

Falls Community Health Governing Board Minutes
Thursday March 21, 2019 at 12:00 pm

Present: Susy Blake, Gwendolyn Martin-Fletcher, Jim Kellar, Bernie Schmidt, Jonathon Ott, Cindy Binkerd via phone,

Absent: Linda Karnof, Dr. Katie Skinner, Bruce Vogt, Tracy Johnson

Staff Present: Jill Franken, Alicia Collura, Amy Richardson, Dr. Jennifer Tinguely, Vanessa Sweeney, Lisa Stensland

Guest: Dr. Mark Huntington

Call to Order: The meeting was called to order by Jonathon Ott at 12:15 pm when quorum was established.

A motion was made to approve the minutes for Falls Community Health Governing Board dated February 21, 2019, supported by Bernie, seconded by Jim, motion carries.

NEW BUSINESS:

FINANCIAL REPORT:

The Falls Community Health reports attached are through the month ending February 28, 2019. We are 17% through the fiscal year. The last financials presented were through the month of December 2018.

Operating Revenues:

- Net Patient Revenue consists of all patient charges and adjustments. Total Net Patient Revenue for February came in at \$281,692 which is 12% of the YTD actuals to annual budget.
- Total Grant Revenue of \$277,595 includes grant drawdowns from the Community Health Center, Ryan White Part C, HIV Prevention, Family Planning and Refugee grants.
- Total Other Revenue is \$39,230 for February, this includes the quarterly Medicaid Health Home payment.

Total Operating Revenues YTD February is \$598,518 which is 11% YTD actuals to annual budget.

Operating Expenses: Operating expenses are classified within 7 categories. Total expenses were \$687,812 for the month of February.

- Personnel expenses are at 10% of the budget. February had 2 pay periods. 2019 is \$440K favorable to YTD budget.
- Professional Services are at 6% of the YTD budget. This category includes payments to Center for Family Medicine, locum providers, interpreter services and laboratory expenses.
- Rentals are at 4% of the YTD budget. Technology charges occur in July of every year.
- Repair and Maintenance is at 2% of the YTD budget.
- Supplies and Materials are at 10% of YTD budget. Category includes general medical and dental supplies, immunization & pharmaceuticals as well as the monthly maintenance of the electronic medical and dental software systems. 2019 is \$53K favorable to YTD budget.
- Training is at 12% of the YTD budget. The majority of expense are continuing education expenses and out of state travel. Majority of non-continuing education is paid through quality and expansion grants.
- Utilities are at 1% YTD budget. The majority of this expense occurs quarterly. Last payment occurred in December.

Non-operating Revenue (Expense):

- Other Revenue is at 20% of the budget and includes USD dental lease payments and recovery of prior year revenue.

Net Income (Loss):

- February actuals are showing net loss of (\$64,747) and YTD net income of \$30,478.

A motion to approve the financial statement as presented supported by Susy, seconded by Gwen, motion carries.

The Federal poverty guidelines published January 11, 2019 were reviewed along with the updated sliding fee discount schedule. Nominal charges remain at \$15.00 for medical services and \$35.00 for dental services for those patients at or below 100% of federal poverty guidelines.

Motion to approve the updated sliding fee discount schedule supported by Jim, seconded by Susy, motion carries.

QUALITY:

The nursing floor changes are to focus on improving care to the rising risk and general care populations.

Highlights of Completed Work

- Identified RN Rising Risk Patients
- Improved chart prep via creating a new chart prep report
- Identified workgroups around each rising risk diagnosis
- Workspace efficiencies
- Identified specifics of huddles
- Provided motivation interviewing training
- Floor nursing training this week on care planning for RN rising risk populations

What to expect on April 1, 2019

- Shift to 1.5 nurses per provider
- Enhanced communication between LPNs and RNs regarding schedules and expectations
 - LPNs will be doing enhanced chart prep
 - RNs will be doing pre-visit prep, rooming the patients and completing care plans on Risking Risk patients
 - Beginning only with Rising Risk- DM (patients who have DM and an A1C of 8 or greater)
- Staff moving into different workspaces
- Medication refills will be automated
 - APPs and Faculty are already turned on
 - 2nd years will be turned on by April 1st

A check list/feedback form will be used with the patients, also the clinical quality metrics should show improvement along with staff satisfaction.

The UDS measures are reviewed with the board annually to ensure we are meeting our goals. Measures that have been targeted over the last year were diabetes, hypertension and tobacco screening and cessation.

The diabetic measure is the percentage of patients 18–75 years of age with diabetes who had an A1c (HbA1c) greater than 9.0. If a patient can keep their A1c in control, there will be fewer long-term complications, such as amputations, blindness, and end-organ damage. Interventions that have been implemented include increased education for those rising risk patients, trialing a group class for education/management, reviewing the care teams twice per year and notifying patients that need to be seen.

The hypertension measure is the percentage of patients 18–85 years of age who had a diagnosis of hypertension and whose blood pressure (BP) was adequately controlled (less than 140/90 mmHg) Controlling High Blood Pressure results in less cardiovascular damage, fewer heart attacks, and less organ damage later in life if there is less uncontrolled hypertension. Interventions implemented include: for the Rising-risk population with uncontrolled HTN + Tobacco Use, Increase education, goal setting, Care Team Dashboard review is done quarterly, reviewing care team lists twice per year and follow up reminders to patients that need to be seen.

The Tobacco screening and cessation measure is the percentage of patients aged 18 years of age and older who (1) were screened for tobacco use one or more times within 24 months, and (2) if identified to be a tobacco user received cessation counseling intervention. Lowering tobacco use along with screening and cessation intervention: Patients will be more likely to quit using tobacco and will therefore have a lower risk of cancer, asthma, emphysema, and other tobacco related illnesses if they are routinely queried about their tobacco use and are provided with cessation counseling and/or pharmacologic intervention if they are tobacco users. Interventions include: for the Rising-risk

population with Uncontrolled HTN + Tobacco Use, increase education and goal setting, adding a column for tobacco use to the HTN Care Team lists for awareness, updated Medcin Nursing Intake form and retrain nursing staff.

The Depression screening measure is the percentage of patients aged 12 years and older screened for depression on the date of the visit using an age-appropriate standardized depression screening tool and if positive, a follow-up plan is documented on the date of the positive screen. Preventive care and screening for depression with a follow-up plan; patients will be more likely to receive needed treatment and less likely to suffer from the complications of depression if they are routinely screened for depression and are provided with a follow-up plan when screened as positive. Interventions include utilization of the Triage Counselor, Counselors meeting 2/month [working to formalize workflows for the referral process (ex: if a patient has an elevated PHQ-9 score, they would automatically meet with the triage counselor)]

Colorectal cancer screening measures the percentage of patients 50 through 75 years of age who had appropriate screening for colorectal cancer. Early intervention is possible and premature death can be averted if patients receive appropriate colorectal cancer screening. Interventions include: an RN Navigator to provide reminders to patients to return kits, scheduling colonoscopies, education to patients on colonoscopy prep. A Happy Birthday "You and your Colon are 50!" cards will be sent. Care Team Dashboards and lists provided quarterly, education mailed to pts, nursing competitions to screen the most patients, and coming up - mailing education to our 49 year olds to get them thinking about getting screened.

ACCESS: Deferred

UDS Report:

Every year, as part of our grant compliance, Falls Community Health is required to submit an annual data report. The report includes: patient demographics and financial status, revenue and expenses, and quality measures and diagnoses. The federal government and Falls Community Health use this information to show and monitor program improvements, monitor quality programs and track fiscal performance.

- Patient Demographics- in 2018, 12,103 patients who generated 41,558 visits. Ten years ago there were 12,263 patients generating 39,848 visits.
- Zip code- 26% of our patients reside in 57103, 27% in 57104, 8% in 57105, 12% in 57106, and 7% in 57110. This did not change much from last year
- Payer Mix- 49 % of our patients are uninsured, 29% on Medicaid, 6% on Medicare and 16% are insured.
- Age/Gender- 0-18 years old 26%, 19-39 years old 37%, 40-64 years old 32% and 65+ 5 %. 47 % are male and 53 % are female.
- Race – 55% are white, 11% are American Indian, 23% Black, 7% Asian, 0% Pacific Islander, 4% more than one race or unreported.
- Language best served- 20% of all patients are best served with a language other than English. There are 32 different languages and the top 3 being Nepali, Spanish and Swahili.
- Homeless- 1,367 patients identified as being homeless, most being between 19-64 years old.
- The number of patients utilizing the Prescription Assistance Program (PAP) has increased from 392 in 2016 to 629 in 2018. Those same years saw the number of refill increase from 1528 to 2839.
- Medication assisted treatment (MAT) has increased from 26 patients in 2016 to 75 in 2018, with the number of prescriptions increasing from 194 to 639 in those same years.

BOARD SELF ASSESSMENT: Deferred

EXECUTIVE DIRECTOR'S REPORT:

See report below:

PUBLIC INPUT:

None at this time

Meeting adjourned at 1pm with loss of quorum.



Jonathan Ott- Board Vice- Chair April 18, 2019

March 2019 FCH Executive Director Board Update

Board Update Patient board member- We have an applicant who has been referred to the Mayor's office to fill the open board position. Her name is Linda Barkey and she was referred by Megan Nagel.

Provider Updates

Dentist Vacancy- Dr. Lacayo very unfortunately will not be joining FCH dental clinic. She has been undergoing tests for a health condition that will require her to stay in NY for treatment needs. We have reposted and received one application for the position.

APP Vacancy- an offer has been accepted to fill the APP open position due to Judy Jacobson's retirement. Pending credentialing and HR screenings, this APP will start mid-July.

Operational Updates

CFM Contract- our agreement with CFM is due for renewal. Denisa, CFM office manager, and Amy have developed a project plan to execute a new agreement before the expiration date of July 31st. Dr. Jean Heisler, CFM faculty and FCH provider will be retiring the end of June. Robust recruitment efforts are underway for her replacement.

FCH 2020 Budget- the city budget process is underway. Among the changes to the process this year is a method of ranking new priorities for the city using a Request for Results application and scoring process to prioritize new programs or initiatives.

One Sioux Falls: Health Priorities-

Triage Center Pilot Implementation: this initiative will create a voluntary midlevel care alternative for those with substance abuse disorder and/or mental illness to provide assessment and early intervention as well as referral to ongoing treatment needs. Phase 1 of the project has been completed: data collection and analysis, along with a project concept plan. Phase 2: further feasibility assessment and development of an implementation plan is currently underway.

Livable Cities Recognition: Health had a goal that Sioux Falls would join the AARP Network of Age-Friendly State/Communities by December 2019. This goal has been completed and Sioux Falls is the newest member of the AARP Network of Age-Friendly Communities – the first South Dakota community to earn the honor.

As a member, Sioux Falls gains access to global resources on age-friendly best practices, models of assessment and implementation, and the experiences of towns and cities around the world.

The Age-Friendly Network was launched in 2012 and operates under the auspices of the World Health Organization's Age-Friendly Cities and Communities Program. Its purpose is to help participating communities become great places for people of all ages by adopting features such as safe, walkable streets; better housing and transportation options; access to key services; and opportunities for residents to participate in civic and community activities.

2019 CHNA Report- the 2019 Community Health Needs Assessment, a joint partnership between SFHD, Sanford, and Avera will be released early April. A press conference is being scheduled to present findings to the public.