-to-five-year strategic plan with time bound measurable goals.
4. Periodically reviewing the mission, vision, values and strategic plan, and recommending changes to the board.
5. Annually reviewing the strategic plan and recommending updates as needed based on changes in the market, community needs, and other factors.
6. Assisting in developing a strategic dashboard of key indicators.
7. Monitoring the organization's performance against measurable targets.

SNCHC Strategic Planning Committee Charter

(Proposed)

Composition:

The Committee shall be comprised of at least three Board members. In addition, the Chief Executive Officer, and FQHC Administrative Manager, will be subject matter Committee members. The Committee shall determine whether members should undergo any initial or annual training to help them fulfill their Committee responsibilities. The members of the Committee shall serve at the pleasure of the Board.

Meetings:

The Committee shall meet two (2) times per year and as deemed necessary to carry out its responsibilities. Meetings may be called by the Chairman of the Committee or any two members thereof. Meetings shall be held at such time and place as may be specified in the notice of meeting. Meetings will be held and posted consistent with Nevada's Open Meeting Law.

SNCHC Strategic Planning Committee Charter

(Proposed)

Voting and Quorum:

Voting on Committee matters shall be on a one vote per member basis. At all meetings, a majority of the total number of voting members of the Committee shall constitute a quorum for the transaction of business, and the act of a majority of the members present at any meeting at which there is a quorum shall constitute the Committee's action or decision.

Committee members who are Community Health Center or Health District staff shall be ex-officio non-voting members. Board members who are not also Committee members may attend Committee meetings but may not vote.

Reports:

All actions authorized or taken by the Committee shall be reported to the Board no later than the next succeeding meeting of the Board.

2. **Receive, Discuss and Accept the Strategic Plan Directional Statement;** direct staff accordingly or take other action as deemed necessary *(for possible action)*

SOUTHERN NEVADA Community HEALTH CENTER
AT THE SOUTHERN NEVADA HEALTH DISTRICT

SNCHC 2025 Strategic Plan

Strategic Framework

Mission, Vision, and Values.

Strategic Framework Consists of:

- **Mission Statement** – our purpose for existing.
- **Vision Statement** – where we are going.
- **Values** – How we intend to conduct our work to fulfill our purpose and get where we are going.

Current Mission, Vision, and Values

Mission

The mission of the Southern Nevada Community Health Center (SNCHC) is to serve residents of the 89107 ZIP code area in addition to Clark County residents from other underserved areas with appropriate and comprehensive outpatient health and wellness, emphasizing prevention and education in a culturally respectful environment.

Vision

It is the Southern Nevada Community Health Center's vision to contribute to the development of healthy communities in which health disparities are diminished and there is access to health care for all.

Values

- Delivering quality care with dignity, equality, sensitivity, professionalism and respect.
- Maintaining high ethical and professional standards.
- Being a culturally competent organization.
- Practicing continuous quality improvement.
- Operating cost effectively and efficiently.
- Providing a work environment conducive to positive attitudes, personal satisfaction and growth.
- Incorporating leadership principles at every level of the Community Health Center.

Proposed Mission, Vision, and Values

Mission

To provide patient-centered primary health care services to the underserved community with an emphasis on integrated, high-quality, and affordable care in a culturally respectful environment.

Vision

Reducing health disparities in the community by empowering patients to achieve their best possible health through equitable access to comprehensive care.

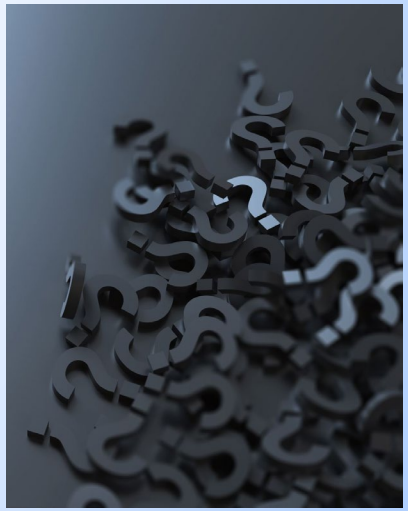
Values

- Commitment
- Accountability
- Respect
- Excellence
- Service

Questions, Suggestions, and/or Ideas?

SOUTHERN NEVADA Community HEALTH CENTER

AT THE SOUTHERN NEVADA HEALTH DISTRICT



3. **Receive, Discuss and Accept the Strategic Plan Goals for CY25 – CY27;** direct staff accordingly or take other action as deemed necessary *(for possible action)*

SOUTHERN NEVADA Community HEALTH CENTER
AT THE SOUTHERN NEVADA HEALTH DISTRICT

Needs Assessment

Why SNCHC is needed.

SOUTHERN NEVADA Community HEALTH CENTER

Primary Care Medical Services

The main purpose for Federally Qualified Health Centers is to provide affordable, high-quality primary health care to underserved communities. SNCHC is working to integrate and sustain ongoing primary care services for other internal SNHD patients including those coming to SNHD for SHC, Refugee, TB, and Immunization services. SNCHC is also working to reach further into the community to provide access to primary care for the underserved population that need it.

Health Professional Shortage Area (HPSA) Scores indicate the level of need for primary, mental, and dental health services. (data.hrsa.org)

Primary Health HPSA Scoring

Clark County, Nevada's
Primary Health HPSA Score is 21/25.

https://bhw.hrsa.gov/workforce-shortage-areas/shortage-designation/scoring

Dental Services

SNCHC is planning the dental clinic buildout at the Fremont location because of the local HPSA score.

Dental Health HPSA Scoring

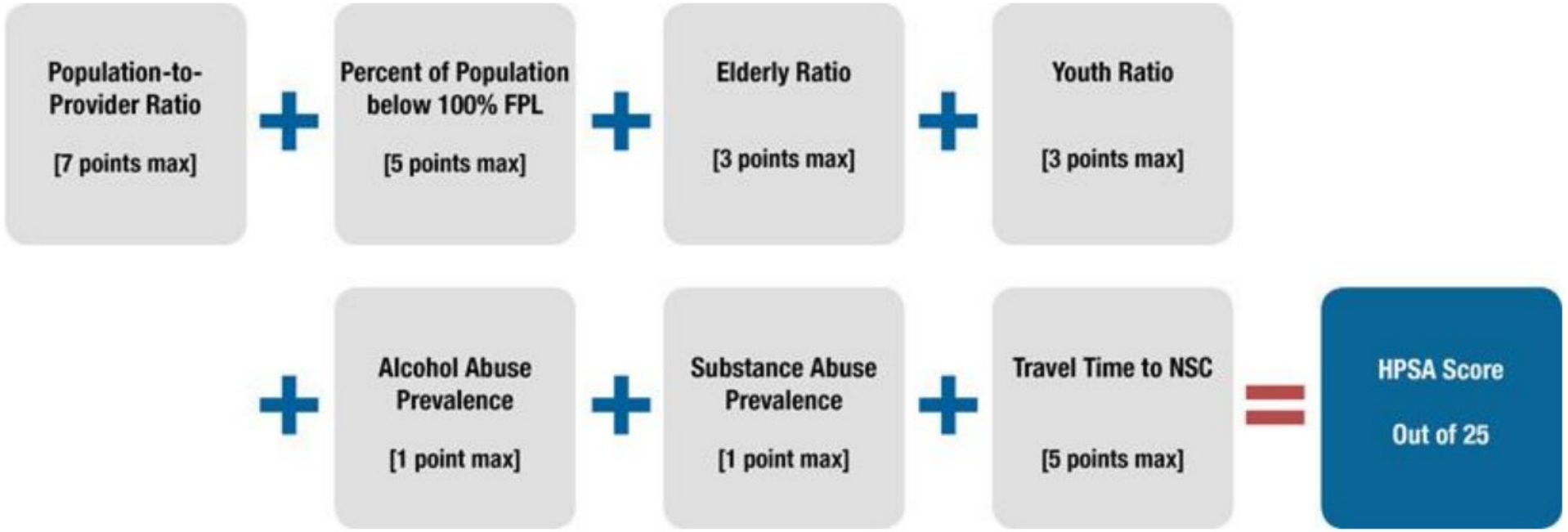
Clark County, Nevada's
Dental Health HPSA Score is 17/26.

https://bhw.hrsa.gov/workforce-shortage-areas/shortage-designation/scoring

Mental Health Services

SNCHC has opened a new Behavioral Health Center because of the local HPSA score.

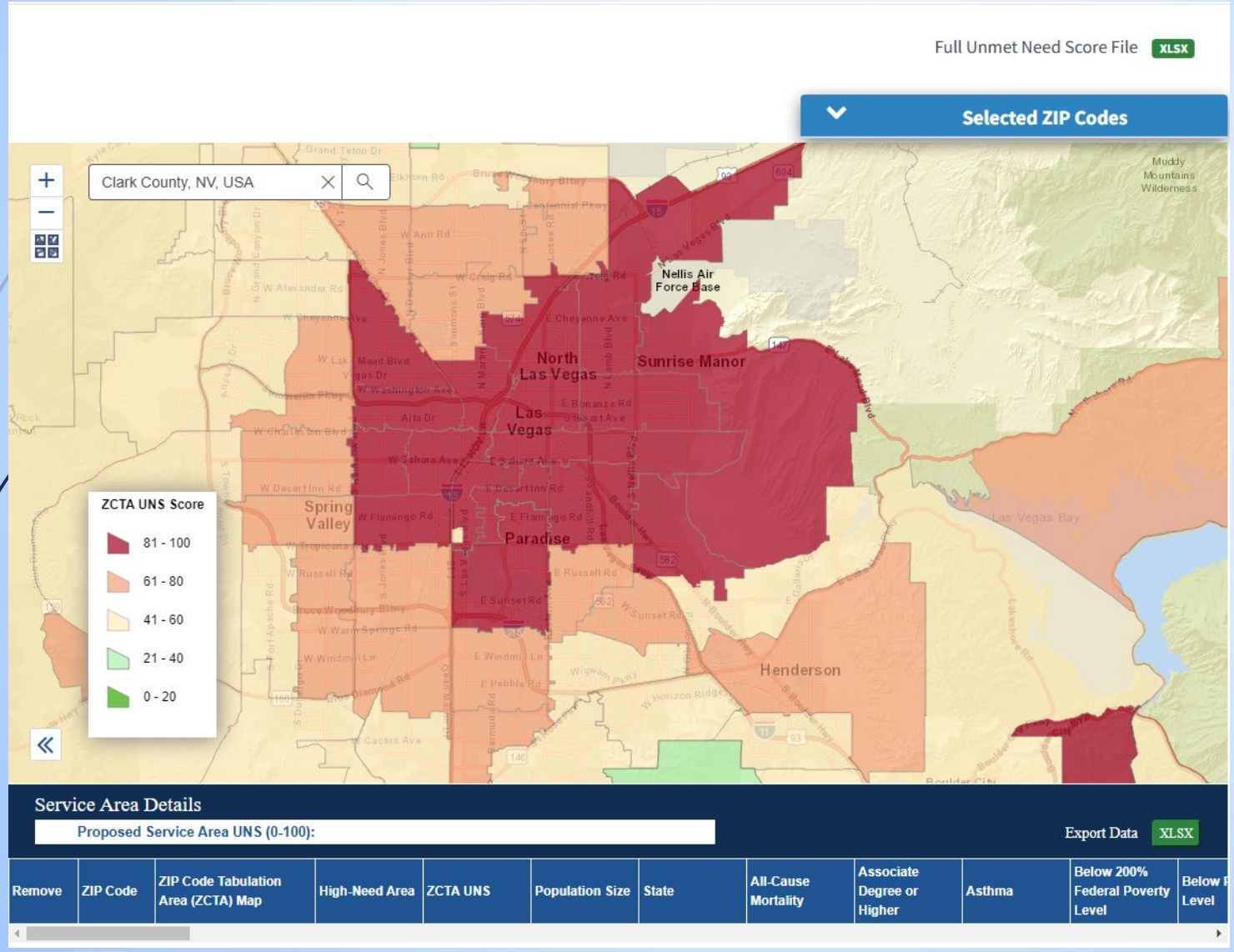
Mental Health HPSA Scoring



Clark County, Nevada's
Mental Health HPSA Score is 20/25.

https://bhw.hrsa.gov/workforce-shortage-areas/shortage-designation/scoring

Unmet Needs Score Map Tool



- This HRSA tool is used to evaluate service area needs for health care services and to determine the need for more health centers.
- 19 ZCTAs in the metro Las Vegas area of Clark County have an unmet needs score between 81-100
- 17 ZCTAs in the metro Las Vegas area of Clark County have an unmet needs score of 61-80.

Nevada Health Workforce Research Center – 2024 Clark County Health Rankings

- 14.4 % of Clark County, Nevada residents under the age of 65 are uninsured,
- There are 242,743 uninsured residents that are not served by health centers.
- The ratio of population to primary care physicians is 1,831:1.
- The ratio of population to other primary care providers is 919:1.
- The ratio of population to dentists is 1,495:1.
- The ratio of population to mental health providers is 417:1

GeoCare Navigator UDS Data

According to the Health Center Program GeoCare Navigator, using the ZIP Code Tabulation Area's (ZCTA) identified in SNCHC's 2023 UDS patient data:

- There are 2,196,524 residents in the identified area.
- There are 704,111 (32.06%) residents in the identified area experiencing low income.
    - Residents experiencing low income (at or below 200% of the Federal Poverty Level) are the target patients that SNCHC works to serve.
    - Only 8.61% of the residents experiencing low income (60,624) are utilizing available health center services, meaning
    - There are 643,487 low-income residents who have not found access to a health center for services yet.
    - According to the 2022 US Census Bureau data, 12.9% of Clark County, Nevada lives in poverty (at or below 100% of the Federal Poverty Level).

Key Findings from The 2022 NV State Health Assessment

- According to the Nevada Department of Health and Human Services Division of Public and Behavioral Health, Nevada ranks 42nd in the nation on a variety of health indicators, and there are 52,644 families in Clark County, Nevada living below poverty.

Table 1. Regional Health Priorities by County/Region

	Clark County	Washoe County	Quad Counties	Northern Nevada Counties	Southern Nevada Counties
1	Access to Care	Mental Health	Access to Care	Substance Use	Mental Health
2	Mental Health	Physical Activity/ Nutrition; Weight Management	Mental Health	Mental Health	Heart Disease
3	Substance Use	Chronic Disease Screenings	Nutrition	Chronic Diseases	Aging Populations

SNCHC Access Data and Preliminary Calendar Year (CY) 2024 UDS Data Show

- The current average number of patients seen per day at SNCHC per provider is 9.2:
  - Primary care = 12.3 patients per provider per day.
  - Family Planning = 9.7 patients per provider per day.
  - Ryan White = 9.4 patients per provider per day.
  - Behavioral Health = 4.7 visits per provider per day.
  - SHC = 10.9 visits per provider per day
- The total number of unduplicated Pts = 11,500
- The total number of pt visits = 27,566
- The total number of Medicaid empaneled pts at the end of December of 2024 = 908.
- The total number of Medicaid Visits conducted in 2024 = 3,908
- The total number of patients seen in 2024 reporting being at or below 200% of the FPL = 9,203/11,500 or 80.02%.
- The total number of patients seen in 2024 who were insured by Medicaid = 2,277/11,500 or 19.8%.
- The total number of patients seen in 2024 who were uninsured = 6,088/11,500 or 52.94%.
- The total number of Mental Health Services provided in 2024 was 1,483 among 550 unduplicated patients.

Data Resources for Needs Assessment

- Health Resources and Services Administration (HRSA)
- HRSA Unmet Needs Map Tool (2025)
- Health Center GeoCare Navigator 2023 UDS Data
- U.S. Census Bureau Data (2022)
- Nevada Health Workforce Research Center (2024)
- Nevada Department of Health and Human Service's (DHHS) Division of Public and Behavioral Health (DPBH) (2022)
- SNCHC Access Data Trends (2024)
- SNCHC Preliminary 2024 UDS Data

2025 Strategic Planning

Goals, Objectives, and Activities

Goals and Objectives

DHO Goals for FQHC

1. Pursue Patient Centered Medical Home (PCMH) accreditation
2. Increase the number of unique patients served by 3%
3. Improve daily access to care (visits) by 3%
4. Optimize and expand services at the Fremont location – SHC/RW/RH
5. Improve financial stability – Increase the number of Medicaid patients served by 5%
6. Enhance integrated Behavioral Health services and optimize new clinic at Decatur
7. Build a dental clinic at Fremont and develop an operational plan
8. Maintain HRSA Compliance

FQHC Priority Docs from Strategic Planning for SNHD

1. Remove barriers to integrated service provision.
2. Financial Sustainability & Stewardship
3. Optimize Operational Efficiencies
4. Develop and Sustain Inclusive and Competent Workforce
5. Grow and share cloud-based services (HIE & Healow)
6. Accelerate Data into actionable execution

FQHC CEO and Team Goals

1. Pursue PCMH
2. Increase # of Unique Pts served by 3%
3. Increase Daily Access to Care by 3%
4. Enhance Services at Fremont (SHC/RW/RH)
5. Enhance Primary/Behavioral Health Integration and Optimize New BH Center at Decatur
6. Build Dental Clinic at Fremont/Build Operational Plan
7. Increase # of Medicaid Pts Served by 5%
8. Maintain HRSA Compliance

FQHC Priority Docs from Strategic Planning for SNHD

1. Improve Access to Care
2. Improve Quality of Care
3. Increase Financial Sustainability
4. Improve Team OVS Survey Scores

SNCHC's 2025 Strategic Goals

GOALS

1) Increase Access to services (# of unduplicated patients and visits) by 3%.
   a) Increase # of patients seen per Provider per day by 3%.
      i) Remove barriers to integrated service provision.
      ii) Optimize operational efficiencies.
   b) Optimize and expand services at the Fremont location – SHC/RW/RH/Dental.
   c) Grow and share cloud-based services (HIE, Healow, Virtual Visits).
   d) Capital Outlay Strategies for expanding access in 2025 –
      i) Build a dental clinic at Fremont and develop an operational plan.
      ii) Open and optimize integrated care workflow at BH Center at Decatur.
   e) Create and implement new external marketing and promotional practices.
      i) Collaborate with other like-minded individuals and organizations to explore and create opportunities to forge new external community partnerships.
      ii) Develop, implement, test, and launch new external marketing practices to bolster SNCHC's brand recognition in the community.

2) Improve Financial Sustainability
   a) Increase Revenue.
      i) Improve the number of Medicaid visits by 5% YOY.
   b) Improve accuracy of budgeting and revenue projections.

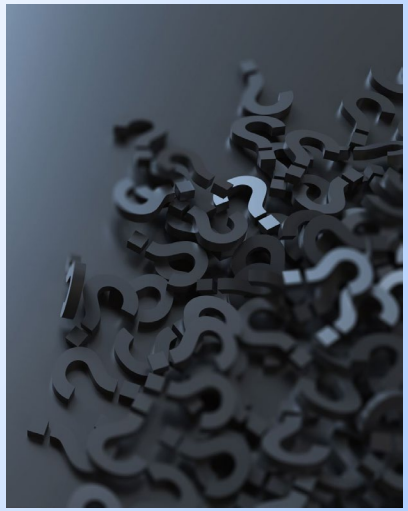
3) Improve Quality
   a) Pursue Patient Centered Medical Home (PCMH) accreditation.
   b) Maintain HRSA Compliance.
   c) Ensure/enhance IT/Cyber-security.
   d) Accelerate communication of current needs assessment, benchmark, and production data for timely decision-enhancing execution.

4) Strengthen Workforce
   a) Improve Team OVS Survey Scores.
   b) Sustain Employee Engagement Committee efforts to enhance workforce experience.
      i) Develop and Sustain Inclusive and Competent Workforce.

Questions, Suggestions, and/or Ideas?

SOUTHERN NEVADA Community HEALTH CENTER

AT THE SOUTHERN NEVADA HEALTH DISTRICT



SNCHC Governing Board

4. **Review, Discuss and Approve the Submission of HRSA Non-Competing Continuous Grant for Health Center Program - Title 10;** direct staff accordingly or take other action as deemed necessary *(for possible action)*

SOUTHERN NEVADA Community HEALTH CENTER
AT THE SOUTHERN NEVADA HEALTH DISTRICT

Noncompeting Continuation (NCC) for SNCHC's Service Area Competition (SAC) Grant

- The SAC is the federally funded grant that gives SNCHC its FQHC designation.
- The SAC is funded by the Health Resources and Services Administration (HRSA).
- The current SAC award has a three-year project period from 2/1/2024 through 1/31/2027.
  - A required grantee activity is to submit a noncompeting continuation (NCC) application each year during the three-year project period.
- The FY2025 NCC application was due on 9/6/2024 but was successfully submitted through HRSA's EHB on 8/20/2024.
  - The FY2025 NCC application submitted was for year two of the three-year grant with a project period of 2/1/2025 through 1/31/2026.
- The amount of the funding for year two was initially $966,000, however, on 11/13/2024 HRSA reached out to request a new budget to reflect an increase in our funding to $1,023,114.
- HRSA approved SNCHC's Health Center NCC application and provided a new Notice of Award on 12/12/2024.

Noncompeting Continuation (NCC) for SNCHC's Title X Federal Grant (Family Planning)

- The Title X Grant is the federally funded award that allows SNCHC to offer family planning services.
- The Title X grant is funded by the U.S. Department of Health and Human Services/Office of the Assistant Secretary for Health/Office of Population Affairs (HHS OASH/OPA).
- The current Title X grant has a five-year project period from 4/1/2022 through 3/31/2027.
  - A required grantee activity is to submit a noncompeting continuation (NCC) application each year during the five-year project period.
- The NCC application was due on 1/6/2025 but was successfully submitted through OPA's GrantSolutions website on 12/31/2024.
  - The NCC application submitted was for year four of the five-year grant with a project period of 4/1/2025 through 3/31/2026.
- The amount of the funding for year four is $1,400,000.
- OPA approval of the NCC application is pending.

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

SOUTHERN NEVADA Community HEALTH CENTER
AT THE SOUTHERN NEVADA HEALTH DISTRICT

SOUTHERN NEVADA Community HEALTH CENTER

AT THE SOUTHERN NEVADA HEALTH DISTRICT

Financial Report
Results as of November 30, 2024

(Unaudited)

Summary of Revenue, Expenses and Net Position (November 30, 2024 – Unaudited)

Revenue

- General Fund revenue (Charges for Services & Other) is $13.85M compared to a budget of $11.72M, a favorable variance of $2.13M.
- Special Revenue Funds (Grants) is $2.69M compared to a budget of $3.28M, an unfavorable variance of $590K.
- Total Revenue is $16.54M compared to a budget of $15.00M, a favorable variance of $1.54M.

Expenses

- Salary, Tax, and Benefits is $5.63M compared to a budget of $5.72M, a favorable variance of $90K.
- Other Operating Expense is $11.59M compared to a budget of $10.10M, an unfavorable variance of $1.49M.
- Indirect Cost/Cost Allocation is $3.27M compared to a budget of $3.20M, an unfavorable variance of $70K.
- Total Expense is $20.50M compared to a budget of $19.01M, an unfavorable variance of $1.49M.

Net Position: is ($3.96M) compared to a budget of ($4.01M), a favorable variance of $50K.

All Funds/Divisions by Type

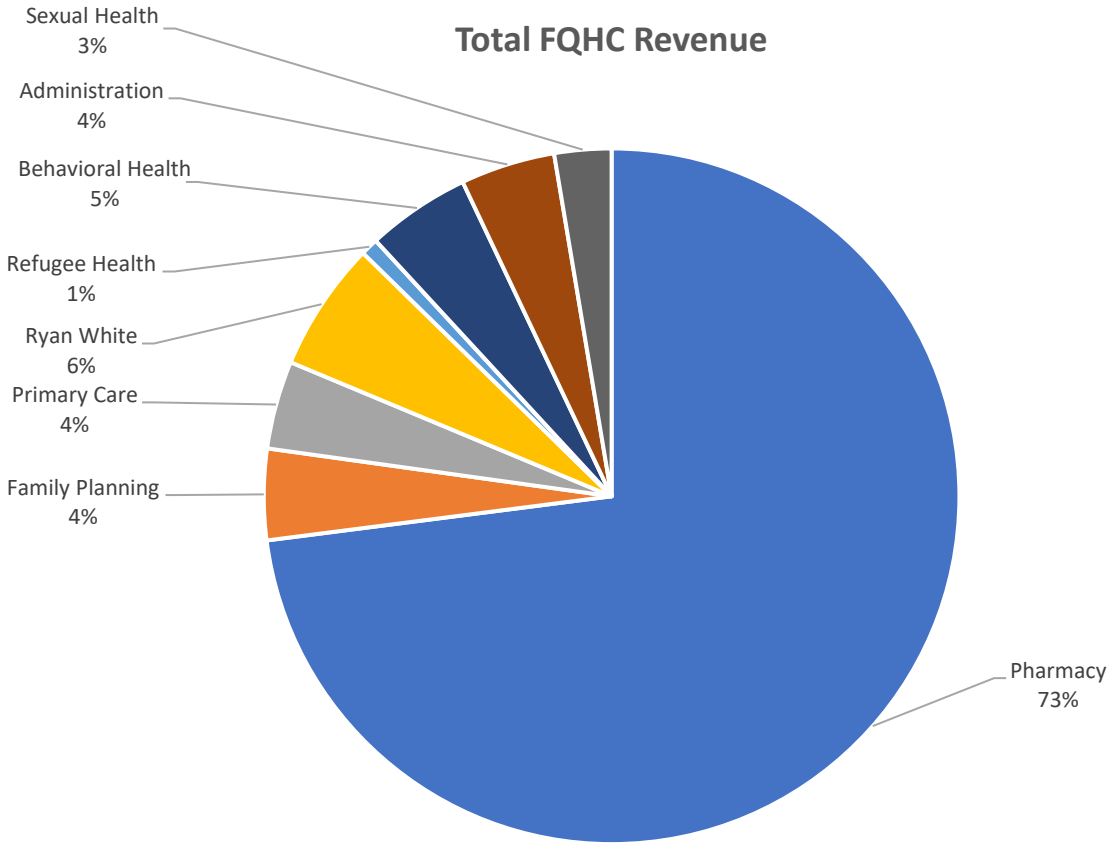
Budget to Actual

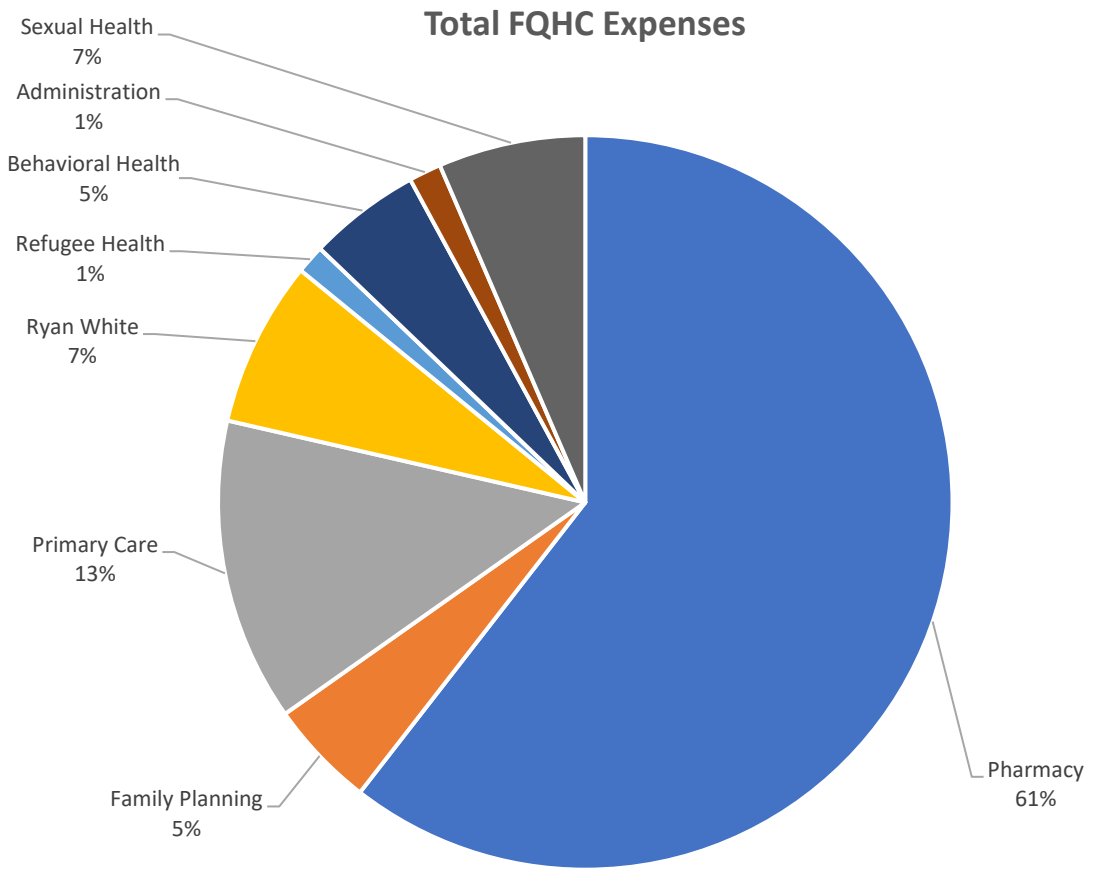
Activity	Budget as of November	Actual as of November	Variance Favorable (Unfavorable)	%	
Charges for Services	11,263,205	13,116,913	1,853,708	16%	1
Other	461,112	726,585	265,473	58%	2
Federal Revenue	1,232,992	1,474,107	241,115	20%	3
Pass-Thru Revenue	1,515,964	961,764	(554,200)	-37%	
State Revenue	529,756	258,321	(271,436)	-51%	
Total FQHC Revenue	**15,003,028**	**16,537,689**	**1,534,660**	**10%**	
Salaries	3,921,614	3,904,472	17,142	0%	
Taxes & Fringe Benefits	1,798,219	1,729,118	69,101	4%	
Total Salaries & Benefits	**5,719,833**	**5,633,590**	**86,243**	**2%**	
Supplies	9,050,962	10,450,104	(1,399,142)	-15%	4
Capital Outlay	380,043	608,318	(228,276)	-60%	5
Contractual	635,121	513,033	122,088	19%	
Travel & Training	27,559	23,443	4,116	15%	
Total Other Operating	**10,093,685**	**11,594,899**	**(1,501,214)**	**-15%**	
Indirect Costs/Cost Allocations	3,195,105	3,267,483	(72,378)	-2%	
Transfers IN	(294,599)	(309,432)	14,833	-5%	
Transfers OUT	294,599	309,432	(14,833)	-5%	
Total Transfers	**3,195,105**	**3,267,483**	**(72,378)**	**-2%**	
Total FQHC Expenses	**19,008,623**	**20,495,972**	**(1,487,349)**	**-8%**	
Net Position	**(4,005,595)**	**(3,958,283)**	**47,312**	**-1%**	

NOTES:

1) PHARMACY PATIENT ENCOUNTERS DRIVING MAJORITY OF GROWTH; PATIENT ENCOUNTERS CONTINUE YEAR-OVER-YEAR GROWTH ACROSS FQHC ESPECIALLY WITH ADDITION OF PHARMACY AT FREMONT CLINIC.
2) WRAP REVENUE REIMBURSEMENTS ARE CONTINUING TO OUTPACE PROJECTIONS IN FY25.
3) DRIVEN BY $592K IN REIMBURSEMENTS FOR BEHAVIORAL HEALTH CLINIC CAPITAL EXPENSES THROUGH NOVEMBER 2024.
4) PHARMACY PATIENT ENCOUNTERS DRIVING CORRESPONDING INCREASE IN MEDICATION SUPPLIES EXPENSES PLUS ADDITIONAL PURCHASES FOR SECOND PHARMACY LOCATION AT FREMONT CLINIC.
5) CAPITAL EXPENSES ASSOCIATED WITH CONSTRUCTION OF NEW BEHAVIORAL HEALTH CLINIC ($592K THROUGH NOVEMBER 2024).

Percentage of Revenues and Expenses by Department





Revenues by Department
Budget to Actuals

Department	Budget as of November	Actual as of November	Variance Favorable (Unfavorable)	%	
Charges for Services, Other, Wrap					
Family Planning	166,099	93,046	(73,053)	-44%	
Pharmacy	10,311,193	12,067,996	1,756,803	17%	1
Oral Health (Dental)	-	-	-	0%	2
Primary Care	210,845	240,075	29,229	14%	
Ryan White	115,210	105,317	(9,893)	-9%	
Refugee Health	22,570	64,793	42,224	187%	
Behavioral Health	114,916	107,715	(7,201)	-6%	
Administration	458,815	726,585	267,770	58%	3
Sexual Health	324,668	437,991	113,322	35%	
OPERATING REVENUE	**11,724,317**	**13,843,518**	**2,119,201**	**18%**	
Grants					
Family Planning	883,787	606,296	(277,491)	-31%	
Oral Health (Dental)	457,439	-	(457,439)	-100%	2
Primary Care	421,522	437,179	15,657	4%	
Ryan White	1,083,267	891,879	(191,388)	-18%	
Refugee Health	94,462	69,885	(24,576)	-26%	
Behavioral Health	338,235	688,952	350,716	104%	4
SPECIAL REVENUE	**3,278,712**	**2,694,191**	**(584,521)**	**-18%**	
TOTAL REVENUE	**15,003,028**	**16,537,709**	**1,534,680**	**10%**	

NOTES:
1) PATIENT ENCOUNTERS CONTINUE YEAR-OVER-YEAR GROWTH ACROSS FQHC ESPECIALLY WITH ADDITION OF PHARMACY AT FREMONT CLINIC.
2) DENTAL CLINIC PLANNED OPENING IN Q4 FY25.
3) WRAP REVENUE REIMBURSEMENTS ARE CONTINUING TO OUTPACE PROJECTIONS IN FY25.
4) INCLUDES PAYMENT FOR GRANT-FUNDED REIMBURSEMENTS FOR BEHAVIORAL HEALTH CLINIC CAPITAL EXPENSES ($592K THROUGH NOVEMBER 2024).

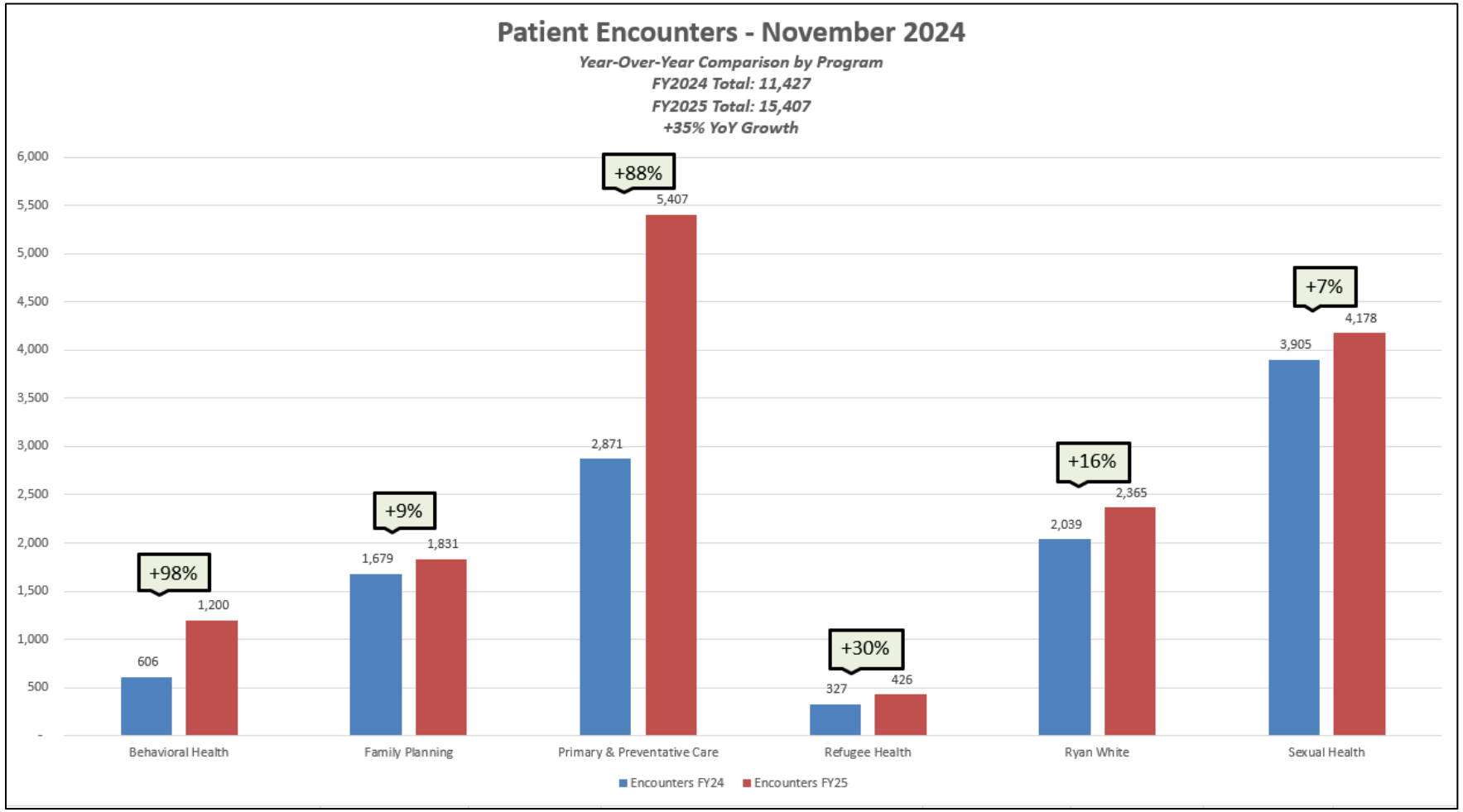
Expenses by Department

Budget to Actuals

Department	Budget as of November	Actual as of November	Variance Favorable (Unfavorable)	%	
Employment (Salaries, Taxes, Fringe)					
Family Planning	963,265	694,364	268,901	28%	
Pharmacy	227,525	252,741	(25,215)	-11%	
Oral Health (Dental)	47,248	-	47,248	100%	1
Primary Care	1,913,712	2,131,467	(217,755)	-11%	
Ryan White	1,127,393	1,124,470	2,923	0%	
Refugee Health	77,449	92,868	(15,419)	-20%	
Behavioral Health	207,789	255,919	(48,131)	-23%	
Administration	48,800	60,973	(12,173)	-25%	
Sexual Health	1,106,652	1,020,788	85,864	8%	
Total Personnel Costs	5,719,833	5,633,590	86,243	2%	
Other (Supplies, Contractual, Capital, etc.)					
Family Planning	351,026	118,577	232,449	66%	
Pharmacy	8,480,575	10,167,648	(1,687,074)	-20%	2
Oral Health (Dental)	333,952	-	333,952	100%	1
Primary Care	123,528	175,581	(52,053)	-42%	
Ryan White	158,328	133,937	24,391	15%	
Refugee Health	55,827	124,592	(68,765)	-123%	
Behavioral Health	248,869	595,053	(346,184)	-139%	3
Administration	235,904	184,000	51,904	22%	
Sexual Health	105,677	95,510	10,167	10%	
Total Other Expenses	10,093,685	11,594,899	(1,501,214)	-15%	
Total Operating Expenses	**15,813,518**	**17,228,489**	**(1,414,971)**	**-9%**	
Indirect Costs/Cost Allocations	3,195,105	3,267,483	(72,378)	-2%	
Transfers IN	(294,599)	(309,432)	14,833	-5%	
Transfers OUT	294,599	309,432	(14,833)	-5%	
Total Transfers & Allocations	3,195,105	3,267,483	(72,378)	-2%	
TOTAL EXPENSES	**19,008,623**	**20,495,972**	**(1,487,349)**	**-8%**	

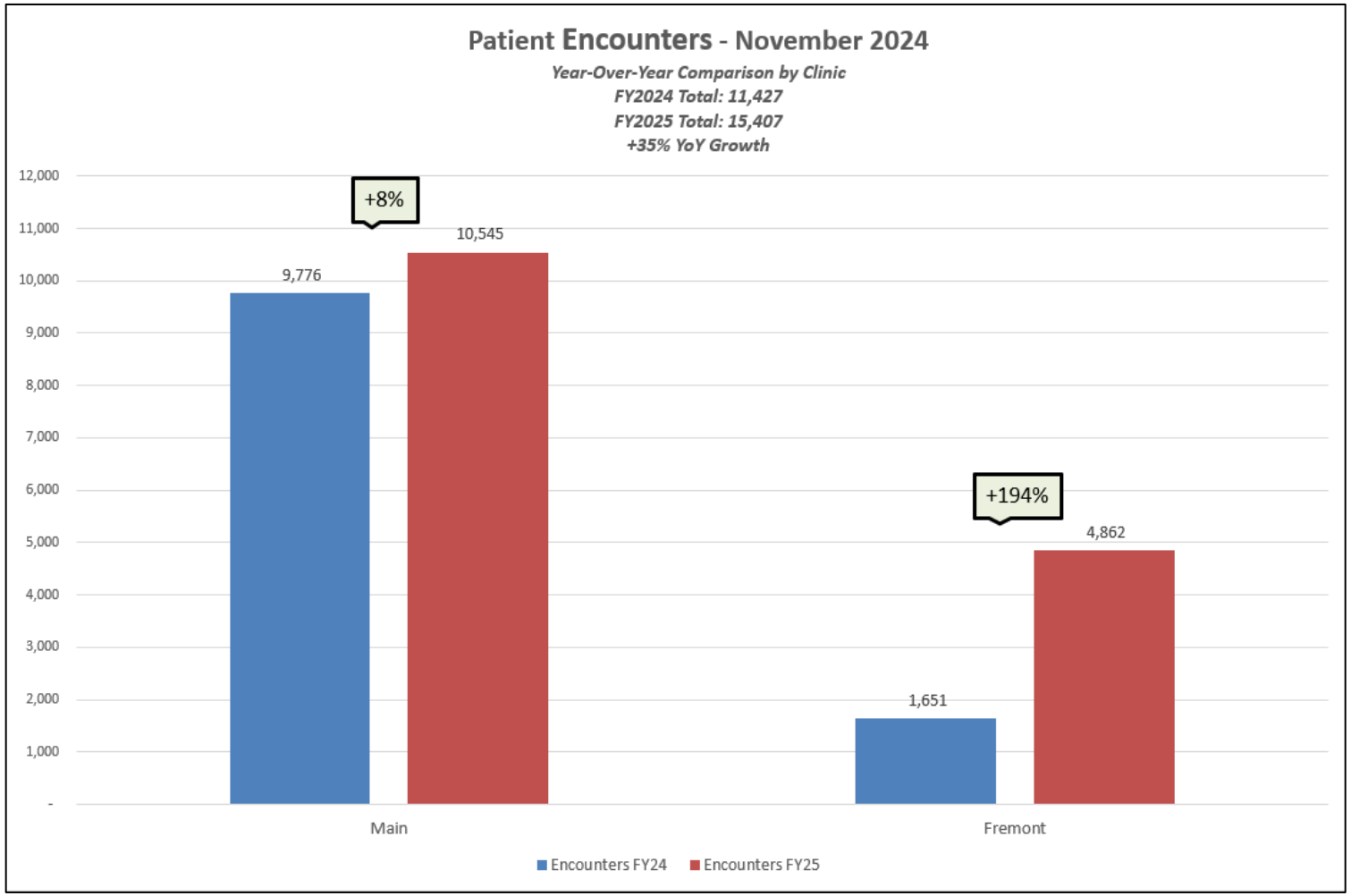
NOTES:
1) DENTAL CLINIC PLANNED OPENING IN Q4 FY25.
2) PHARMACY PATIENT ENCOUNTERS DRIVING CORRESPONDING INCREASE IN MEDICATION SUPPLIES EXPENSES PLUS ADDITIONAL PURCHASES FOR SECOND PHARMACY LOCATION AT FREMONT CLINIC.
3) CAPITAL EXPENSES ASSOCIATED WITH CONSTRUCTION OF NEW BEHAVIORAL HEALTH CLINIC ($592K THROUGH NOVEMBER 2024).

Patient Encounters By Department



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

Patient Encounters By Clinic



Financial Report Categorization

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

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

Additional Visualizations

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

YTD by Month – November 30, 2024

By Department

Southern Nevada Community Health Center

Year-to-Date Revenues/Expenses by Department

Fiscal Year 2025 as of November 30, 2024

DEPARTMENT	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	YTD TOTALS	YTD AVERAGES
Administration (301)	122,752	125,348	118,972	120,830	102,739	726,585	118,128
Family Planning (309)	91,661	148,951	135,840	157,890	215,430	749,772	149,954
Pharmacy (333)	2,383,597	2,574,661	2,339,657	2,454,031	2,316,050	12,067,996	2,413,599
Dental Health (336)	-	-	-	-	-	-	-
Primary Care (337)	144,427	157,797	134,070	141,115	247,717	825,126	165,025
Ryan White (338)	177,359	210,374	250,019	216,541	263,422	1,117,715	223,543
Refugee Health (344)	28,153	9,890	11,929	23,025	42,134	115,131	23,026
Behavioral Health (345)	280,629	337,075	78,806	45,553	64,743	806,805	161,361
Sexual Health (350)	101,840	76,971	77,277	102,402	79,500	437,991	87,598
TOTAL REVENUES	**3,330,418**	**3,641,067**	**3,146,570**	**3,261,387**	**3,331,736**	**16,847,121**	**3,342,235**

DEPARTMENT	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	YTD TOTALS	YTD AVERAGES
Administration (301)	37,218	73,998	67,276	42,945	70,971	292,408	58,482
Family Planning (309)	130,361	180,167	163,917	191,449	348,427	1,014,321	202,864
Pharmacy (333)	2,995,246	2,292,351	2,692,359	1,881,673	2,595,525	12,457,153	2,491,431
Dental Health (336)	-	-	-	-	-	-	-
Primary Care (337)	442,767	610,833	531,333	509,600	896,366	2,990,899	598,180
Ryan White (338)	224,923	320,915	281,139	270,657	489,638	1,587,273	317,455
Refugee Health (344)	59,154	(5,281)	5,096	88,306	82,220	229,495	45,899
Behavioral Health (345)	278,625	389,717	90,104	55,852	94,900	909,199	181,840
Sexual Health (350)	189,325	249,162	241,255	248,806	396,107	1,324,656	264,931
TOTAL EXPENSES	**4,357,619**	**4,111,863**	**4,072,480**	**3,289,287**	**4,974,155**	**20,805,403**	**4,161,081**

NET POSITION:	(1,027,201)	(470,796)	(925,909)	(27,900)	(1,642,420)	(3,958,283)	(818,845)

YTD by Month – November 30, 2024

By Type

Southern Nevada Community Health Center

Year-to-Date Revenues/Expenses by Type

Fiscal Year 2025 as of November 30, 2024

REVENUE TYPE	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	YTD TOTALS	YTD AVERAGES
Charges for Services	2,599,053	2,736,809	2,537,814	2,706,173	2,537,044	13,116,893	1,093,074
Other	122,752	125,348	118,972	120,830	102,739	726,585	60,549
Contributions	-	-	-	20	-	20	2
Intergovernmental	533,730	689,780	450,756	399,849	620,076	2,694,191	224,516
TOTAL REVENUES	**3,255,536**	**3,551,937**	**3,107,543**	**3,226,872**	**3,259,858**	**16,537,689**	**3,280,349**
EXPENSE TYPE	**Jul-24**	**Aug-24**	**Sep-24**	**Oct-24**	**Nov-24**	**YTD TOTALS**	**YTD AVERAGES**
Salaries	485,229	707,618	685,316	697,394	1,328,915	3,904,472	780,894
Taxes and Benefits	223,019	316,343	312,100	320,374	557,282	1,729,118	345,824
Travel and Training	280	4,192	5,219	9,813	3,939	23,443	4,689
Supplies	2,518,508	1,890,853	2,242,689	1,605,394	2,192,659	10,450,104	2,090,021
Contractual	119,166	122,427	96,763	103,521	71,157	513,033	102,607
Property	248,000	327,602	32,716	-	-	608,318	121,664
TOTAL EXPENSES	**3,594,204**	**3,369,035**	**3,374,803**	**2,736,495**	**4,153,952**	**17,228,489**	**3,445,698**
TRANSFER TYPE	**Jul-24**	**Aug-24**	**Sep-24**	**Oct-24**	**Nov-24**	**YTD TOTALS**	**YTD AVERAGES**
Indirect/Cost Allocation	688,533	653,698	658,649	518,277	748,326	3,267,483	653,497
Transfer In	(74,882)	(89,130)	(39,028)	(34,515)	(71,877)	(309,432)	(61,886)
Transfer Out	74,882	89,130	39,028	34,515	71,877	309,432	61,886
TOTAL TRANSFERS	**688,533**	**653,698**	**658,649**	**518,277**	**748,326**	**3,267,483**	**653,497**
NET POSITION:	(1,027,201)	(470,796)	(925,909)	(27,900)	(1,642,420)	(3,958,283)	(818,845)

Questions?

6. **Review, Discuss and Approve the Quality Management Plan;** direct staff accordingly or take other action as deemed necessary *(for possible action)*

SOUTHERN NEVADA Community HEALTH CENTER
AT THE SOUTHERN NEVADA HEALTH DISTRICT

Southern Nevada Community Health Center Quality Management Plan

I. PURPOSE

As part of the Southern Nevada Community Health Center's (SNCHC) dedication to providing quality care, the health center has implemented a Quality Management Program, a systematic, organization-wide approach to providing high quality care and service to clients. Through this systematic approach, the Quality Management Program provides a mechanism to constantly survey the performance of SNCHC and provides opportunities to improve performance levels.

II. SCOPE

SNCHC's Quality Management Program is outlined in its Quality Management Plan (QMP). The Plan's scope involves the physicians, mid-level providers, nurses, allied health disciplines, administrators, managers, and staff that provide or support the provision of care to underserved individuals of our community. The program focuses on improving key organizational functions within SNCHC, and is aligned with HRSA's BPHC Program Expectations, the NCQA Patient-Centered Medical Home (PCMH) standards, and appropriate guidelines of the Federal Tort Claims Act (FTCA).

Southern Nevada Community Health Center Quality Management Plan

IV. GOALS AND OBJECTIVES

The goal of the plan is to increase the value of services by enhancing clinical quality, the patient's experience, and access to care while strengthening the ability of SNCHC to deliver sustainable cost-effective care.

Objectives

A. To design and implement effective processes to meet the needs of patients in a manner consistent with the health center's mission, vision, values, and strategic goals.

B. To promote and implement evidenced based care that addresses health equity and disparities in the communities served by SNCHC.

C. To collect and use data to monitor the stability of exiting processes, identify opportunities for improvement, identify strategies that will lead to desired improvement, and evaluate the effectiveness of programs.

D. To aggregate and analyze data on an ongoing basis and to evaluate tactics that will lead to improved clinical effectiveness and operation efficiency.

E. To implement systems and processes that will reduces and/or mitigate errors.

F. To promote and foster collaboration and a culture focused on quality improvement and risk mitigation at all levels of the organization.

G. To educate leaders and staff regarding continuous quality improvement and increase participation in performance improvement activities.

IX. CEO COMMENTS & STAFF REPORTS

RANDY SMITH, CHIEF EXECUTIVE OFFICER - FQHC

SOUTHERN NEVADA Community HEALTH CENTER
AT THE SOUTHERN NEVADA HEALTH DISTRICT

Administrative Updates

- HRSA UDS annual report due 2/15/24
- HRSA FPAR 2.0 annual report due 2/28/25
- Dr. Robin Carter hired as SNCHC's New Medical Director: Starts 2/3/25
- Behavioral Health Clinic at Decatur Open House: 1/14/25
- HRSA Behavioral Health Technical Assistance engagement in March 2025
- HRSA Family Planning Title X site visit: September 2025

HRSA Operational Site Visit

- 3-day onsite visits: February 25th – 27th
- Pre-visit phone call with health center leadership on January 28th
- Documents uploaded by February 11th
- Entrance Conference @ 9am on February 25th – Board participation opportunity
- Exit Conference on February 27th, time to be determined – Board participation opportunity
- Wednesday, February 26th @ 12pm – Board member only session
  - **It is very important for *all available* Board members to attend and actively participate in this meeting**

Southern Nevada Community Health Center
Strategic Planning Committee Charter
(As approved by the Governing Board on Month/Date/Year)

Committee Purpose:
The Strategic Planning Committee assists the board with its responsibilities for Southern Nevada Community Health Center's (SNCHC) mission, vision, values and strategic direction.

Scope of Duties and Responsibilities:
The specific responsibilities of the Strategic Planning Committee include:

1. Making recommendations to the full board related to the organization's mission, vision, values, strategic initiatives, major programs and services.
2. Helping management identify critical community needs and strategic issues facing the organization, assisting in analysis of strategic options.
3. Ensuring management has established an effective strategic planning process, including the development of a three-to-five-year strategic plan with time bound measurable goals.
4. Periodically reviewing the mission, vision, values and strategic plan, and recommending changes to the board.
5. Annually reviewing the strategic plan and recommending updates as needed based on changes in the market, community needs, and other factors.
6. Assisting in developing a strategic dashboard of key indicators.
7. Monitoring the organization's performance against measurable targets.

Composition:
The Committee shall be comprised of at least three Board members. In addition, the Chief Executive Officer, and FQHC Administrative Manager, will be subject matter Committee members. The Committee shall determine whether members should undergo any initial or annual training to help them fulfill their Committee responsibilities. The members of the Committee shall serve at the pleasure of the Board.

Meetings:
The Committee shall meet two (2) times per year and as deemed necessary to carry out its responsibilities. Meetings may be called by the Chairman of the Committee or any two members thereof. Meetings shall be held at such time and place as may be specified in the notice of meeting. Meetings will be held and posted consistent with Nevada's Open Meeting Law.

Voting and Quorum:
Voting on Committee matters shall be on a one vote per member basis. At all meetings, a majority of the total number of voting members of the Committee shall constitute a quorum for the transaction of business, and the act of a majority of the members

present at any meeting at which there is a quorum shall constitute the Committee's action or decision.

Committee members who are Community Health Center or Health District staff shall be ex-officio non-voting members. Board members who are not also Committee members may attend Committee meetings but may not vote.

Reports:
All actions authorized or taken by the Committee shall be reported to the Board no later than the next succeeding meeting of the Board.

SNCHC 2025 Strategic Plan

Strategic Framework

Mission Vision Values

Strategic Framework Consists of:

- **Mission Statement** – our purpose for existing
- **Vision Statement** – where we are going
- **Values** – How we intend to conduct our work to fulfill our purpose and get where we are going.

Current Mission, Vision, and Values

Mission

The mission of the Southern Nevada Community Health Center (SNCHC) is to serve residents of the 89107 ZIP code area in addition to Clark County residents from other underserved areas with appropriate and comprehensive outpatient health and wellness, emphasizing prevention and education in a culturally respectful environment.

Vision

It is the Southern Nevada Community Health Center's vision to contribute to the development of healthy communities in which health disparities are diminished and there is access to health care for all.

Values

- Delivering quality care with dignity, equality, sensitivity, professionalism and respect.
- Maintaining high ethical and professional standards.
- Being a culturally competent organization.
- Practicing continuous quality improvement.
- Operating cost effectively and efficiently.
- Providing a work environment conducive to positive attitudes, personal satisfaction and growth.
- Incorporating leadership principles at every level of the Community Health Center.

Proposed Mission, Vision, and Values

Mission

To provide patient-centered primary health care services to the underserved community with an emphasis on integrated, high-quality, and affordable care in a culturally respectful environment.

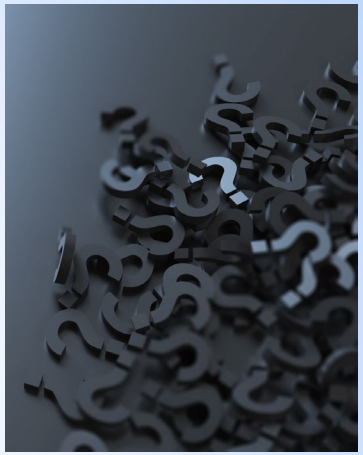
Vision

Reducing health disparities in the community by empowering patients to achieve their best possible health through equitable access to comprehensive care.

Values

- Commitment
- Accountability
- Respect
- Excellence
- Service

Questions Suggestions, and/or Ideas?



SOUTHERN NEVADA Community HEALTH CENTER

AT THE SOUTHERN NEVADA HEALTH DISTRICT

Needs Assessment Considerations:

The following needs assessment data supports the strategic plan for 2025:

According to the Health Resources and Services Administration, the Clark County Health Professional Shortage Area (HPSA) scores are:

- The Primary Care HPSA is 21/25.
- The Mental Health HPSA is 20/25.
- The Dental HPSA score is 17/26.

According to the Unmet Needs Score Map Tool:

- 19 ZCTAs in the metro Las Vegas area of Clark County have an unmet needs score between 81-100
- 17 ZCTAs in the metro Las Vegas area of Clark County have an unmet needs score of 61-80.

According to the Nevada Health Workforce Research Center, the 2024 Clark County Health Rankings state:

- 14.4 % of Clark County, Nevada residents under the age of 65 are uninsured,
- There are 242,743 uninsured residents that are not served by health centers.
- The ratio of population to primary care physicians is 1,831:1.
- The ratio of population to other primary care providers is 919:1.
- The ratio of population to dentists is 1,495:1.
- The ratio of population to mental health providers is 417:1

According to the Health Center Program GeoCare Navigator's 2023 UDS Data for the ZIP Code Tabulation Area's (ZCTA) where current SNCHC patients reside in Clark County, NV:

- There are 2,196,524 residents in the identified area.
- There are 704,111 (32.06%) residents experiencing low income.
- Only 8.61% of the residents experiencing low income (60,624) are utilizing available health center services, meaning
- There are 643,487 low-income residents who have not found access to a health center for services yet.

According to the 2022 US Census Bureau data, 12.9% of Clark County, Nevada lives in poverty.

According to the Nevada Department of Health and Human Services Division of Public and Behavioral Health:

- Nevada ranks 42nd in the nation on a variety of health indicators.
- There are 52,644 families in Clark County, Nevada living below poverty.
- The top three regional health priorities for Clark County, NV are:
    - Access to Care
    - Mental Health
    - Substance Use

SNCHC Access Data Trends Show

- The current average number of patients seen per day at SNCHC per provider is 9.2:
    - Primary care = 12.3 patients per provider per day.
    - Family Planning = 9.7 patients per provider per day.
    - Ryan White = 9.4 patients per provider per day.
    - Behavioral Health = 4.7 visits per provider per day.
    - SHC = 10.9 visits per provider per day.

2024 SNCHC UDS Data Show

- The total number of unduplicated Pts = 11,500
- The total number of pt visits = 27,566
- The total number of Medicaid empaneled pts at the end of December of 2024 = 908.
- The total number of Medicaid Visits conducted in 2024 = 3,908
- The total number of patients seen in 2024 reporting being at or below 200% of the FPL = 9,203/11,500 or 80.02%.
- The total number of patients seen in 2024 who were insured by Medicaid = 2,277/11,500 or 19.8%.
- The total number of patients seen in 2024 who were uninsured = 6,088/11,500 or 52.94%.
- The total number of Mental Health Services provided in 2024 was 1,483 among 550 unduplicated patients.

Goal 1: Increase Access to services (number of unduplicated patients seen and visits conducted) by 3%.

Objectives:

a) *Increase # of patients seen per Provider per day by 3%.*
b) *Optimize and expand services at the Fremont location – SHC/RW/RH/Dental.*
c) *Grow and share cloud-based services (HIE, Healow, Virtual Visits).*
d) *Capital Outlay Strategies for expanding access in 2025 – Dental and BH Center Buildout and service lines.*

Goal 1 – Objective A: Increase # of patients seen and visits conducted by 3% YOY.				
Activity	Specific Activities	Person(s) Responsible	Benchmark / Measure / Timeline	Update/Progress
1. Remove barriers to integrated service provision and optimize the operational efficiencies to maximize access to services.	a. Create/implement/and leverage internal marketing opportunities to appropriately increase the number of internal integrated care referrals. b. Create/implement/and leverage internal marketing opportunities to become the medical home for patients receiving SNHD services but are not yet primary care patients. (Immunizations, TB, Refugee, & SHC) c. Optimize number of patient visits scheduled to increase the quantity of patient visits conducted per provider per day. d. Reduce no show rate/maximize access on patient schedule. e. Use quality improvement, personnel, and technology resources to optimize access to care. f. Increase the number of Medicaid empaneled patients assigned to SNCHC providers by 5%. ○ Covered in Goal 2, Objective A, Activity 1.	CEO, Ops Managers, Admin Manager, Admin Analyst, QMC, Billing Manager, Pharmacy Manager, BH Manager, SHC Manager, Medical Director, and other divisional teams.	2025 Unduplicated Pt Count for CY 2025 goal = 11,845, which reflects a growth of 3% YOY. CY 2025 Pt visit count goal = 28,393, which reflects a growth of 3% YOY.	

Goal 1 – Objective B: Optimize and expand services at the Fremont location – SHC/RW/RH/Dental				
Activity	Specific Activities	Person(s) Responsible	Benchmark / Measure / Timeline	Update/Progress
1. Collaborate with SHC, Dental Consultant / Dentist, and BH Manager to optimize operational workflows and procedures.	a. Ensure the IT/Cyber-security, and EMR functionality is conducive to appropriately documenting in patient charts, billing for services, and tracking statistical progress and results. b. Ensure all necessary credentialing is completed for new service lines, to ensure services are reimbursable. c. Continue meeting regularly with billing for revenue cycle collaboration and optimization of credentialing process and needs. d. Create/implement/and leverage internal marketing opportunities to appropriately increase the number of internal integrated care referrals. e. Create/implement/and leverage external marketing opportunities get the word out about the new service lines. f. Create and implement a work plan for each new service line with the help of SMEs and test workflows with team.	CEO, Ops Managers, Admin Manager, Admin Analyst, QMC, Revenue Cycle Manager, Pharmacy Manager, BH Manager, SHC Manager, Medical Director, Dental Consultant, Chief Information Officer, Informatics Scientist, Informatics Supervisor, AZARA Help Desk, IT Manager, eCW help desk	Establish method of tracking and reporting site specific UDS data through AZARA by end of March 2025. Verify that all credentialing is complete or at least underway prior to services being provided. All should be completed by September 2025. Draft workplans for each new service line with the expertise of collaborators and feedback from staff by May 2025. Implement new workflows by end of June 2025.	

Goal 1 – Objective C: Grow and share cloud-based services e.g., HIE, Healow, Virtual Visits.				
Activity	Specific Activities	Person(s) Responsible	Benchmark / Measure / Timeline	Update/Progress
1. Research, identify, create, implement, and test workflows and opportunities to increase patient and team utilization and efficiency of cloud-based services, care	a. Verify ongoing IT/Cyber-security, and EMR functionality is conducive to appropriately conducting patient-interfacing activities through HIPAA compliant practices. b. Research, identify, create, implement, and test workflows to conduct interfacing communication with the patients in between visits, and to ensure timely action is taken on communication when a message is sent or received to or from patients, or referred providers.	Chief Information Officer, Informatics Scientist, Informatics Supervisor, AZARA Help Desk, IT Manager, eCW help desk, Admin Supervisor, QMC, Admin Manager,	Create a regular IT check-in meeting to review any potential or past issues. Close 50% of the number of empaneled-patient care gaps identified by insurance companies by the end of the year.	

coordination, and other virtual activities, such as the Health Information Exchange, Healow, Insurance Portals, and Virtual Visits.	c. Research, identify, create, implement, and test workflows to conduct pre-visit planning that includes use of AZARA, HIE, care coordination with other providers, test results, insurance portal or other quality care gap data, and internal care integration. d. Research, identify, create, implement, and test workflows to support growth in the number of virtual visits, especially for medication refill appointments and other simple follow up visits. e. Create/implement/and leverage internal and external marketing opportunities get the word out about the technological services provided.	Admin Analyst, Operations Managers, Medical Director	Increase number of virtual visits by 5%. Goal = 2,756 Create an internal/external workflow to market/promote technological support systems and processes to existing and potential patients.	

Goal 1 – Objective D: Capital Outlay Strategies for expanding access in 2025 – Buildout and Optimize Dental and BH Center service lines.

Activity	Specific Activities	Person(s) Responsible	Benchmark / Measure / Timeline	Update/Progress
1. Build a dental clinic at Fremont and develop an operational plan.	a. Engage Chief Facilities Officer on architect, construction, and buildout plans. b. Work with appropriate SNHD team members and Dental Consultant/Dentist to organize the layout design, operational workflow, timeline, budget, EMR, Billing credentialing, and IT setup needed to operate the dental clinic. c. Research, identify, create, implement, and test workflows to provide integrated dental services. d. Track progress with regular meetings. e. Create/implement/and leverage internal and external marketing opportunities get the word out about the dental clinic. f. Facilitate the Dental PPS rate process with Nevada State Medicaid.	Chief Facilities Officer, Facilities Manager, Chief Information Officer, Informatics Scientist, Informatics Supervisor, AZARA Help Desk, IT Manager, eCW help desk, FQHC CEO, Dental Consultant / Dentist, Admin Supervisor, QMC, Admin Manager, Admin Analyst, Operations Managers, Medical Director, Revenue Cycle Manager	Set up regular meetings to collaborate and follow up on progress of project. Complete buildout and operationalization of Dental clinic at Fremont by June 30, 2025, for service provision beginning July 1, 2025. Develop an internal/external marketing program to promote upcoming dental services. Deploy the marketing program in the neighborhood and inside all FQHC clinics one month prior to opening.	

2. Open and optimize integrated care workflow at BH Center at Decatur.	a. Increase number of unduplicated patients and services provided by 5% YOY. b. Test and refine workflows to provide integrate mental/behavioral health services. c. Track progress with regular meetings. a. Create/implement/and leverage internal and external marketing opportunities get the word out about Behavioral Health Center.	FQHC CEO, Admin Supervisor, QMC, Admin Manager, Admin Analyst, Operations Managers, Medical Director, BH Manager	Increase the number of unduplicated patients who received mental health services at SNCHC YOY by 5%. 2025 CY Goal = 578 Increase the number of mental health services provided at SNCHC YOY by 5%. 2025 CY Goal = 1,558	

Goal 1 – Objective E: Create and implement new external marketing and promotional practices.

Activity	Specific Activities	Person(s) Responsible	Benchmark / Measure / Timeline	Update/Progress
1. Collaborate with other like-minded individuals and organizations to explore and create opportunities to forge new external community partnerships.	a. Research and identify other like-minded organizations that serve the same target population as SNCHC and facilitate a working relationship. b. Establish new MOU/MOAs and other partnerships to provide more access to services and broaden SNCHC's reach in the community. ○ Establish a method of exchanging medical records, results, and reports for improved care coordination. c. Track referrals to existing and new community partners to monitor activity and trends. d. Enhance insurance company relations, partnerships, and empanelment.	Board Members, CEO, Chief Information Officer, Informatics Scientist, Informatics Supervisor, AZARA Help Desk, IT Manager, eCW help desk, Admin Supervisor, QMC, Admin Manager, Admin Analyst, Operations Managers, Medical Director, Contracts department, procurement department	Identify three new potential community partners by the end of the year. Create a community partnership with one new partner by the end of the year. Aim to have more than 67% of referred patients have reports/results/progress notes for referred services. Increase frequency of insurance meetings to monthly with more than just Medicaid orgs.	

2. Develop, implement, test, and launch new external marketing practices to bolster SNCHC's brand recognition in the community.	a. Research, identify, create, implement, and test workflows to and launch new external marketing practices to bolster SNCHC's brand recognition in the community b. Discover affordable options to promote SNCHC through media, word of mouth, external provider referrals, and partnerships.	Board Members, CEO, Chief Information Officer, Informatics Scientist, Informatics Supervisor, AZARA Help Desk, IT Manager, eCW help desk, Admin Supervisor, QMC, Admin Manager, Admin Analyst, Operations Managers, Medical Director, Contracts department, procurement department, Communications Department	Create and implement an external marketing/promotional program to bolster community awareness of SNCHC and its services by end of calendar year.	

Goal 2: Improve Financial Sustainability.

Objectives:

a) Increase Revenue.

b) Improve accuracy of budgeting and revenue projections.

Goal 2 – Objective A: Increase Revenue.				
Activity	Specific Activities	Person(s) Responsible	Benchmark / Measure / Timeline	Update/Progress
1. Improve financial stability of payor mix by increasing the number of Medicaid patient visits by 5%.	a. Build trust with Medicaid insurance organizations. ○ Work with insurance provider representatives to develop a working collaborative relationship. ○ Work with QMC/QWG and clinical teams to optimize the quality P4P metrics and reporting required by insurance providers to become a preferred provider to increase the number of patients being empaneled to SNCHC.	Informatics Scientist, Informatics Supervisor, AZARA Help Desk, IT Manager, eCW help desk, Admin Supervisor, QMC, Admin Manager,	Increase the number of SNCHC's CY 2025 Medicaid Visits by 5% YOY. Goal = 4,104 Increase the number of SNCHC's CY 2025 unduplicated Medicaid	

	○ Organize and deploy an ongoing campaign to outreach to empaneled patients to establish care. ○ Close quality care gaps identified by the empanelment documentation, and any other gaps identified during patient visits. ○ Ensure there is available access on the patient schedule to see empaneled patients. b. CHW CCM services – ○ provide services to free up more provider space on the patient schedule. ○ Leverage internal workflows and community partnerships to ensure uninsured patients are assisted in applying for Medicaid and other SDOH services. c. PrEP expansion – Pharmacist provide services to free up more provider space on the patient schedule. d. Ongoing revenue cycle meeting review of Medicaid payor activity.	Admin Analyst, Operations Managers, Medical Director	patients by 5% YOY. Goal = 2,391	

Goal 2 – Objective B: Improve accuracy of budgeting and revenue projections.				
Activity	Specific Activities	Person(s) Responsible	Benchmark / Measure / Timeline	Update/Progress
1. Improve accuracy of budgeting and revenue projections.	a. Set up regular Business Office meetings to review: ○ Financial spend down schedule updates with the FQHC Accountant. ○ Actual spending versus budget. ○ Update payer mix data. b. Update revenue projection workbook.	Informatics Scientist, Informatics Supervisor, AZARA Help Desk, IT Manager, eCW help desk, Admin Supervisor, QMC, Admin Manager, Admin Analyst, FQHC Accountant, Financial Analyst	Goal = No grant dollars unspent. Goal = Meet or exceed budgeted expenses Goal = Current revenue projections for clinic services are off by 25.88%. Improve accuracy of revenue projection to 15% or less.	

Goal 3: Improve Quality.

Objectives:

a) Pursue Patient Centered Medical Home (PCMH) accreditation.
b) Maintain HRSA Compliance.
c) Ensure/enhance IT/Cyber-security.
d) Accelerate communication of current needs assessment, benchmarks, and production data for timely decision-enhancing execution.

Goal 3 – Objective A: Pursue Patient Centered Medical Home (PCMH) accreditation.				
Activity	Specific Activities	Person(s) Responsible	Benchmark / Measure / Timeline	Update/Progress
1. Consult with NVPCA SME on PCMH accreditation process, complete requirements, and submit application.	a. Set up regular meetings and progress reviews with the NVPCA PCHM consultant to discuss: ○ Collaborate with FQHC team to determine which PCMH criteria will be pursued for compliance. b. Work with QMC/QWG, IT, Informatics, clinical, and administrative teams to implement and test the workflows and processes to comply with selected required and elected PCMH criteria. c. Using the PDSA Cycle method, refine workflows and procedures to create a culture of PCMH compliant practices. d. Document and track electronic recorded evidence of adherence to selected required and elected PCMH criteria for ○ Demonstrate to NCQA SNCHC is compliant ○ Presentation to the Leadership team for issues that need correction or celebration. e. Submit PCMH application. f. Receive PCMH accreditation.	Informatics Scientist, Informatics Supervisor, AZARA Help Desk, IT Manager, eCW help desk, Admin Supervisor, QMC, Admin Manager, Admin Analyst, Operations Managers, Medical Director, FQHC CEO, Revenue Cycle Manager, Pharmacy Manager, BH Manager, SHC Manager, Medical Director, Dental Consultant, Chief Information Officer, NVPCA Consultant, Quality Work Group	Commit to becoming a PCMH and begin the accreditation process by meeting with the NVPCA Consultant by March 2025. Determine the required and selected PCMH criteria that SNCHC will comply with by May of 2025. Develop, implement, test, and refine workflows and procedures to comply with and have evidentiary support for PCMH regulations by November 2025. Submit the PCMH application to NCQA by December of 2025.	

			Receive PCMH accreditation by April of 2026.	

Goal 3 – Objective B: Maintain HRSA Compliance.

Activity	Specific Activities	Person(s) Responsible	Benchmark / Measure / Timeline	Update/Progress
1. Health Center Program compliance.	a. Continue adhering to HRSA requirements for Federally Qualified Health Center designation. ○ The annual Patient Target is 9,980 minimum. ▪ 95%, or 9,482 is the threshold. ○ Submit Catchment Area CIS after 2024 UDS report is submitted, if necessary. ○ Successfully complete and correct any findings from the on-site visit in February 2025. b. Continue adhering to FTCA requirements for FTCA redeeming. ○ Quarterly Risk Assessments need to be completed and presented. ○ The annual risk management report needs to be presented to the board. ○ Risk mgmt. training needs to be completed by all clinical staff for OB and other clinical risk factors, and HIPAA compliance. ○ The Risk Manager must complete annual risk management training. c. Work with QMC/QWG, IT, Informatics, clinical, and administrative teams to implement and test workflows and processes to comply with required reporting and quality requirements. d. Continue pursuing and obtain the new PPS rate.	Informatics Scientist, Informatics Supervisor, AZARA Help Desk, IT Manager, eCW help desk, Admin Supervisor, QMC, Admin Manager, Admin Analyst, Operations Managers, Medical Director, FQHC CEO, Revenue Cycle Manager, Pharmacy Manager, BH Manager, SHC Manager, Medical Director, Dental Consultant, Chief Information Officer, NVPCA Consultant, Quality Work Group, CFO, Financial Analyst, Associate General Counsel	Provide services for 9,980 or more unduplicated patients in CY 2025. Conduct and complete the HRSA on-site visit for compliance in February 2025 and work to have no findings listed on the NOA. Update HRSA EHB form 5b service sites and form 5a required and additional services as needed. Submit redeeming FTCA application for redeeming by June 27, 2025. Submit 2024 UDS report by February 15, 2025. Acquire final PPS Rate by June 2025.	

Goal 3 – Objective C: Ensure/enhance IT/Cyber-security.

Activity	Specific Activities	Person(s) Responsible	Benchmark / Measure / Timeline	Update/Progress
1. Conduct regular checks on cyber-security threats, issues, challenges, training, and incidents.	a. Set up regular meetings with IT to determine ○ If there were any cyber incidents, or near misses that could have been prevented. ○ If training on process enhancement, accuracy, or other pertinent issues is necessary. ○ If data is accurate and consistent throughout eCW, CAREWare, and AZARA. b. Work with QMC/QWG, IT, Informatics, clinical, and administrative teams to implement and test workflows and processes to comply with required reporting and quality requirements. c. Upcoming migrations, updates, or changes to existing or new software or hardware.	Informatics Scientist, Informatics Supervisor, AZARA Help Desk, IT Manager, eCW help desk, Admin Supervisor, QMC, Admin Manager, Admin Analyst, Operations Managers, Medical Director, FQHC CEO, Revenue Cycle Manager, Pharmacy Manager, BH Manager, SHC Manager, Medical Director, Dental Consultant, Chief Information Officer, Quality Work Group	Regular meetings are set up at least bi-annually to review potential or existing cyber-security issues. Help Desk tickets being submitted within a week of discovering problems with systems, reporting, accuracy, or other data issues. PDSA cycles being created and regularly reviewed until the desired outcome is achieved.	

Goal 3 – Objective D: Accelerate communication of current needs assessment, benchmarks, and production data for timely decision-enhancing execution.

Activity	Specific Activities	Person(s) Responsible	Benchmark / Measure / Timeline	Update/Progress
1. Obtain accurate data as quickly as possible each month to have a greater impact on leadership's decision-making capacity.	a. Request data for the next five weeks' worth of reports due, and for the previous month. b. Verify accuracy of data by cross checking multiple data sources and anecdotal operational information.	Informatics Scientist, Informatics Supervisor, AZARA Help Desk, IT Manager, eCW help desk, Admin Supervisor, QMC, Admin Manager, Admin Analyst, Operations Managers, Medical Director, FQHC CEO, Revenue	By the 5th of the month, request data for the prior month, and for any reports that are due in the next 5 weeks. Help Desk tickets being submitted within a week of discovering problems with systems, reporting, accuracy, or other data issues.	

		Cycle Manager, Pharmacy Manager, BH Manager, SHC Manager, Medical Director, Dental Consultant, Chief Information Officer, Quality Work Group		
2. Organize and share data promptly with those who have the most involvement in affecting change and improvement.	a. As soon as the data has been verified, organize the data into a report for the leadership team and send to Tawana. b. Disseminate data to all pertinent parties that need the data to make better decisions. c. Work with QMC/QWG, IT, Informatics, clinical, and administrative teams to implement and test PDSA cycles for improved results.	Informatics Scientist, Informatics Supervisor, AZARA Help Desk, IT Manager, eCW help desk, Admin Supervisor, QMC, Admin Manager, Admin Analyst, Operations Managers, Medical Director, FQHC CEO, Revenue Cycle Manager, Pharmacy Manager, BH Manager, SHC Manager, Medical Director, Dental Consultant, Chief Information Officer, Quality Work Group	Send verified data to leadership team and Tawana for monthly reporting on or before the 8th of the month. All pertinent decision-makers need to have actionable data by the 10th of each month, so change can affect 2/3 of the month, which should affect monthly trends. PDSA cycles being created and regularly reviewed until the desired outcomes are achieved.	

Goal 4: Strengthen Workforce.

Objectives:

a) Improve Team OVS Survey Scores.

b) Sustain Employee Engagement Committee efforts to enhance workforce experience.

Goal 4 – Objective A: Improve Team OVS Survey Scores.

Activity	Specific Activities	Person(s) Responsible	Benchmark / Measure / Timeline	Update/Progress
1. Obtain at least two sets of OVS survey results each year to track results.	a. Have at least 80% of the FQHC team participate in the OVS survey at least once per year. b. Have a secondary sampling survey conducted after the first OVS survey to track the progress of results.	Admin Supervisor, QMC, Admin Manager, Admin Analyst, Operations Managers, Medical Director, FQHC CEO, Pharmacy Manager, BH Manager, SHC Manager, Medical Director, Dental Consultant / Dentist, Quality Work Group, HR Business Partner, EEC, FQHC Team, HR	80% of FQHC Team participate in the OVS survey at least once per year. Subsequent survey conducted among a sampling of the team within the calendar year to track trends.	
2. Organize and share OVS results promptly with the team and those who have the most involvement in affecting change and improvement.	a. Results will be presented to the leadership, and then to the FQHC Team at a Staff Meeting. b. Leadership will take steps to improve issues that are clearly objective c. Employee Engagement Committee (EEC) will organize a subsequent meeting with the team members to discuss results with the team members to understand why the team answered OVS questions the way they did. d. EEC to solicit feedback from the team on how to improve the OVS scores without creating budgetary challenges or operational barriers to care for patients. e. EEC will report the findings of the team's feedback regarding the OVS survey results to leadership within a month of the OVS survey results being available with a proposed plan to improve results.	Admin Supervisor, QMC, Admin Manager, Admin Analyst, Operations Managers, Medical Director, FQHC CEO, Pharmacy Manager, BH Manager, SHC Manager, Medical Director, Dental Consultant / Dentist, Quality Work Group, HR Business Partner, EEC, FQHC Team, HR	Results of the OVS survey to be presented to FQHC leadership within 30 days of the results being posted. Results of the OVS survey to be shared with the rest of the FQHC team within 60 days of the results being posted. EEC reports to the leadership team what their findings are, and their recommendations on what to do to improve the scores within 90 days.	

Goal 4 – Objective B: Sustain Employee Engagement Committee efforts to enhance workforce experience.				
Activity	Specific Activities	Person(s) Responsible	Benchmark / Measure / Timeline	Update/Progress
1. The Employee Engagement Committee will monitor the effect of their efforts to improve the OVS scores.	a. Once OVS survey results are received, and employee feedback has been received and shared with the leadership team, the Employee Engagement Committee (EEC) will plan events, recognition, or other activities that are most likely to engage the team and improve the OVS scores and the FQHC's culture. b. EEC will use OVS survey results to identify any training and/or development needs for the team to improve inclusivity, safety and security, enhance the work experience, and/or develop and enhance skill sets. ○ EEC will work with appropriate SNHD professionals, if possible, to provide training and development, where appropriate.	Admin Manager, Operations Managers, Medical Director, FQHC CEO, Pharmacy Manager, BH Manager, SHC Manager, Medical Director, Dental Consultant / Dentist, HR Business Partner, EEC, FQHC Team, HR	OVS survey results to be discussed at every monthly EEC meeting to track progress and efforts being made to improve scores measuring the team's experience. EEC will seek leadership's approval of all communication with and for the team. EEC organizes at least one development focused training for the team during 2025.	
2. The EEC will research, develop, implement, and execute ways to finance the projects, events, and recognition they wish to conduct for the next year.	a. The EEC will use its list of planned events, recognition, and other activities, consult with HR on what kind of budget HR has for them, and then estimate how much more funding is needed for the calendar year. b. Once the amount needed has been identified, the EEC will seek ways to financially support their needs sustainability.	Admin Supervisor, QMC, Admin Manager, Admin Analyst, Operations Managers, Medical Director, FQHC CEO, Pharmacy Manager, BH Manager, SHC Manager, Medical Director, Dental Consultant / Dentist, Quality Work Group, HR Business Partner, EEC, FQHC Team, HR	EEC will present to the leadership team what their plan for sustainability is by the end of March 2025.	

SOUTHERN NEVADA Community HEALTH CENTER

AT THE SOUTHERN NEVADA HEALTH DISTRICT

Financial Report
Results as of November 30, 2024

(Unaudited)

Summary of Revenue, Expenses and Net Position (November 30, 2024 – Unaudited)

Revenue

- General Fund revenue (Charges for Services & Other) is $13.85M compared to a budget of $11.72M, a favorable variance of $2.13M.
- Special Revenue Funds (Grants) is $2.69M compared to a budget of $3.28M, an unfavorable variance of $590K.
- Total Revenue is $16.54M compared to a budget of $15.00M, a favorable variance of $1.54M.

Expenses

- Salary, Tax, and Benefits is $5.63M compared to a budget of $5.72M, a favorable variance of $90K.
- Other Operating Expense is $11.59M compared to a budget of $10.10M, an unfavorable variance of $1.49M.
- Indirect Cost/Cost Allocation is $3.27M compared to a budget of $3.20M, an unfavorable variance of $70K.
- Total Expense is $20.50M compared to a budget of $19.01M, an unfavorable variance of $1.49M.

Net Position: is ($3.96M) compared to a budget of ($4.01M), a favorable variance of $50K.

All Funds/Divisions by Type

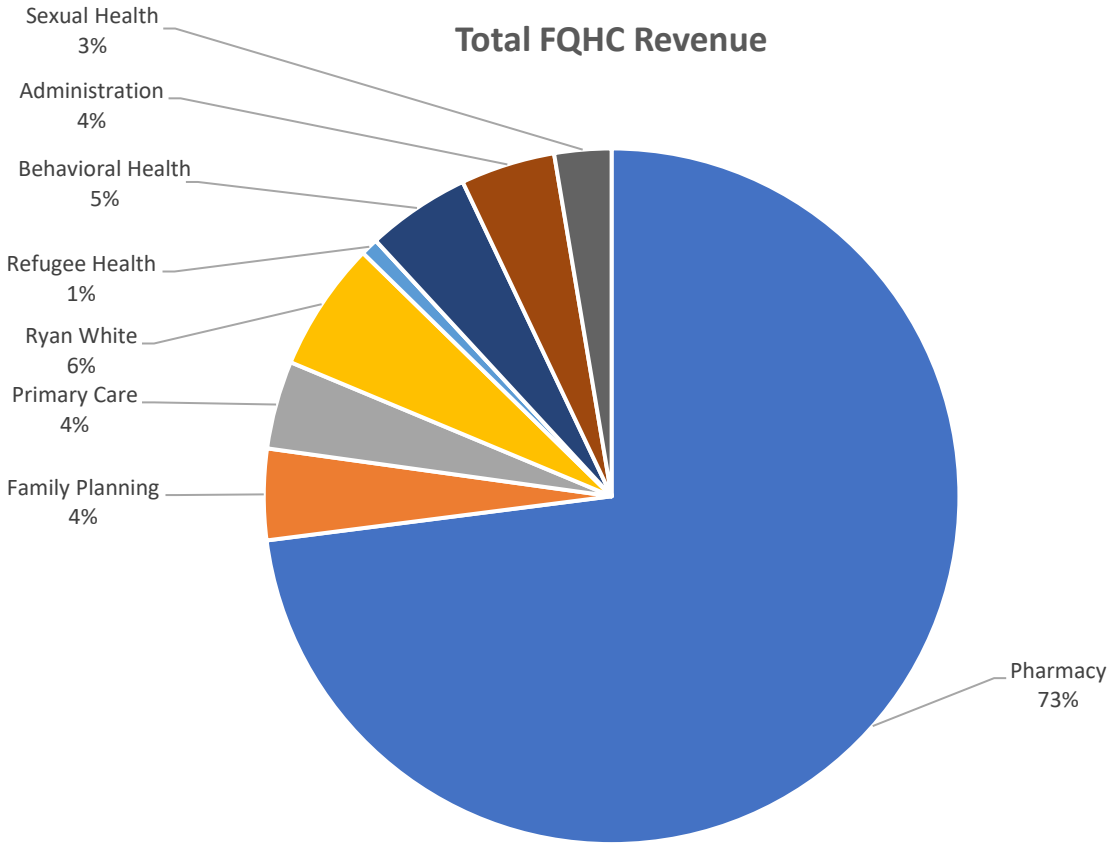
Budget to Actual

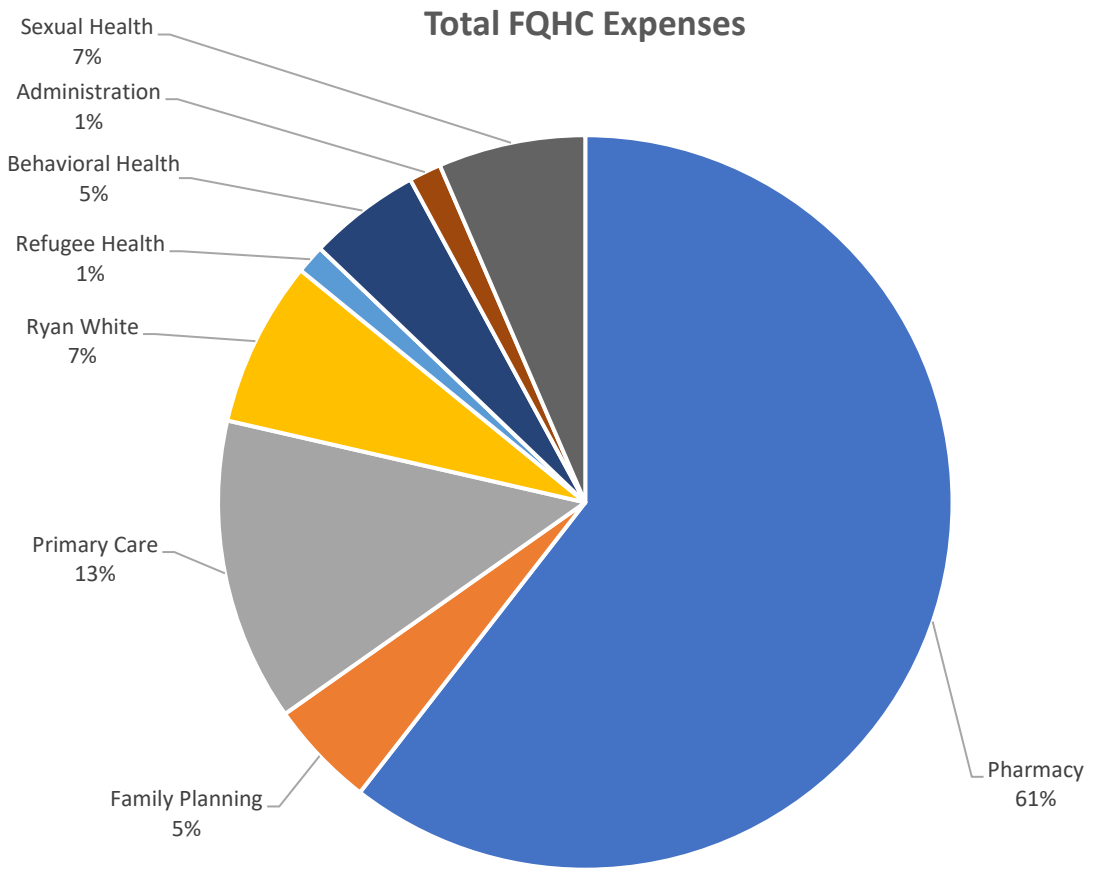
Activity	Budget as of November	Actual as of November	Variance Favorable (Unfavorable)	%	
Charges for Services	11,263,205	13,116,913	1,853,708	16%	1
Other	461,112	726,585	265,473	58%	2
Federal Revenue	1,232,992	1,474,107	241,115	20%	3
Pass-Thru Revenue	1,515,964	961,764	(554,200)	-37%	
State Revenue	529,756	258,321	(271,436)	-51%	
Total FQHC Revenue	**15,003,028**	**16,537,689**	**1,534,660**	**10%**	
Salaries	3,921,614	3,904,472	17,142	0%	
Taxes & Fringe Benefits	1,798,219	1,729,118	69,101	4%	
Total Salaries & Benefits	**5,719,833**	**5,633,590**	**86,243**	**2%**	
Supplies	9,050,962	10,450,104	(1,399,142)	-15%	4
Capital Outlay	380,043	608,318	(228,276)	-60%	5
Contractual	635,121	513,033	122,088	19%	
Travel & Training	27,559	23,443	4,116	15%	
Total Other Operating	**10,093,685**	**11,594,899**	**(1,501,214)**	**-15%**	
Indirect Costs/Cost Allocations	3,195,105	3,267,483	(72,378)	-2%	
Transfers IN	(294,599)	(309,432)	14,833	-5%	
Transfers OUT	294,599	309,432	(14,833)	-5%	
Total Transfers	**3,195,105**	**3,267,483**	**(72,378)**	**-2%**	
Total FQHC Expenses	**19,008,623**	**20,495,972**	**(1,487,349)**	**-8%**	
Net Position	**(4,005,595)**	**(3,958,283)**	**47,312**	**-1%**	

NOTES:

1) PHARMACY PATIENT ENCOUNTERS DRIVING MAJORITY OF GROWTH; PATIENT ENCOUNTERS CONTINUE YEAR-OVER-YEAR GROWTH ACROSS FQHC ESPECIALLY WITH ADDITION OF PHARMACY AT FREMONT CLINIC.
2) WRAP REVENUE REIMBURSEMENTS ARE CONTINUING TO OUTPACE PROJECTIONS IN FY25.
3) DRIVEN BY $592K IN REIMBURSEMENTS FOR BEHAVIORAL HEALTH CLINIC CAPITAL EXPENSES THROUGH NOVEMBER 2024.
4) PHARMACY PATIENT ENCOUNTERS DRIVING CORRESPONDING INCREASE IN MEDICATION SUPPLIES EXPENSES PLUS ADDITIONAL PURCHASES FOR SECOND PHARMACY LOCATION AT FREMONT CLINIC.
5) CAPITAL EXPENSES ASSOCIATED WITH CONSTRUCTION OF NEW BEHAVIORAL HEALTH CLINIC ($592K THROUGH NOVEMBER 2024).

Percentage of Revenues and Expenses by Department





Revenues by Department
Budget to Actuals

Department	Budget as of November	Actual as of November	Variance Favorable (Unfavorable)	%	
Charges for Services, Other, Wrap					
Family Planning	166,099	93,046	(73,053)	-44%	
Pharmacy	10,311,193	12,067,996	1,756,803	17%	1
Oral Health (Dental)	-	-	-	0%	2
Primary Care	210,845	240,075	29,229	14%	
Ryan White	115,210	105,317	(9,893)	-9%	
Refugee Health	22,570	64,793	42,224	187%	
Behavioral Health	114,916	107,715	(7,201)	-6%	
Administration	458,815	726,585	267,770	58%	3
Sexual Health	324,668	437,991	113,322	35%	
OPERATING REVENUE	**11,724,317**	**13,843,518**	**2,119,201**	**18%**	
Grants					
Family Planning	883,787	606,296	(277,491)	-31%	
Oral Health (Dental)	457,439	-	(457,439)	-100%	2
Primary Care	421,522	437,179	15,657	4%	
Ryan White	1,083,267	891,879	(191,388)	-18%	
Refugee Health	94,462	69,885	(24,576)	-26%	
Behavioral Health	338,235	688,952	350,716	104%	4
SPECIAL REVENUE	**3,278,712**	**2,694,191**	**(584,521)**	**-18%**	
TOTAL REVENUE	**15,003,028**	**16,537,709**	**1,534,680**	**10%**	

NOTES:
1) PATIENT ENCOUNTERS CONTINUE YEAR-OVER-YEAR GROWTH ACROSS FQHC ESPECIALLY WITH ADDITION OF PHARMACY AT FREMONT CLINIC.
2) DENTAL CLINIC PLANNED OPENING IN Q4 FY25.
3) WRAP REVENUE REIMBURSEMENTS ARE CONTINUING TO OUTPACE PROJECTIONS IN FY25.
4) INCLUDES PAYMENT FOR GRANT-FUNDED REIMBURSEMENTS FOR BEHAVIORAL HEALTH CLINIC CAPITAL EXPENSES ($592K THROUGH NOVEMBER 2024).

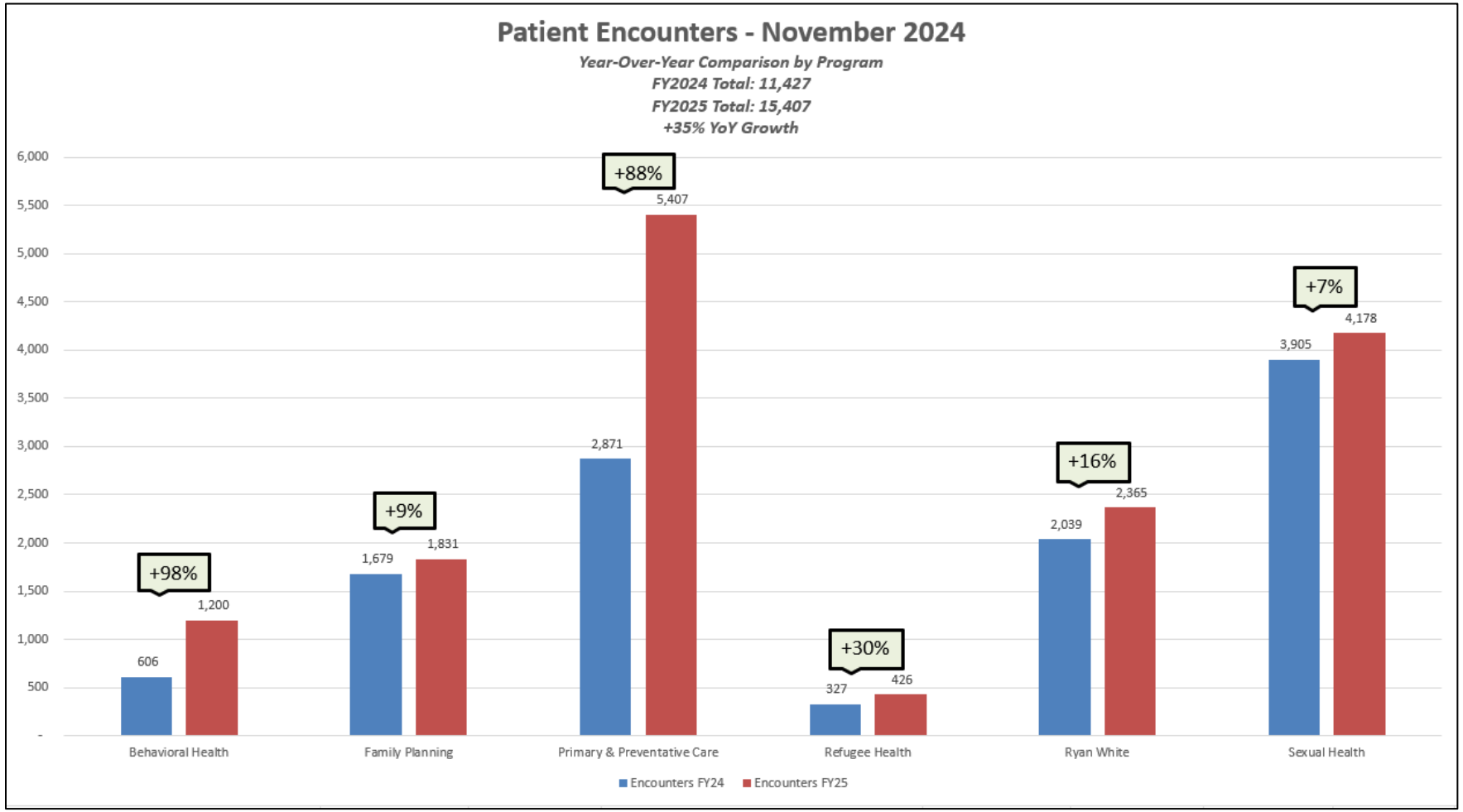
Expenses by Department

Budget to Actuals

Department	Budget as of November	Actual as of November	Variance Favorable (Unfavorable)	%	
Employment (Salaries, Taxes, Fringe)					
Family Planning	963,265	694,364	268,901	28%	
Pharmacy	227,525	252,741	(25,215)	-11%	
Oral Health (Dental)	47,248	-	47,248	100%	1
Primary Care	1,913,712	2,131,467	(217,755)	-11%	
Ryan White	1,127,393	1,124,470	2,923	0%	
Refugee Health	77,449	92,868	(15,419)	-20%	
Behavioral Health	207,789	255,919	(48,131)	-23%	
Administration	48,800	60,973	(12,173)	-25%	
Sexual Health	1,106,652	1,020,788	85,864	8%	
Total Personnel Costs	5,719,833	5,633,590	86,243	2%	
Other (Supplies, Contractual, Capital, etc.)					
Family Planning	351,026	118,577	232,449	66%	
Pharmacy	8,480,575	10,167,648	(1,687,074)	-20%	2
Oral Health (Dental)	333,952	-	333,952	100%	1
Primary Care	123,528	175,581	(52,053)	-42%	
Ryan White	158,328	133,937	24,391	15%	
Refugee Health	55,827	124,592	(68,765)	-123%	
Behavioral Health	248,869	595,053	(346,184)	-139%	3
Administration	235,904	184,000	51,904	22%	
Sexual Health	105,677	95,510	10,167	10%	
Total Other Expenses	10,093,685	11,594,899	(1,501,214)	-15%	
Total Operating Expenses	**15,813,518**	**17,228,489**	**(1,414,971)**	**-9%**	
Indirect Costs/Cost Allocations	3,195,105	3,267,483	(72,378)	-2%	
Transfers IN	(294,599)	(309,432)	14,833	-5%	
Transfers OUT	294,599	309,432	(14,833)	-5%	
Total Transfers & Allocations	3,195,105	3,267,483	(72,378)	-2%	
TOTAL EXPENSES	**19,008,623**	**20,495,972**	**(1,487,349)**	**-8%**	

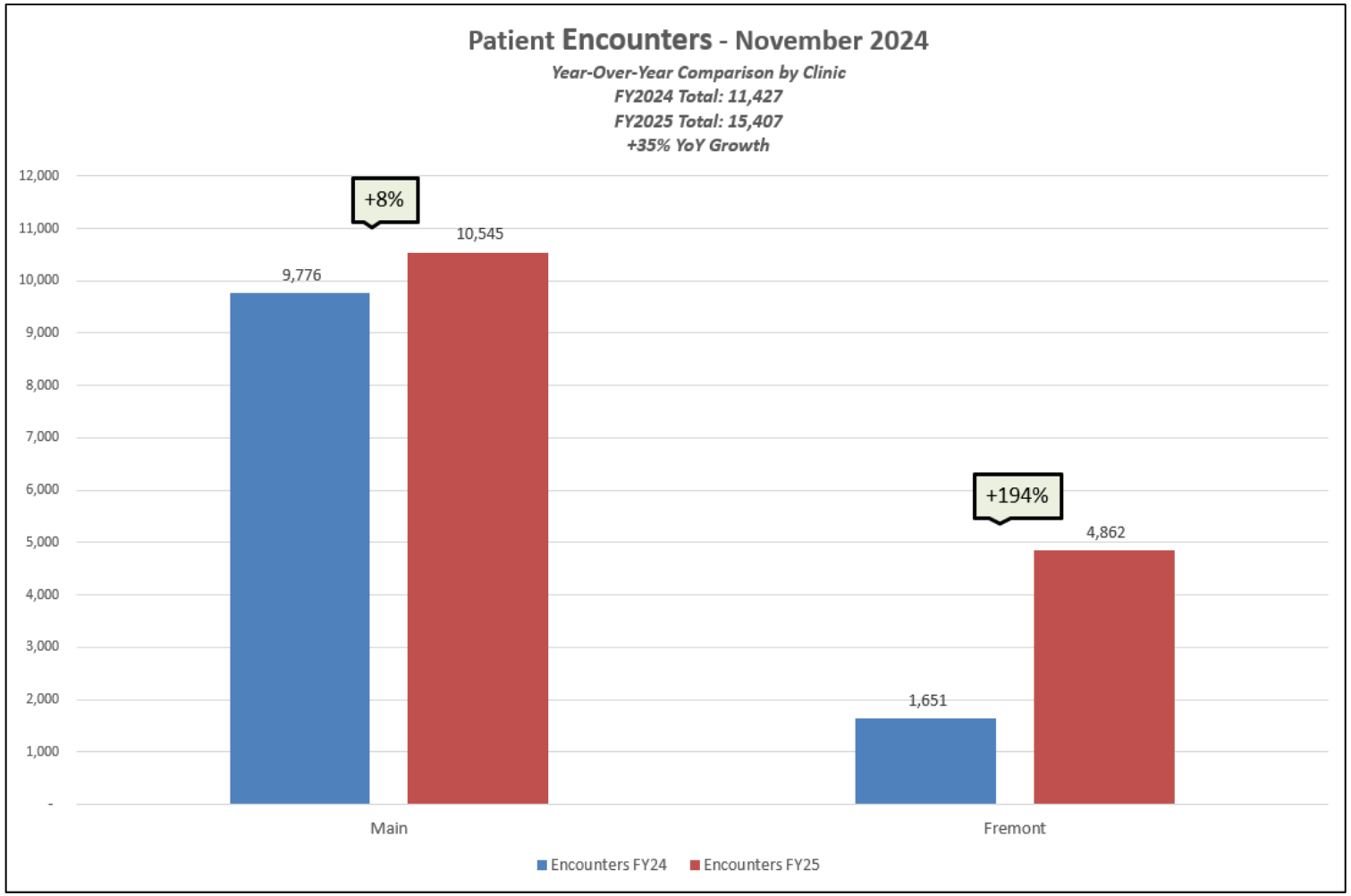
NOTES:
1) DENTAL CLINIC PLANNED OPENING IN Q4 FY25.
2) PHARMACY PATIENT ENCOUNTERS DRIVING CORRESPONDING INCREASE IN MEDICATION SUPPLIES EXPENSES PLUS ADDITIONAL PURCHASES FOR SECOND PHARMACY LOCATION AT FREMONT CLINIC.
3) CAPITAL EXPENSES ASSOCIATED WITH CONSTRUCTION OF NEW BEHAVIORAL HEALTH CLINIC ($592K THROUGH NOVEMBER 2024).

Patient Encounters By Department



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

Patient Encounters By Clinic



Financial Report Categorization

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

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

Additional Visualizations

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

YTD by Month – November 30, 2024

By Department

Southern Nevada Community Health Center

Year-to-Date Revenues/Expenses by Department

Fiscal Year 2025 as of November 30, 2024

DEPARTMENT	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	YTD TOTALS	YTD AVERAGES
Administration (301)	122,752	125,348	118,972	120,830	102,739	726,585	118,128
Family Planning (309)	91,661	148,951	135,840	157,890	215,430	749,772	149,954
Pharmacy (333)	2,383,597	2,574,661	2,339,657	2,454,031	2,316,050	12,067,996	2,413,599
Dental Health (336)	-	-	-	-	-	-	-
Primary Care (337)	144,427	157,797	134,070	141,115	247,717	825,126	165,025
Ryan White (338)	177,359	210,374	250,019	216,541	263,422	1,117,715	223,543
Refugee Health (344)	28,153	9,890	11,929	23,025	42,134	115,131	23,026
Behavioral Health (345)	280,629	337,075	78,806	45,553	64,743	806,805	161,361
Sexual Health (350)	101,840	76,971	77,277	102,402	79,500	437,991	87,598
TOTAL REVENUES	**3,330,418**	**3,641,067**	**3,146,570**	**3,261,387**	**3,331,736**	**16,847,121**	**3,342,235**

DEPARTMENT	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	YTD TOTALS	YTD AVERAGES
Administration (301)	37,218	73,998	67,276	42,945	70,971	292,408	58,482
Family Planning (309)	130,361	180,167	163,917	191,449	348,427	1,014,321	202,864
Pharmacy (333)	2,995,246	2,292,351	2,692,359	1,881,673	2,595,525	12,457,153	2,491,431
Dental Health (336)	-	-	-	-	-	-	-
Primary Care (337)	442,767	610,833	531,333	509,600	896,366	2,990,899	598,180
Ryan White (338)	224,923	320,915	281,139	270,657	489,638	1,587,273	317,455
Refugee Health (344)	59,154	(5,281)	5,096	88,306	82,220	229,495	45,899
Behavioral Health (345)	278,625	389,717	90,104	55,852	94,900	909,199	181,840
Sexual Health (350)	189,325	249,162	241,255	248,806	396,107	1,324,656	264,931
TOTAL EXPENSES	**4,357,619**	**4,111,863**	**4,072,480**	**3,289,287**	**4,974,155**	**20,805,403**	**4,161,081**

NET POSITION:	(1,027,201)	(470,796)	(925,909)	(27,900)	(1,642,420)	(3,958,283)	(818,845)

YTD by Month – November 30, 2024

By Type

Southern Nevada Community Health Center

Year-to-Date Revenues/Expenses by Type

Fiscal Year 2025 as of November 30, 2024

REVENUE TYPE	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	YTD TOTALS	YTD AVERAGES
Charges for Services	2,599,053	2,736,809	2,537,814	2,706,173	2,537,044	13,116,893	1,093,074
Other	122,752	125,348	118,972	120,830	102,739	726,585	60,549
Contributions	-	-	-	20	-	20	2
Intergovernmental	533,730	689,780	450,756	399,849	620,076	2,694,191	224,516
TOTAL REVENUES	**3,255,536**	**3,551,937**	**3,107,543**	**3,226,872**	**3,259,858**	**16,537,689**	**3,280,349**
EXPENSE TYPE	**Jul-24**	**Aug-24**	**Sep-24**	**Oct-24**	**Nov-24**	**YTD TOTALS**	**YTD AVERAGES**
Salaries	485,229	707,618	685,316	697,394	1,328,915	3,904,472	780,894
Taxes and Benefits	223,019	316,343	312,100	320,374	557,282	1,729,118	345,824
Travel and Training	280	4,192	5,219	9,813	3,939	23,443	4,689
Supplies	2,518,508	1,890,853	2,242,689	1,605,394	2,192,659	10,450,104	2,090,021
Contractual	119,166	122,427	96,763	103,521	71,157	513,033	102,607
Property	248,000	327,602	32,716	-	-	608,318	121,664
TOTAL EXPENSES	**3,594,204**	**3,369,035**	**3,374,803**	**2,736,495**	**4,153,952**	**17,228,489**	**3,445,698**
TRANSFER TYPE	**Jul-24**	**Aug-24**	**Sep-24**	**Oct-24**	**Nov-24**	**YTD TOTALS**	**YTD AVERAGES**
Indirect/Cost Allocation	688,533	653,698	658,649	518,277	748,326	3,267,483	653,497
Transfer In	(74,882)	(89,130)	(39,028)	(34,515)	(71,877)	(309,432)	(61,886)
Transfer Out	74,882	89,130	39,028	34,515	71,877	309,432	61,886
TOTAL TRANSFERS	**688,533**	**653,698**	**658,649**	**518,277**	**748,326**	**3,267,483**	**653,497**
NET POSITION:	(1,027,201)	(470,796)	(925,909)	(27,900)	(1,642,420)	(3,958,283)	(818,845)

Questions?

I. PURPOSE

As part of the Southern Nevada Community Health Center's (SNCHC) dedication to providing quality care, the health center~~SHCHC~~ has implemented a Quality Management Program, a systematic, organization-wide approach to ~~provide~~providing ~~uncompromising~~ high quality care and service to clients. Through this systematic approach, the Quality Management Program provides a mechanism to constantly survey the performance of SNCHC and provides opportunities to improve performance levels.

II. SCOPE

SNCHC's Quality Management Program is outlined in its Quality Management Plan (QMP). The Plan's scope involves the physicians, mid-level providers, nurses, allied health disciplines, ~~community service agencies,~~ administrators, managers, and staff that provide or support the provision of care to underserved ~~the uninsured or underinsured~~ individuals of our community. The program focuses on improving key organizational functions within SNCHC, and is aligned with HRSA's BPHC Program Expectations, the NCQA Patient-Centered Medical Home (PCMH) standards, and appropriate guidelines of the Federal Tort Claims Act (FTCA). The key functions are assessed by collecting and analyzing data related to one or more dimensions of performance, which includes but may not be limited to efficacy, appropriateness (evidenced-based medical practice), availability, timeliness, effectiveness, continuity, safety, efficiency, and respect and caring. The six key functional areas within the scope of SNCHC's QMP are:

- Care Management: Biological, social, and/or quality of life consequences of patient health through clinical and social evaluation and management of care and services in areas such as preventive health, acute or chronic conditions, and behavioral and oral health.
- Safety: Capabilities to promote a safe environment for ~~clients~~ patients by ~~evaluation in~~evaluating areas such as client and provider education, continuity, and coordination of care.
- Financial and Administrative: Ability to manage the financial and administrative aspects of the organization efficiently and effectively.
- Network Quality: Periodic peer review assessments of client records by physicians or by other licensed health professionals under the supervision of physicians of the appropriateness of the utilization of services; capabilities, satisfaction, accessibility, and availability of healthcare and human services, including monitoring and evaluation of quality care/quality service complaints, credentialing/recredentialing, and adverse occurrence tracking to deliver up to date and evidence based medical care.
- Client Satisfaction: Ability to meet the needs of SNCHC patients and ultimately engaged our population base in the management of their health.
- Customer Service: Capabilities, satisfaction, accessibility of the provision of customer service. Organizational arrangements, including a focus of

responsibility~~,~~ to support the quality assurance program and the provision of high-quality patient care.

III. INTEGRATION OF QUALITY MANAGEMENT PLAN WITH GUIDING PRINCIPLES AND PRIORITIES

This plan will be aligned with SNCHC's Strategic Plan and annual work plans. The key attributes that support SNCHC's vision of a health delivery system describes a system that:

- Is centered upon treating people with dignity and improving the health of our patients.
- Provides an integrated continuum of care.
- Demands excellence in service by meeting or exceeding our patient's expectations.
- Requires effective communication and information sharing.
- Continually improves its operating and clinical practices by meeting and exceeding staff expectations.
- Is best achieved by teamwork.
- Uses resources optimally.
- Is scientific and results oriented.
- Provides a safe environment for patients, visitors, and staff.
- Delivers value-based care that aligns with the best scientific evidence combined with committed and compassionate judgment of expert clinicians. Care that embodies the tenet of treating our patients holistically not as an individual/isolated organ system but as a whole – encompassing social, behavioral, and economic components.

IV. GOALS AND OBJECTIVES

The goal of the plan is to increase the value of services by enhancing clinical quality, the patient's experience, and access to care while strengthening the ability of SNCHC to deliver sustainable cost-effective care.

Objectives

A. To design and implement effective processes to meet the needs of patients in a manner consistent with the health center's mission, vision, values, ~~goals,~~ and strategic ~~plans~~goals.

B. To promote and implement evidenced based care that addresses health equity and disparities in the communities served by SNCHC.

C. To collect and use data to monitor the stability of exiting processes, identify opportunities for improvement, identify strategies~~changes~~ that will lead to desired improvement, and evaluate the effectiveness of programs.

D. To aggregate and analyze data on an ongoing basis and to evaluate~~i~~ tactics~~dentify changes~~ that will lead to improved clinical effectiveness and operation efficiency.

E. To implement systems and processes that will ~~and a~~ reduces~~tion~~ and/or mitigate ~~in~~ errors.

F. To promote and foster collaboration and a culture focused on quality improvement and risk mitigation at all levels of the organization.

G. To educate leaders and staff regarding continuous quality improvement and increase participation in performance improvement activities.

V. ORGANIZATION

Quality improvement and assurance activities are conducted at SNCHC by:

A. **SNCHC Board:** The SNCHC Board is the final authority and is ultimately responsible for approving the QMP as well as monitoring activities and performance. The board delegates authority and responsibility to the health center's Chief Executive Officer ~~Director~~ who in turn, may delegate authority and responsibility to the ~~Chief~~ Medical ~~Officer~~Director ~~(CMO)~~ and/or other chosen designees.

B. **SNCHC Quality, Risk and Credentials Committee:** The Quality, Risk and Credentials Committee is a committee of the SNCHCH Governing Board. The Committee helps perform work related to the boards requirement to establish goals and activities around quality improvement and quality assurance and to monitor the health center's performance in these areas. The Committee meets at least quarterly and more frequently as needed.

The Committee in collaboration with leadership identifies and prioritizes improvement opportunities; ensuring that adequate resources are available to accomplish performance improvement and assurance initiatives. The Committee receives, reviews, and evaluates performance improvement activities and reports regularly to the SNCHC Governing Board. The Committee is responsible for the following activities:

1. Reviews and ~~recommends~~recommends for the approval of the Quality Management Plan (QMP) ~~Plan~~ to the Board.
2. Monitors patient and employee satisfaction.
3. Monitors progress towards clinical quality performance goals and risk management mitigation activities. Performs benchmarking against relevant sources.
4. Reviews and recommends to the Board for approval the annual Risk Management Plan.
5. Overseeing the effectiveness of the medical staff credentialing process.

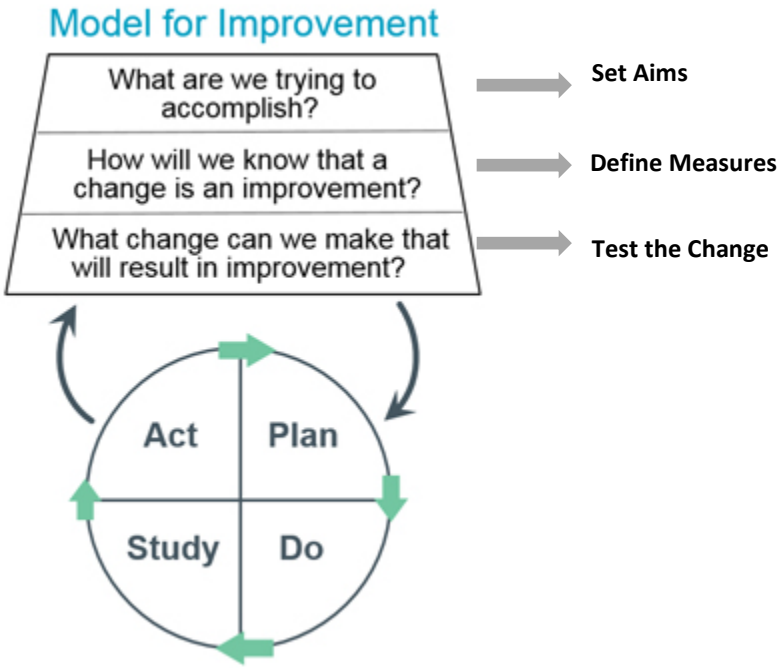
6. Reviews and recommends to the Board for approval medical staff appointments, reappointments, and clinical privileges.

C. **Quality Improvement Work Group:** This group is comprised of health center leadership and staff. The purpose of the work group is to facilitate the application of health center's quality improvement and quality assurance activities. The group will provide leadership support, prioritization of initiatives, review and analysis audits/reports and implementation of improvement activities.

VI. PERFORMANCE IMPROVEMENT PROCESS

SNCHC will use an Improvement Model that consists of three fundamental questions and a Plan-Do-Study-Act (PDSA) cycle (Deming Cycle) to test, implement, and evaluate changes.

Figure 1: Model for Improvement



VII. COLLECTION AND CONTINOUS MONITORING OF DATA

SNCHC's ongoing collection and monitoring program covers a multitude of variables including clinical, financial, operational, as well as patient and staff satisfaction.

Data collection activities will be based on priorities set by SNCHC's Strategic Plan and the Quality, Risk and Credentials Committee. In collaboration and support of staff, the Committee will consider the population served by the Health Center, ~~as well as,~~as well as

high risk, high volume, and problem prone activities that occur. Requirements for data collection imposed by funding sources and legal/regulatory agencies will also be included, when appropriate. The data collected will be used to monitor the stability of existing processes, identify opportunities for improvement, identify changes that lead to improvement, and/or to demonstrate sustained improvement.

The following table is a summary of the data collection efforts that are currently underway at SNCHC along with the schedule outlining when data will be collected, analyzed, and reported.

Table 1: Data Collection Plan

Clinical Quality			
Performance Measure	**Collected**	**Reported**	**Person Responsible**
Peer Reviews of Licensed Independent Practitioners (LIPs)	Quarterly	Annually	~~CMO/Dental Director~~ ~~FQHC Operations Officer, FQHC CHN Manager~~Medical Director & Quality Management Coordinator
Patient Appointment Availability, Access to Clinical Advice, No-Show Rates	Monthly	Biannually	Medical Director, ~~Sr. FQHC Manager, FQHC~~ CHN Manager, & BH Manager
Review of Uniform Data System (UDS) Information	Monthly	Quarterly	FQHC Administrative Manager & ~~,~~ Quality Management Coordinator
Patient Satisfaction Surveys Results	Daily	Quarterly	~~FQHC Manager, FQHC~~ CHN Manager, BH Manager, & Quality Management Coordinator
Patient Complaints/Grievances	Daily	Quarterly	FQHC Administrative Manager~~,~~ ~~FQHC CHN Manager, Quality Management Coordinator~~
HRSA and NCQA (PCMH) Requirements	As Per Guidelines	As Deemed Necessary	FQHC Administrative Manager & ~~, FQHC CHN Manager,~~ Quality Management Coordinator
Clinical Indicators Targeted for Improvement (PDSA)	Quarterly	Quarterly	Medical Director, BH Manager, & ~~CMO,~~ Quality Management Coordinator~~, Sr. Compliance Specialist~~

Table 2: Data Collection Plan for Safety and Risk Management

Safety and Risk Management (Reports to the SNCHC Board)			
Performance Measure	**Collected**	**Reported**	**Person Responsible**
Incident Reporting (Patient Safety,	Daily	Monthly (Sentinel	FQHC Administrative Manager, CHN Manager, &

Safety and Risk Management (Reports to the SNCHC Board)			
Performance Measure	**Collected**	**Reported**	**Person Responsible**
Employee Safety)		Events) Quarterly (All Others)	BH Manager~~Quality Management Coordinator, Sr. Compliance Specialist~~
Health Information Technology (HIT) Security Review	Biannually	Annually	Chief Information Officer
HIPAA Compliance	Monthly	Annually	FQHC Administrative Manager & Sr. Compliance Specialist

Table 3: Data Collection Plan for Human Resources Committee

Credentialing, Privileging, and Engagement (Reports to the SNCHC Board as necessary)			
Performance Measure	**Collected**	**Reported**	**Person Responsible**
Competency Reviews of Staff (In Conjunction with Annual Review)	Annually	Annually	~~CMO/Dental Director/CAN~~Medical Director
Staff Engagement	Periodically~~Annually~~	Periodically~~Annually~~	~~Human Resources (HR) Director~~Chief Executive Officer
Staff Competency (Patterns and Trends)	Annually	Annually	~~FQHC Sr. Manager, FQHC CHN Manager~~Medical Director, CHN Manager, BH Manager, & Pharmacy Manager

Table 4: Data Collection Plan for Fiscal Committee

Revenue Cycle and Utilization: (Reports to the SNCHC Board)			
Performance Measure	**Collected**	**Reported**	**Person Responsible**
Operating Revenue	Monthly~~Quarterly~~	Monthly~~Annually~~	Chief Financial Officer & FQHC Administrative Manager
Profit Center Report	Monthly~~Monthly~~	Monthly~~Annually~~	Chief Financial Officer & FQHC Administrative Manager

Other information may be collected on an as needed basis and will be based upon performance improvement objectives or other rationales.

VIII. AGGREGATION AND ANALYSIS OF DATA

Decision-making will be supported by data collection and information analysis. Data will be aggregated and analyzed by the organization in such a way that current performance levels, patterns, or trends can be identified. The ~~organization~~ health center will utilize

appropriate statistical tools and techniques to analyze and display data.

When appropriate, data will be trended and compared internally over time. In addition, external sources of information will be used to benchmark SNCHC performance when it is available and appropriate to identify opportunities for improvement.

Analysis will be conducted when data indicates that levels of performance, patterns, or trends vary substantially from those expected and for those topics chosen by SHND as priorities for improvement.

At a minimum, each clinical and financial performance indicator collected for the purposes of UDS reporting will be tracked quarterly~~monthly~~. In addition, each committee will have the responsibility to establish meaningful monitoring in their area of expertise and make recommendations to the Board regarding the level of information to be shared regularly.

Each PDSA activity will establish quantitative tracking methodology and a corresponding performance goal as part of its process. More intensive aggregations and analysis of data may be required in an active PDSA activity above and beyond general monitoring.

IX. QUALITY ASSURANCE ACTIVITIES

A. Credentialing and Privileging

All SNCHC Licensed Independent Practitioners (LIPs), Other Licensed and Certified Practitioners (OLCPs), and Other Clinical Staff (OCS) are credentialed and privileged at the time of hire and are re-credentialed and privileged every two years. Modifications and/or the removal or reinstatement of privileges can occur at any time basedecause ofupon the results of ongoing professional evaluation.

B. Clinical Practice Guidelines

SNCHC's clinicians and staff will provide health care services with utmost accuracy, efficiency, confidentiality, and precision. All applications of health care or health care related services will be guided by appropriate governing entities. SNCHC adheres to current evidence-based clinical guidelines, standards of care, and standards of practice in the provision of medical, dental, and behavioral health services. (See Protocols and Medical Orders, and Confidentiality Privacy of PHI Policy).

C. Risk Management

All employees will be informed of the principles of risk management at the start of employment, annually, and as deemed necessary. Risk management is defined by the Joint Commission as "clinical and administrative activities undertaken to identify, evaluate, and reduce the risk of injury to patients, staff, and visitors, and the risk of loss to the organization itself." SNCHC supports the establishment of a culture that emphasizes implementing evidence-base best practices, learning from error analysis,

and providing constructive feedback rather than blame and punishment. Employees are encouraged to bring their risk management concerns to the Safety Officer, Compliance Officer, their supervisor, or the FQHC Administrative ~~Operations Officer or a member of the Safety and Risk Management Committee~~ at any time.

D. Incident Reporting

All employees are oriented to the Incident Reporting Policy and Procedure that provides guidance for reporting 1) Incidents affecting patients or visitors, 2) Injury, illness or near-miss events affecting employees, and 3) non-safety related incidents affecting patients. A summary of incidents is reported quarterly to the Quality, Risk and Credentials Committee and governing board. ~~Incidents will be assigned a "category of harm" and those incidents that have a category of harm of E-I will be reported to the Board (See Patient Safety Policy). A summary of all incidents is reported the board quarterly.~~

E. Patient Satisfaction

All SNCHC locations and service lines participate in patient satisfaction surveys. SNCHC surveys patients routinely in the two most prevalent languages of the patient population, in either English, or Spanish. Aggerate and service line survey results are share with the health center's leadership ~~weekly~~ and ~~with all~~ staff monthly. Additionally, survey results are reviewed and tabulated quarterly by staff and reported to the Quality, Risk and Credentials Committee. Improvements are recommended based on the survey results. A summary is provided annually to the Board.

F. Patient Grievance

SHND has a patient grievance and complaint process that ensures patients can freely voice complaints/grievances and recommend changes without being subject to discrimination, retaliation or unreasonable interruption of care, treatment, or service (See Client Complaints/Grievance Policy). The health center's leadership team attempts to resolve grievances informally at first. The ~~FQHC Operations Officer~~Chief Executive Officer will support the resolution of formal grievances. The Quality, Risk and Credentials Committee is given a report on the number and type of grievances on a quarterly basis and is responsible for ensuring the resolution of grievances and collaborates with leadership to ensure resolution of grievance and the implementation of improvements to mitigate future grievances.

G. Clinical Audits

Quality is monitored through audits, data review, and analysis to assure problems are identified (i.e., peer reviews, front desk/billing/health information technology audits, personnel files, UDS data, program audits etc.) and reported to the appropriate manager and the management team. All audits are reviewed by the Quality Improvement Work Group. This group will provide direction and resources to respond to audit findings as well as quality improvement and quality assurance activities.

H. Policies and Procedures

Policies and procedures related to quality improvement and assurance are initiated

by health center leadership, reviewed, and recommended by the Quality, Risk and Credentials Committee to the SNCHC Governing Board for final review and approval. Policies are reviewed on a three-year schedule or earlier as needed by the Quality Improvement Work Group. Policies with substantial changes are sent to the Governing Board for approval. Upon hire, staff members are assigned job-relevant policies and procedures through an online policy management system. Each time a policy is updated, all staff members who are assigned that document are required to read and acknowledge it.

Protocols, standing orders, and procedures are developed and approved by the ~~FQHC Operations~~Chief Executive Officer or their designee and are reviewed annually. These documents are also kept in the online document management software system.

I. Patient Safety Program

SNCHC is committed to improving safety for its patients at all its locations. This continuous quality improvement plan has incorporated the activities and functions necessary to establish and maintain a comprehensive program for patient safety and will be implemented at all levels of the organization.

Activities and functions that have been incorporated to address patient safety include:

- All patients will be given a copy of the Patient Rights and Responsibilities along with the Notice of Privacy Practices at their first visit. These documents are available upon request after their initial visit. Patients will sign a form verifying that they have read/acknowledged the Patient Rights and Responsibilities and Notice of Privacy Practices.
- Annual FTCA required trainings for clinical staff.
- Annual HIPPA ~~trainings~~training for staff.
- Communication with patients about patient safety including patient education and informing patients about their care.
- Staff education including related orientation and training and expectations for Incident Reporting.
- Safety improvement activities included in Section VII of this plan under "Collection and Continuous Monitoring of Data."
- Annual Infection Control trainings for staff.
- Reporting of results to staff, committees, executive leadership, and governance.
- Process for proactive risk reduction and analysis of adverse and sentinel events.

X. PERFORMANCE IMPROVEMENT INITIATIVES

Performance improvement initiatives will be facilitated through the Quality Improvement Work Group based on the data identified and reviewed in Section VII. A key part of this data is the UDS data which will be reviewed annually in ~~February~~March

or ~~March~~April. After analyzing the UDS data and comparing it to the clinic's internal goals, state and national counterparts, and Healthy People 2030 goals for clinical quality, initiatives will be reassessed and determined. Initiatives will be aligned with SNCHC's Strategic Plan. As other opportunities or challenges arise, SNCHC may add or delete goals using the Plan-Do-Study Act (PDSA) process.

XI. DOCUMENTATION OF QUALITY IMPROVEMENT ACTIVITIES

Quality improvement activities will be documented utilizing a variety of tools and forms. The Governing Board and its Committees will document their activities in a minutes' format. The Quality Improvement Work Group PDSA cycles will be documented on a cycle of change form or on PDSA worksheets. Other forms and tools that may be used to document activities include narrative reports and trend sheets.

XII. EDUCATION and TRAINING

Educational and training needs for quality improvement and quality assurance activities will be identified by ~~Quality~~the Quality Improvement Work Group and/or the ~~FQHC Operations Officer~~ health center management team and will be provided in the appropriate setting. To ensure training occurs, a training plan for new employee orientation and ongoing training has been developed for each position type and is followed. Providers are required to have continuing medical education through lectures and seminars and their involvement in such activities are monitored annually. This will provide them with the opportunity to keep up with current trends and evidenced based medical care.

XIII. ANNUAL PLAN EVALUATION

The Quality Improvement Work Group is responsible for performing an annual evaluation of the appropriateness and effectiveness of the Quality Management Plan. The result of the annual evaluation is reviewed with the Quality, Risk and Credentials Committee. The Quality Management Plan is approved by the Governing Board annually.

XIV. CONFIDENTIALITY

SHND will maintain the confidentiality of patient records, including all information as to personal facts and circumstances obtained by SHND staff about recipients of services. Specifically, SNCHC will not divulge such information without the individual's consent except as may be required by law or as may be necessary to provide service to the individual or to provide for medical audits by the Secretary of HHS or his/her designee with appropriate safeguards for confidentiality of patient records.

Confidentiality statements are signed by all SNCHC employees, contracted providers, SNCHC Board, and guests. Information including, but not limited to, minutes, reports, medical records, or other documents used will be maintained to insure confidentiality for patients and providers. Access to these records will be restricted to the

administrative personnel as deemed necessary and will be kept in a locked file.

All information generated from the Quality Management Plan is considered confidential and will be exempt from subpoena or discovery. This is in accordance with Laws 2005, LB 361, Sections 71-8701 to 71-8721, which is known as the Patient Safety Act. Discussions in the context of peer reviews and medical record reviews are completely confidential.

XV. RESPONSIBILITIES

A. **SNCHC Board:** The SNCHC Board is ultimately accountable for the quality of care and services provided by SNCHC through the development of a comprehensive performance program. The Board delegates responsibility for implementation and evaluation of this program through the Quality, Risk and Credentials Committee and the Executive Director.

B. **Chief Executive ~~Director~~Officer:** The Chief Executive ~~Director~~Officer is responsible for implementation and evaluation of the CMP Plan as outlined in the above plan. In collaboration with the SNCHC Board, the ~~Executive Director~~CEO will work with the health center's management team to align the performance improvement activities with the strategic plan and prioritize improvement efforts.

C. **Quality Improvement Work Group:** A group of leadership and staff of SNCHC who operationalize the Quality Management Plan

D. ~~**FQHC Operations Officer/Chief Medical Officer/Medical Director/Dental Director/Behavioral Health Director**~~**Manager/Pharmacy Manager:** These positions are responsible for providing leadership support of the quality improvement/assurance program and to ensure the provision of high-quality care.

E. **Community Health Nurse Managers/Supervisors:** Directors, managers, and supervisors are responsible for the implementation of the QM program for their respective units/clinics/programs. In addition, these managers may serve as chairs, team leaders or as members of committees, subcommittees, teams, and/or task forces.

F. **Clinical Staff:** Clinical staff members should be familiar with the performance measures and QM initiatives of SNCHC and their respective unit/program/clinic. Clinical staff will be active participants in the performance improvement activities through participation on committees, subcommittees, teams, and task forces as appointed as well as through the implementation of improvement activities. The purpose of this participation is to bring the care provider's perspective to the performance improvement opportunities and initiatives of SNCHC as well as resolution of problems.

G. **Other Professional and Clinic ~~assified~~ Staff:** Staff members should be familiar with performance measures and Quality Improvement Work Group initiatives underway for SNCHC and their specific unit/program/clinic. Staff members will be asked to participate in these activities as well as participate on committees, subcommittees, teams, and task forces as appointed. The purpose of this participation is to provide a broader perspective of performance improvement opportunities and initiatives at SNCHC as well as resolution of problems.

Effective (Original) Date: 01/08/2020
Approval Date:
Distribution: All FQHC Division Staff
Review & Update: Annually
Revision Date(s): 01/01/2022, 05/10/2023, 01/09/2025
Responsible for Review & Update: FQHC Operations Officer
Distribution: All FQHC Division Staff
Rescinded Date: N/A
Related Policies/Reference: Quality Management Policy, Credentialing and Privileging Policy and Procedure, Protocol Development and Use Policy and Procedure, Risk Management Policy and Plan, Incident Reporting Policy and Procedure, Patient Grievance and Complaint Policy and Procedure

MEMORANDUM

Date: **January 21, 2025**

To: Southern Nevada Community Health Center Governing Board

From: Randy Smith, Chief Executive Officer, FQHC RS

Fermin Leguen, MD, MPH, District Health Officer FL

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

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

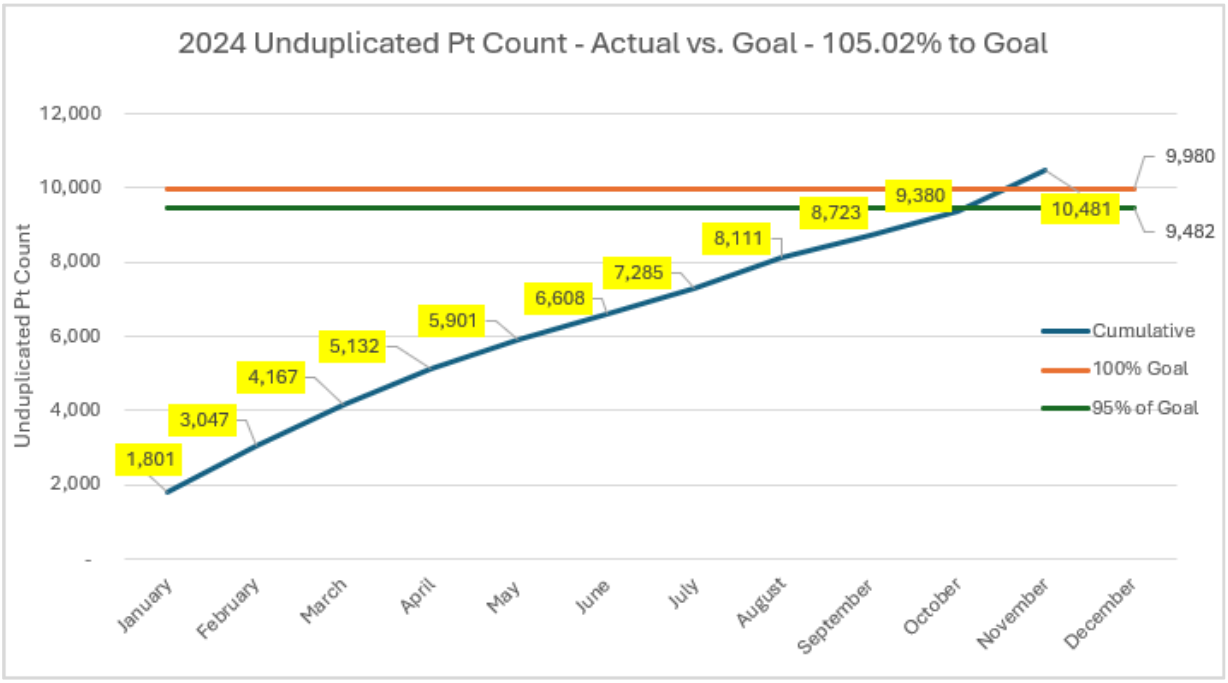
November Highlights

Administrative

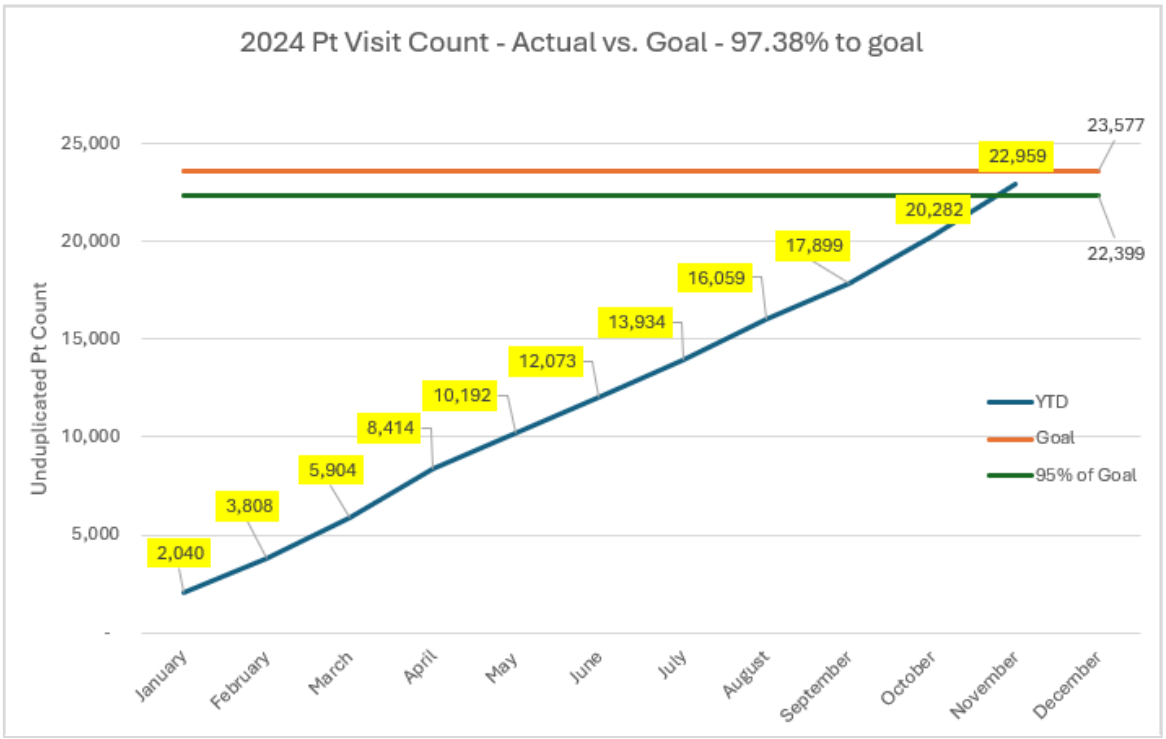
- HRSA Operational Site Visit (OSV): 2/25/25 – 2/27
- HRSA Title X site visit: 9/2025
- Ryan White site visit successfully completed on 11/6/24 with no findings.
- New Medical Director hired. Start date: 2/3/25
- Behavioral Health Clinic at Decatur buildout complete. Soft opening on 11/24.
    - Open House: 1/14/25

Access

Unduplicated Patients through November 2024



Patient Visits through November of 2024



Provider Visits by Program and Site – November 2024

Facility	Program	NOV '25	NOV '24	NOV YoY %	FY25 YTD	FY24 YTD	FY YTD YoY%
Decatur	Family Health	485	421	13%	2,873	1,909	34%
Fremont	Family Health	317	91	71%	1,728	665	62%
Total	**Family Health**	**802**	**512**	**36%**	**4,601**	**2,574**	**44%**
Decatur	Family Planning	132	148	-12%	798	685	14%
Fremont	Family Planning	55	46	16%	578	389	33%
Total	**Family Planning**	**187**	**194**	**-4%**	**1,376**	**1,074**	**22%**
Decatur	Sexual Health	384	592	-54%	2,602	2,839	-9%
Fremont	Sexual Health	133			640		
ASEC	Sexual Health		133		113	644	
Total	**Sexual Health**	**517**	**725**	**-40%**	**3,355**	**3,483**	**-4%**
Decatur	Behavioral Health	108	126	-17%	604	629	-4%
Fremont	Behavioral Health	113	0		593	1	
Total	**Behavioral Health**	**221**	**126**	**43%**	**1,197**	**630**	**47%**
Decatur	Ryan White	133	199	-50%	1,107	1,107	0%
Fremont	Ryan White	32			110		
Total	**Ryan White**	**165**	**199**	**-21%**	**1,217**	**1,107**	**9%**
FQHC Total		**1,892**	**1,756**	**7%**	**11,746**	**8,868**	**25%**

Pharmacy Services

	Nov-23	Nov-24		FY24	FY25		% Change YOY
Client Encounters (Pharmacy)	1,396	1,265	↓	5,355	5,449	↑	1.8%
Prescriptions Filled	1,934	2,058	↑	7,478	8,847	↑	18.3%
Client Clinic Encounters (Pharmacist)	31	61	↑	136	212	↑	55.9%
Financial Assistance Provided	16	24	↑	70	120	↑	71.4%
Insurance Assistance Provided	8	9	↑	18	44	↑	144.4%

A. Dispensed 2,058 prescriptions for 1,265 clients.
B. Pharmacist completed 61 client clinic encounters.
C. Assisted 24 clients to obtain medication financial assistance.
D. Assisted nine (9) clients with insurance approvals.

Family Planning Services

A. Family Planning program access is up 22% year-over-year. The program team administrators and clinical staff are engaged in a quality improvement project to increase access to care with the aim of simplifying the scheduling process and reducing waste in the appointment schedules.

B. The program is scheduled for a comprehensive site visit and audit of program compliance in September 2025. Work to prepare for the audit will commence following the health center's OSV in February 2025.

HIV / Ryan White Care Program Services

A. The Ryan White program received 67 referrals between November 1st and November 30th. There were three (3) pediatric clients referred to the Medical Case Management program in November and the program received three (3) referrals for pregnant women living with HIV during this time.

B. There were 450 total service encounters in the month of November provided by the Ryan White program Linkage Coordinators, Eligibility Workers, Care Coordinators, Nurse Case Managers, Community Health Workers, and Health Educator. There were 258 unduplicated clients under these programs in November.

C. The Ryan White ambulatory clinic provided a total of 341 visits in the month of November: 22 initial provider visits and 119 established provider visits including 11 tele-health visits (established clients). There were 24 nurse visits, and 176 lab visits provided. There were 51 Ryan White services provided under Behavioral Health by licensed mental health therapists and the Psychiatric APRN during the month of November and 37 unduplicated clients served. There were 14 Ryan White clients seen by the Registered Dietitian under Medical Nutrition services in November.

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

FQHC-Sexual Health Clinic (SHC)

A. The FQHC-Sexual Health Clinic (SHC) clinic provided 951 unique services to 655 unduplicated patients for the month of November.

B. There are currently more than 100 patients receiving injectable treatment for HIV prevention (PrEP).

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

D. The FQHC-SHC staff continues to offer Mpox evaluation and referral for vaccine.

E. The FQHC-SHC staff attended "Cultural Intelligence for Advanced Practice Providers: Moving a Contextually Based Model Forward for Workforce Training."

F. One Medical Assistant is continuing orientation in FQHC-SHC.

Refugee Health Program (RHP)

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

Client required medical follow- up for Communicable Diseases	-
Referrals for TB issues	2
Referrals for Chronic Hep B	0
Referrals for STD	4
Pediatric Refugee Exams	32
Clients encounter by program (adults)	40
Refugee Health screening for November 2024	72
Total for FY24-25	**305**

Eligibility and Insurance Enrollment Assistance

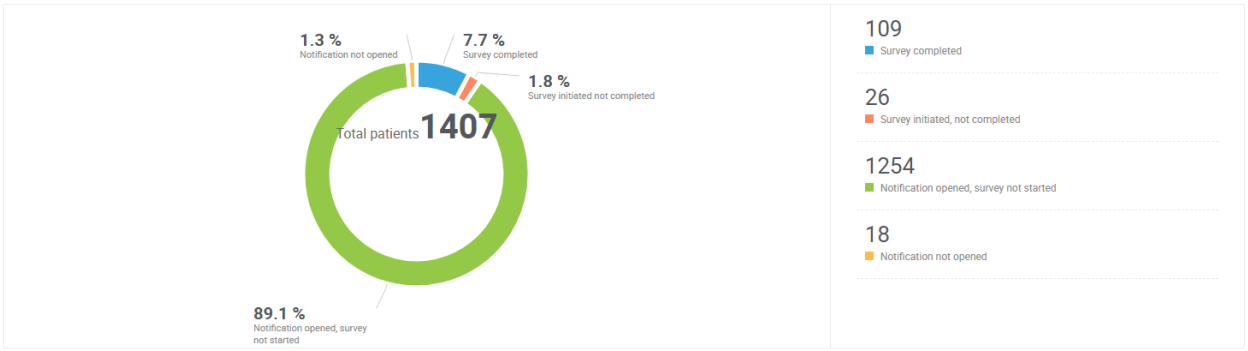
Patients in need of eligibility assistance continue to be identified and referred to community partners for help with determining eligibility for insurance and assistance with completing applications.

Patient Satisfaction: See attached survey results.

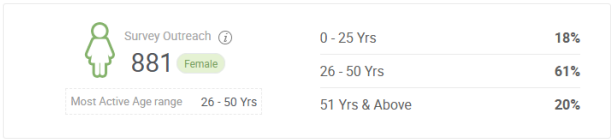
SNCHC continues to receive generally favorable responses from survey participants when asked about ease of scheduling an appointment, waiting time to see their provider, care received from providers and staff, understanding of health care instructions following their visit, hours of operation, and recommendation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

Southern Nevada Health Center
Patient Satisfaction Survey – November 2024

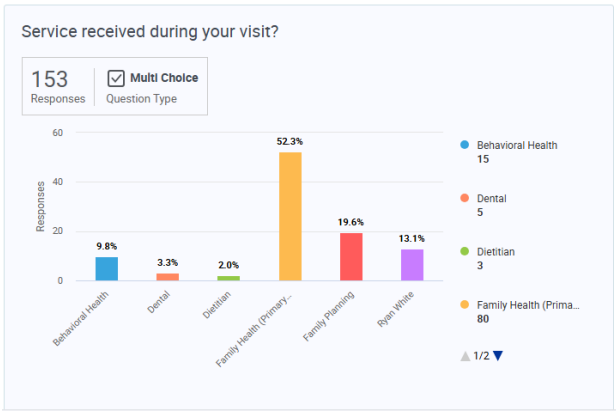
Overview

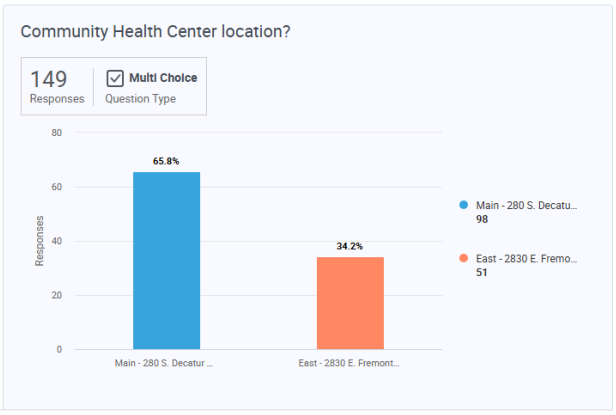


Gender



Service and Location

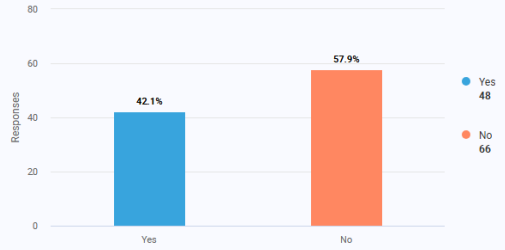




Provider, Staff, and Facility

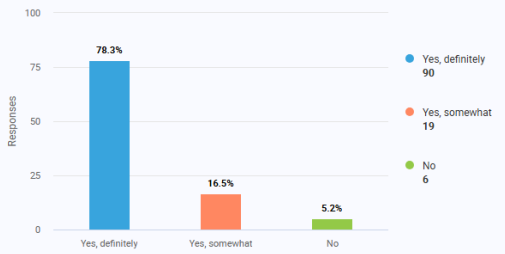
Was your most recent visit for an illness, injury or condition that needed care right away?

114 Responses | Multi Choice Question Type



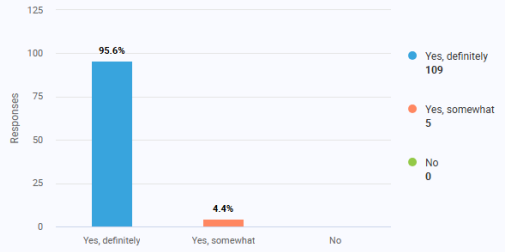
Was the recent visit as soon as you needed?

115 Responses | Multi Choice Question Type



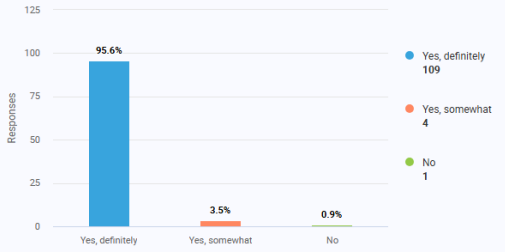
During your most recent visit, did this provider explain things in a way that was easy to understand?

114 Responses | Multi Choice Question Type



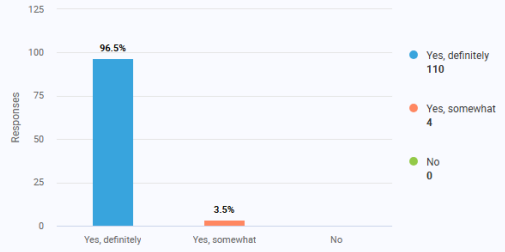
During your most recent visit, did this provider listen carefully to you?

114 Responses | Multi Choice Question Type



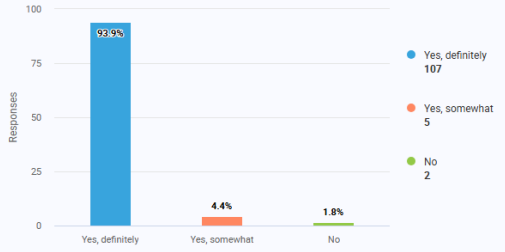
During your most recent visit, did this provider show respect for what you had to say?

114 Responses | Multi Choice Question Type



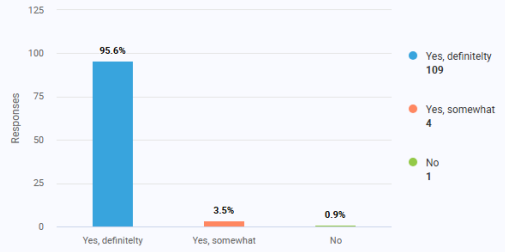
During your most recent visit, did this provider spend enough time with you?

114 Responses | Multi Choice Question Type



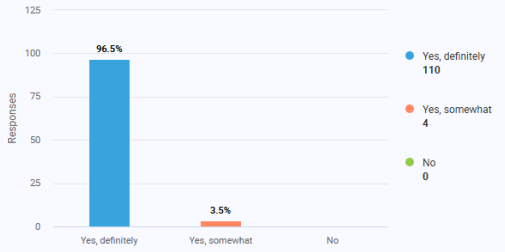
Thinking about your most recent visit, were the staff as helpful as you thought they should be?

114 Responses | Multi Choice Question Type



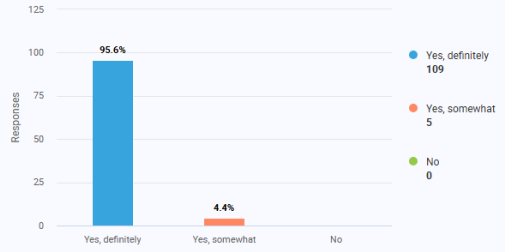
Thinking about your most recent visit, did the staff treat you with courtesy and respect?

114 Responses | Multi Choice Question Type



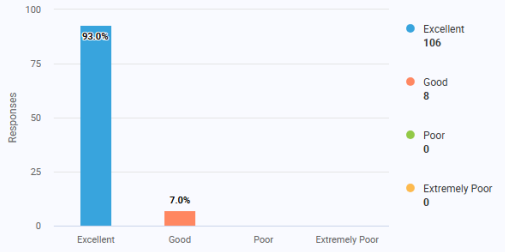
Thinking about your recent visit, was it easy to schedule an appointment?

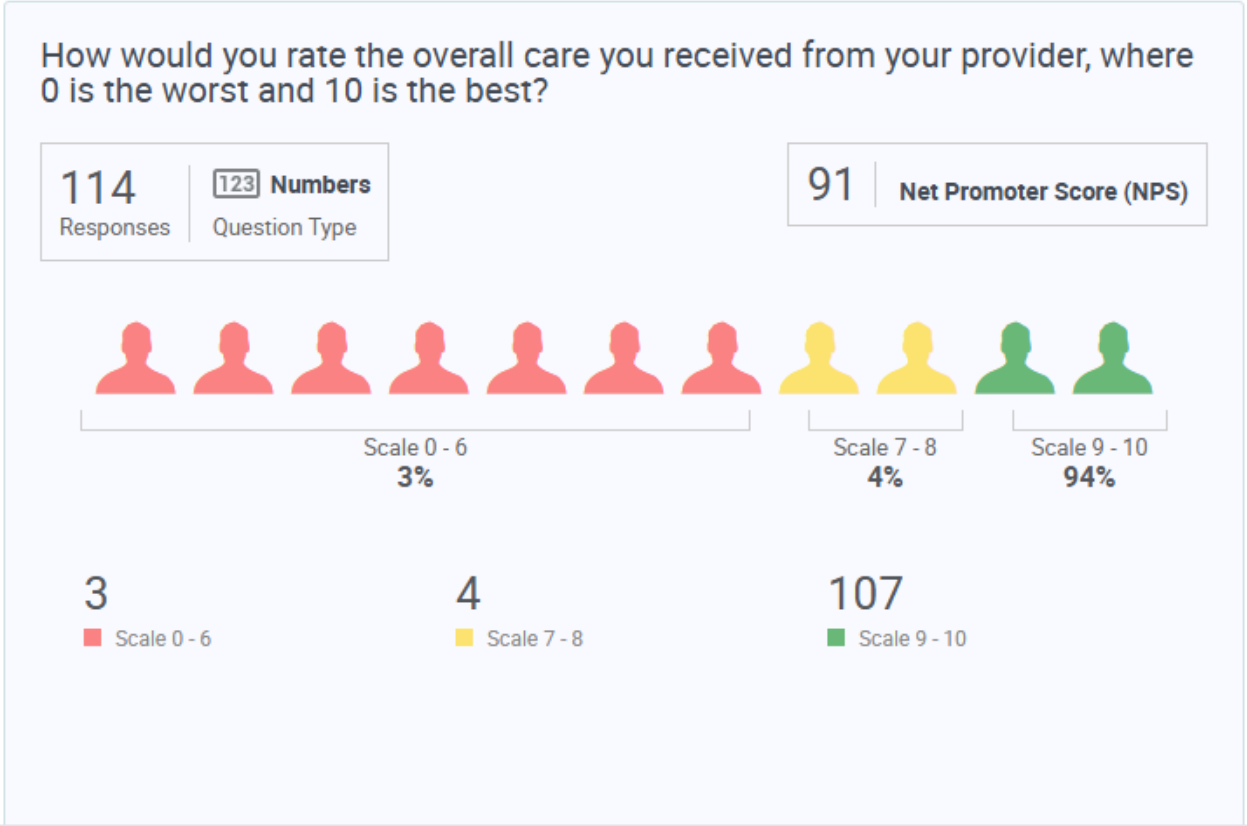
114 Responses | Multi Choice Question Type



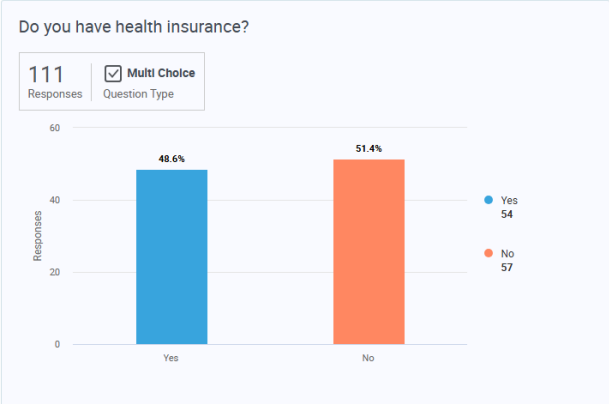
Thinking about the facility, how was the overall cleanliness and appearance?

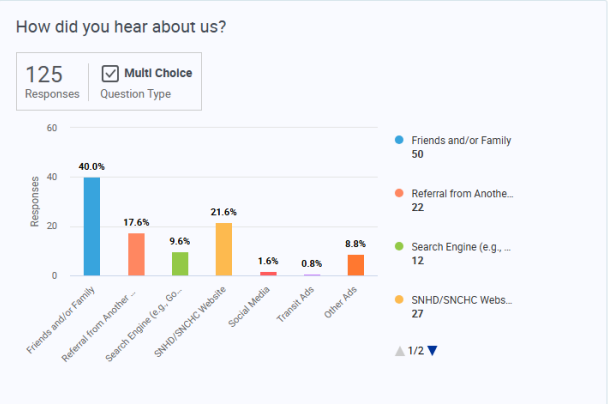
114 Responses | Multi Choice Question Type





General Information





SOUTHERN NEVADA Community HEALTH CENTER
AT THE SOUTHERN NEVADA HEALTH DISTRICT

MEMORANDUM

Date: **January 21, 2025**

To: Southern Nevada Community Health Center Governing Board

From: Randy Smith, Chief Executive Officer, FQHC RS

Fermin Leguen, MD, MPH, District Health Officer FL

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

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

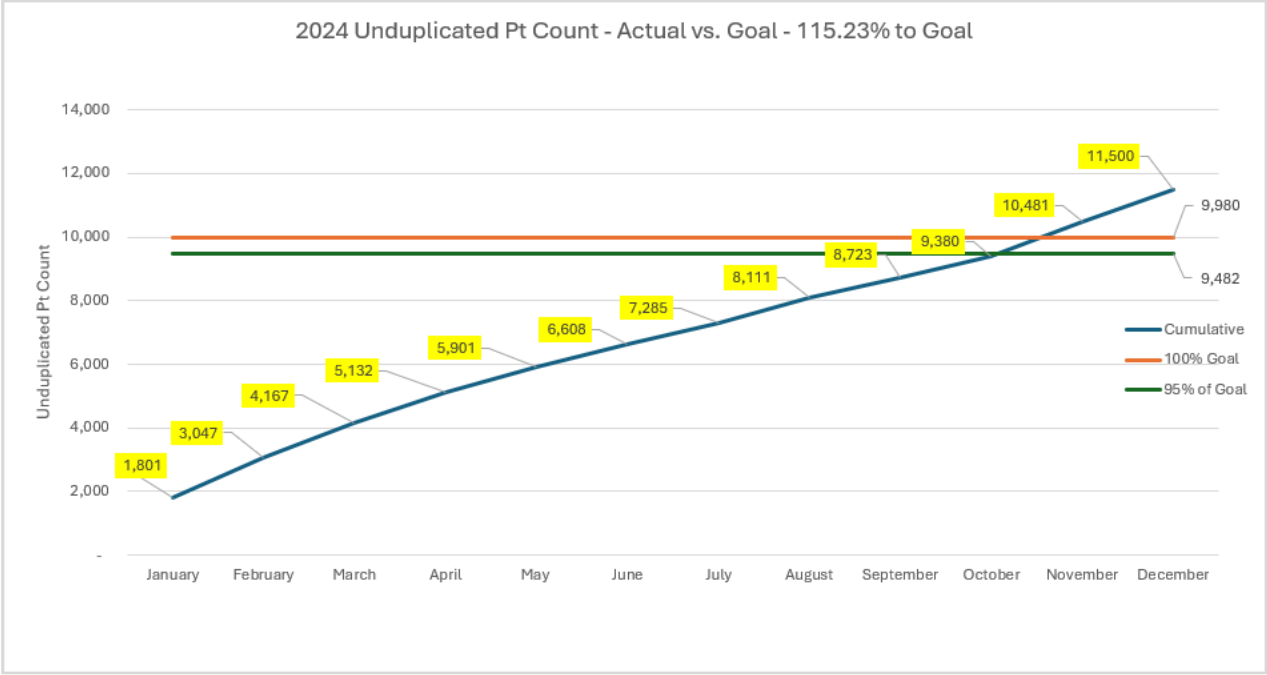
December Highlights

Administrative

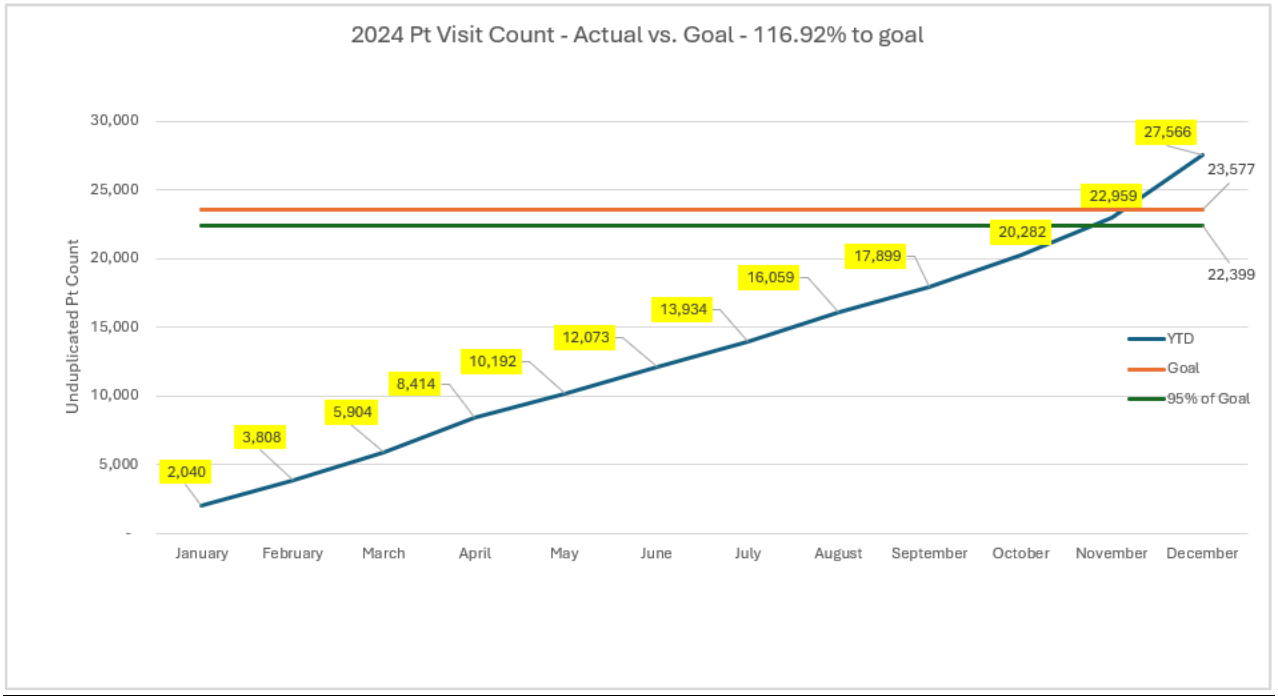
- HRSA Operational Site Visit (OSV): 2/25/25 – 2/27/25
- HRSA UDS annual report due 2/15/24
- HRSA FPAR 2.0 annual report due 2/28/25
- HRSA Family Planning Title X site visit: September 2025
- New Medical Director hired. Start date: 2/3/25
- Behavioral Health Clinic at Decatur Open House: 1/14/25
- HRSA Behavioral Health Technical Assistance engagement in March 2025
- Desiree Petersen, Community Health Worker awarded SNHD's employee of the year
- Annual unduplicated patient and visit goals exceeded in CY24

Access

Unduplicated Patients CY24



Patient Visits CY24



Provider Visits by Program and Site – December 2024

Facility	Program	DEC '24	DEC '23	DEC YoY %	FY25 YTD	FY24 YTD	FY YTD YoY%
Decatur	Family Health	640	306	52%	3,028	2,215	27%
Fremont	Family Health	257	115	55%	1,668	780	53%
Total	**Family Health**	**897**	**421**	**53%**	**4,696**	**2,995**	**36%**
Decatur	Family Planning	139	119	14%	805	804	0%
Fremont	Family Planning	159	60	62%	682	449	34%
Total	**Family Planning**	**298**	**179**	**40%**	**1,487**	**1,253**	**16%**
Decatur	Sexual Health	389	536	-38%	2,607	3,375	-29%
Fremont	Sexual Health	82			589		
ASEC	Sexual Health		99		113	743	
Total	**Sexual Health**	**471**	**635**	**-35%**	**3,309**	**4,118**	**-24%**
Decatur	Behavioral Health	99	94	5%	595	723	-22%
Fremont	Behavioral Health	100	0		580	1	
Total	**Behavioral Health**	**199**	**94**	**53%**	**1,175**	**724**	**38%**
Decatur	Ryan White	215	162	25%	1,189	1,269	-7%
Fremont	Ryan White	33			111		
Total	**Ryan White**	**248**	**162**	**35%**	**1,300**	**1,269**	**2%**
FQHC Total		**2,113**	**1,491**	**29%**	**11,967**	**10,359**	**13%**

Pharmacy Services

	Dec-23	Dec-24		FY24	FY25		% Change YOY
Client Encounters (Pharmacy)	1,198	1,413	↑	7,949	8,417	↑	5.9%
Prescriptions Filled	1,629	2,448	↑	11,041	13,866	↑	25.6%
Client Clinic Encounters (Pharmacist)	23	61	↑	190	344	↑	81.1%
Financial Assistance Provided	16	38	↑	102	200	↑	96.1%
Insurance Assistance Provided	1	12	↑	27	58	↑	114.8%

A. Dispensed 2,448 prescriptions for 1,413 clients.
B. Pharmacist completed 61 client clinic encounters.
C. Assisted 38 clients to obtain medication financial assistance.
D. Assisted 12 clients with insurance approvals.

Family Planning Services

A. Family Planning program access was up 40% in December and is up 16% year-over-year. The program team administrators and clinical staff are engaged in a quality improvement project to increase access to care with the aim of simplifying the scheduling process and reducing waste in the appointment schedules.

B. The program is scheduled for a comprehensive site visit and audit of program compliance in September 2025. Work to prepare for the audit is under way and will commence in full following the health center's OSV in February 2025.

HIV / Ryan White Care Program Services

A. The Ryan White program received 63 referrals between December 1st and December 31st. There were five (5) pediatric clients referred to the Medical Case Management program in December and the program received four (4) referrals for pregnant women living with HIV during this time.

B. There were 464 total service encounters in the month of December provided by the Ryan White program Linkage Coordinators, Eligibility Workers, Care Coordinators, Nurse Case Managers, Community Health Workers, and Health Educator. There were 269 unduplicated clients served under these programs in December.

C. The Ryan White ambulatory clinic had a total of 478 visits in the month of December: 24 initial provider visits and 198 established provider visits including 14 tele-visits (established clients). There were 30 nurse visits and 226 lab visits. There were 50 Ryan White services provided under Behavioral Health by the licensed mental health therapists and the Psychiatric APRN during the month of December with 44 unduplicated clients served. There were 10 Ryan White clients seen by the Registered Dietitian under Medical Nutrition services in December.

D. The Ryan White clinic continues to utilize the Rapid StART project, which has a goal of rapid treatment initiation for newly diagnosed patients with HIV. The program continues to receive referrals and accommodate clients on a walk-in basis. There were seven (7) patients seen under the Rapid StART program in December.

FQHC-Sexual Health Clinic (SHC)

A. The FQHC-Sexual Health Clinic (SHC) clinic conducted 471 provider encounters in the month of December.

B. There are currently more than 100 patients receiving injectable treatment for HIV prevention (PrEP). Patients scheduled for PrEP appointments are no-showing at a high rate. The Decatur CHN Manager is working with the SHC team to pilot new approaches to increase utilization of this service and reduce waste in the appointment schedules

C. The FQHC-SHC continues to collaborate with UMC on referrals for evaluation and treatment of neurosyphilis. The SHC is collaborating with the PPC- Sexual Health and Outreach Prevention Programs

(SHOPP) with the Gilead FOCUS grant to expand express testing services for asymptomatic patients and provide linkage to care for patients needing STI, Hepatitis C or HIV treatment services.

D. The FQHC-SHC staff continues to offer Mpox evaluation and referral for vaccine.

Refugee Health Program (RHP)

Services provided in the Refugee Health Program for the month of December 2024.

Client required medical follow- up for Communicable Diseases	-
Referrals for TB issues	5
Referrals for Chronic Hep B	1
Referrals for STD	1
Pediatric Refugee Exams	21
Clients encounter by program (adults)	33
Refugee Health screening for December 2024	54
Total for FY24-25	**359**

Eligibility and Insurance Enrollment Assistance

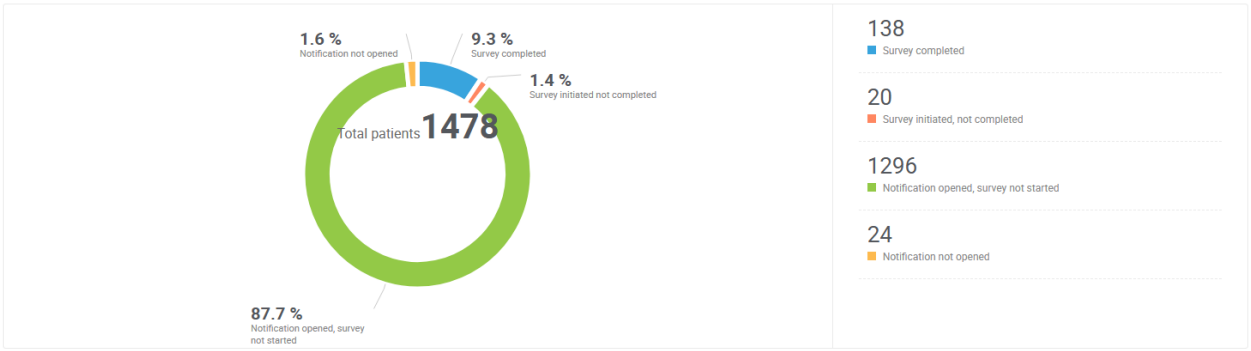
Patients in need of eligibility assistance continue to be identified and referred to community partners for help with determining eligibility for insurance and assistance with completing applications.

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.

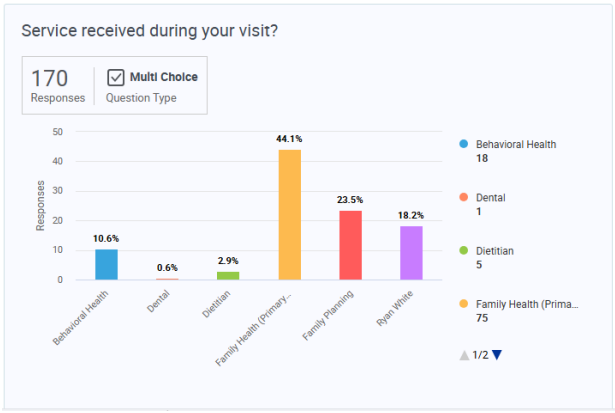
Southern Nevada Health Center
Patient Satisfaction Survey – December 2024

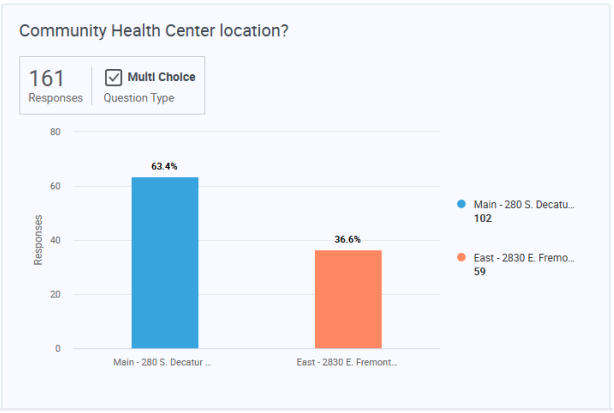
Overview



Gender

Service and Location

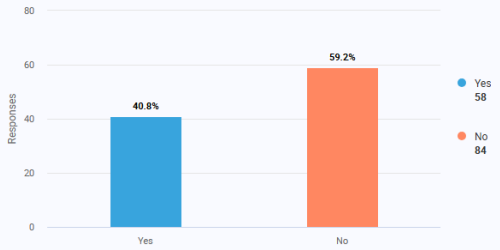




Provider, Staff, and Facility

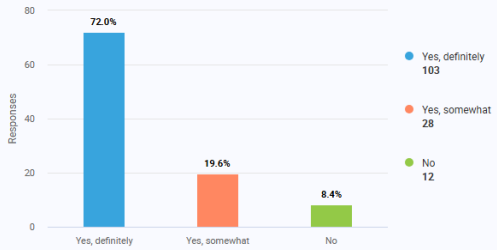
Was your most recent visit for an illness, injury or condition that needed care right away?

142 Responses | Multi Choice Question Type



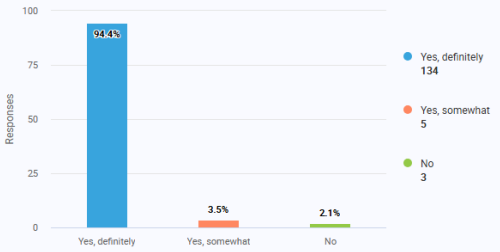
Was the recent visit as soon as you needed?

143 Responses | Multi Choice Question Type



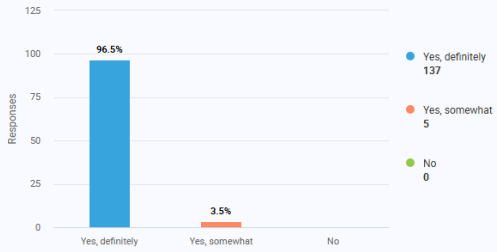
During your most recent visit, did this provider explain things in a way that was easy to understand?

142 Responses | Multi Choice Question Type



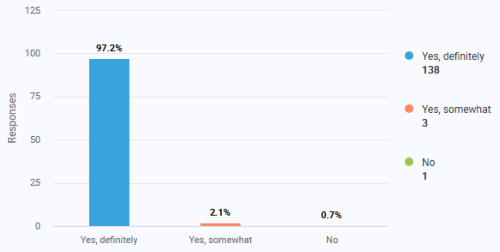
During your most recent visit, did this provider listen carefully to you?

142 Responses | Multi Choice Question Type



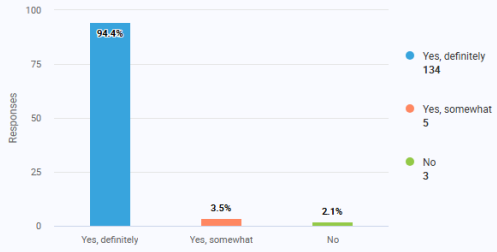
During your most recent visit, did this provider show respect for what you had to say?

142 Responses | Multi Choice Question Type



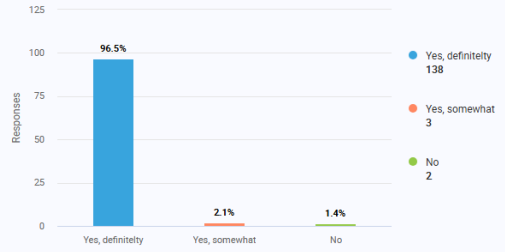
During your most recent visit, did this provider spend enough time with you?

142 Responses | Multi Choice Question Type



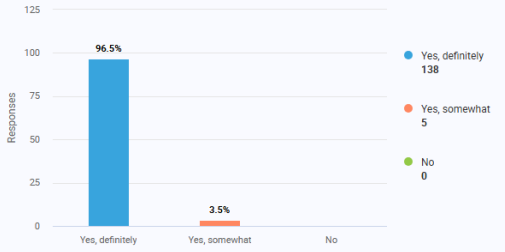
Thinking about your most recent visit, were the staff as helpful as you thought they should be?

143 Responses | Multi Choice Question Type



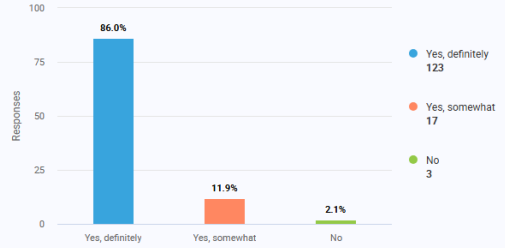
Thinking about your most recent visit, did the staff treat you with courtesy and respect?

143 Responses | Multi Choice Question Type



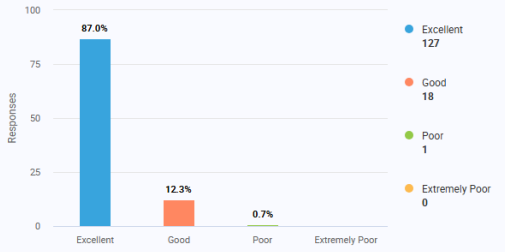
Thinking about your recent visit, was it easy to schedule an appointment?

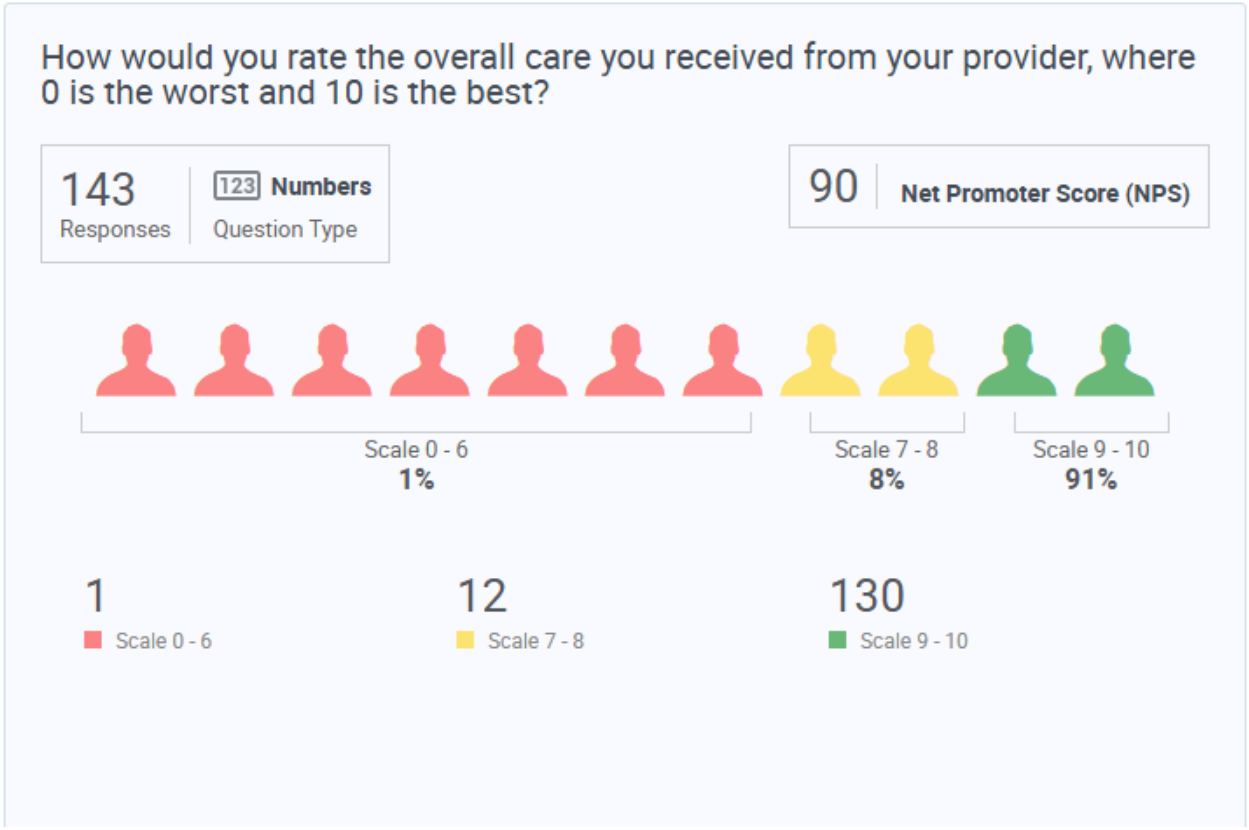
143 Responses | Multi Choice Question Type



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

146 Responses | Multi Choice Question Type





General Information