Community Health Centers
OF BENTON & LINN COUNTIES

Board of Directors' Policies & Procedures

Community Health Centers
OF BENTON & LINN COUNTIES

BOARD POLICY & PROCEDURE

Governance Policy #01
CHC Governing Style

Effective 09/24/2012
Reviewed: 12/2024

POLICY

The Board will govern by encouraging diversity in viewpoints and an emphasis on:

- Outward vision rather than internal focus,
- Strategic leadership more than administrative detail,
- A clear distinction between Board and Executive Director roles,
- Collective rather than individual decisions,
- A focus on the future rather than the past or present, and
- Being proactive rather than reactive

Accordingly:

1. The Board will direct, control, and inspire the organization by establishing written policies that reflect the Board's values and desired outcomes. The Board's major policy focus will be on the intended long-term effects of the Community Health Center on the target populations and the larger community, not on the administrative or programmatic means of attaining those outcomes.

2. The Board will demonstrate the discipline needed to govern with excellence. Members will demonstrate their commitment to governance in attendance, preparation for meetings, following approved policies and procedures, respecting board and staff roles, and assuring informed decision-making.

3. The Board, not the staff, will govern. The Board will initiate policy, not merely react to staff initiatives. The Board will use the expertise of individual members to enhance the ability of the Board as a whole rather than allow individual judgments to become Board values.

4. The Board will promote Board development by regularly evaluating its performance to identify areas for improvement. The Board will ensure new members receive orientation and mentoring in the governance process. Board members should be familiar with the National Association of Community Health Centers - Governance Guide for Health Center Boards as the model from which the Health Center Board governs.

5. The Board meets monthly. Members will follow Robert's Rules of Order.

ATTACHMENT: Governance Model

The Board uses the John Carver Policy Governance Model. The promises that attract a Board to Policy Governance fall into four categories:

- Clear distinction between board and CEO roles
- Efficient governance process
- Greater accountability to owners
- Fulfillment of the board's mission
-

<u>The Principles of Policy Governance</u>

1. The Trust in Trusteeship
   Because Board members act as trustees on behalf of a larger group the Board must identify who that larger group is and make certain that the organization achieves its goals.

2. The Board Speaks with One Voice or Not at all
   The Board's decision must be clear, recorded in policy, and upheld by all the members as if it had been a decision each made individually. No member has the authority to speak for the board unless specifically authorized to do so by the whole Board.

3. Board Decisions Should Be Policy Decisions
   Because the Board's voice is expressed in its policies, board decision-making is always an amendment of or an addition to an existing policy.

4. Boards Should Formulate Policy by Determining the Broadest Values Before Progressing to Narrower Ones.
   Boards should delegate details and concentrate on why those details matter.

5. A Board Should Define and Delegate Rather Than React and Ratify.
   A Board should not be led by staff members or by its committees. The Board itself should work together to define the results the organization is to produce.

6. Ends Determination Is the Pivotal Duty of Governance.
   On behalf of the ownership, the Board must establish the target toward which the staff works in terms of the benefits to be produced, the people to be served, and the cost of meeting these goals. This is the heart of governance.

7. The Board Can Best Control Staff Means by Limiting, Not Prescribing.
   Boards cannot oversee all the staff in the organization. It is easier for the Board to tell the CEO/Executive Director what the goals are and then to allow the CEO to use their expertise and experience to determine how best to get there within the limits established by Board policy.

8. A Board Must Explicitly Design Its Products and Processes
   All Board members should clearly understand why the Board exists. The purpose is not to oversee the staff but to define the future on behalf of the ownership and to ensure

the future is achieved ethically and prudently.

9. A Board Must Form an Empowering and Safe Linkage with Management
   The Board must understand their role and the staff's role for the organization and the staff must have a similar understanding. As long as these roles do not overlap, then the staff can work freely within the Board's established limitations.

10. CEO/Executive Director Performance Must Be Monitored Rigorously but Only Against Policy Criteria
    The Board judges the staff only according to the Board's own rules and the staff will know those rules because they have been stated in the policies

Community Health Centers
OF BENTON & LINN COUNTIES

BOARD POLICY & PROCEDURE

Governance Policy #02
Board By-laws and Policies

Effective: 03/2009
Reviewed: 12/2024

POLICY

The Board is responsible for leading the Community Health Center toward the desired outcomes and representing the community and the populations served in determining and monitoring appropriate organizational performance.

To assure effective governance:

1. **By-laws:** The Board will follow the By-laws established and review the By-laws at least every three years. The Executive Committee will be responsible for facilitating the By-laws review.

   Recommendations for changes to the By-laws may be introduced by:

   a) The Executive Director to ensure compliance with Health Resources and Services Administration (HRSA) regulations

   b) Any Board member may suggest a change in By-laws to the Executive Committee. The Executive Committee will review the request and bring it to the full Board for further consideration. Revisions and amendments will follow the process outlined in the By-laws.

2. **Board Policies:** The Board will have written governing policies that address components of governance. Policies should be reviewed every three years; however, revisions may occur at any time throughout the year.

   Policies are organized in the following manner:

   a) Governance Process Policies: Describe how the Board operates and carries out its responsibilities, how organizational performance is monitored to achieve expected results in key performance areas, and how the Executive Director is evaluated.

   b) Additional Policies outline Board responsibilities for oversight, authority, and approval in compliance with HRSA governance requirements. These policies address the sliding fee program, budget, monitoring financial performance, quality improvement, services and hours of operation, and strategic planning.

Community Health Centers
OF BENTON & LINN COUNTIES

BOARD POLICY & PROCEDURE

P & P: #3 GOVERNANCE PROCESS
CHC Board & Board of Commissioners Relationship

Effective 9/24/12
Reviewed: 2016, 2021, 2024

POLICY

The CHC is a public entity with expectations for governance as outlined in HRSA Policy Information Notice 2014-01: Health Center Program Governance. The Health Center fulfills the requirements through a Co-Applicant Agreement between the Health Center Board of Directors and Benton County Board of Commissioners.

A portion of the policy statement provided in *Section IV Public Center Governance, A. Public Center Co-Applicant Provision* is stated: "When the public agency's board cannot independently meet all applicable health center governance requirement, a separate "co-applicant" must be established whose governing board meets section 330 governance requirements. In the co-applicant arrangement, the public agency receives the section 330 grant and co-applicant serves as the "health center board" with the two collectively considered as the "health center" or "public center." The guidance provides further clarification on governance expectations for the co-applicant and the public entity.

Accordingly;

1. Language outlining approval authority is outlined in the following documents.
   a) ***BCHC Board of Directors By-laws:*** Reference Article V where general parameters are defined
   b) ***Cooperative Operational Agreement:*** Created in March 2004, and updated July 2023, for the Benton County Board of Commissioners and Benton Community Health Center Board to jointly apply for the FQHC grant. Section (3) provides general references to Operation of the Center. A copy of the agreement is available in the Board Manual, Board Operations Section.
2. To provide further clarity for the approval process the following approval/concurrence responsibilities are recommended:

Function/Process	Board of Directors	Board of Commissioners or Designee
Federal grants	X	X
Other grants	X	Over $50K
Financial oversight	X	
Budget	X	X
Fees	X	

Sliding Fee & Collections	X	
Contracts	X	
Hire & Evaluation of ED	X	
Personnel Policies		X
Facilities/Lease		X
Scope of Services	X	
Hours of Operation & locations	X	
Quality of care audit procedures	X	
Credentialing	X	
Pt satisfaction & grievance process	X	
Strategic Plan	X	X
Selection of Board Members	X	

3. Regular communication between the Board of Directors and Benton County Commissioners is very important. Some of the specific methods include;
   a) One County Commissioner regularly attends the Health Center Board meetings.
   b) Health Center Board minutes are available to County Commissioners
   c) The Health Center Director as a Benton County Department Head meets with Commissioners on the same schedule as other Department Heads. Minutes of that meeting are available to the Board of Directors
   d) Commissioners are invited to attend Board meetings as needed when critical issues are to be discussed.
   e) The Board Chair may attend meetings with the BOC when critical issues are discussed.

Community Health Centers
OF BENTON & LINN COUNTIES

BOARD POLICY & PROCEDURE

P & P: #04 **GOVERNANCE PROCESS**
Board Meeting & Agenda Planning

Effective 02/2013
Reviewed: 03/2025

POLICY

To perform the responsibilities of the Community Health Center Board and accomplish desired goals, the Board meets monthly and follows a governance style consistent with Board policies and By-laws. The Board develops an annual agenda planning calendar to ensure that important topics of interest, training, and required activities are completed.

Accordingly:

1. Meetings are scheduled on the third (3rd) Monday of each month from 6:30 p.m. – 8:30 p.m. In the event there is a conflict due to a holiday, the meeting will be moved either to the fourth (4th) or fifth (5th) Monday as determined by the Board.
2. As a Public FQHC, Health Center Board meetings are subject to Public Meeting Laws and are open to the public.
3. Meetings are led by the Board Chair and are conducted using Robert's Rules of Order.
4. The agenda aligns with the strategic plan, focusing on Thriving Communities, Organizational Excellence, Patient-Centered Care, and Fiscal Vitality. The agenda includes monthly reports from the Medical Director and the Health Financial Officer.
5. The Agenda will include a consent agenda format. Consent agenda items are used to address actions requiring Board approval that are more routine, such as minutes, reports, established grants and contracts, standing items specified by the Bureau as requiring approval, such as the sliding fee scale, etc. It may also be used to approve Board work related to policy and procedure development and review. To discuss agenda items, they must be removed from the consent agenda. All consent agenda items are approved through one motion approving the consent agenda.
6. Each year, the Board and Executive Director will conduct agenda planning for the next calendar year. This activity will be coordinated with the review and update of the organization's strategic plan.
7. Agenda planning can also include consideration of the following:
   a) The Board Development Committee's input to assist in planning education topics for the year. Board education will be recommended in the areas of governance topics, enhancing understanding of current services and potential service gaps, and broader

health policy and transformation initiatives at the local, state, and federal level impacting the organization.

b) Input from selected groups, community organizations, and target populations to gain a broader understanding of issues and gaps within the communities served by the Health Center.

c) Review of Board policies & procedures as needed.

Community Health Centers
OF BENTON & LINN COUNTIES

BOARD POLICY & PROCEDURE

P & P: #05 **GOVERNANCE POLICY**
Board Member Responsibilities

Effective 03/2009
Reviewed: 03/2022, 05/2025

POLICY

The Board **speaks with one voice and** as a whole is responsible for the governance of the Community Health Center. Individual Board members will put the interest of the Health Center above personal, special interest groups, or business interests. Board member responsibilities relate directly to the Health Center's organizational needs and circumstances.

Board Member Guidelines & Responsibilities:

1. Attend all Board meetings and other Board-sponsored functions.
2. Serve on committees, task forces, or workgroups and offer to take on special assignments.
3. Review the agenda and supporting materials before Board and committee meetings.
4. Be informed and participate in determining the organization's mission, services, policies, and programs.
5. Understand that no member has the authority to speak for the Board unless specifically authorized to do so by the whole Board.
6. Inform others in the service area about the organization and enhance awareness within the community.
7. Be aware of developments in health care that may impact Federally Qualified Health Centers.
8. Understand and follow established Board policies. Review and approve policies, including quality assurance and quality improvement policies.
9. Follow conflict of interest and confidentiality policies; ensure legal and ethical integrity and accountability.
10. Assist the Board in carrying out its fiduciary responsibilities, including development of the biennial budget and reviewing the organization's monthly financial reports.
11. Assure effective organizational planning. Actively participate in the strategic planning process.

12. Understand that the Board's role is governance (how goals are accomplished), and operations are the responsibility of staff. Refrain from making individual member requests of the staff.
13. Participate in recruitment, evaluation, and ongoing support of the Executive Director.
14. Determine the board strategic composition needs (i.e. experience, service area representation, etc.) and fulfill the composition requirements for the health center board with at least 51% patient majority.

Health Center Board members, like all members of corporate Boards – for-profit and nonprofit alike – have certain fundamental obligations as Board members. These are further described below.

Duty of Care

Health Center Board members are held to a "standard of care" in carrying out their responsibilities as Board members. That standard, which applies to Board members of nonprofit organizations generally, is the care that an "ordinarily prudent person" would take if he or she had those responsibilities. Thus, Board members can take risks and can make mistakes without fear of being held personally liable as long as they exercise reasonable care in making decisions.

The Duty of Loyalty

The duty of loyalty means that a Board member must put the Health Center's interests above the member's interests, including the interests of family members, a particular service area, and business associates. A common threat to fulfilling the duty of loyalty occurs when a Board member, or a person or organization closely related to the member, has business dealings with the Health Center. The minimum requirement for fulfilling the duty of loyalty in potential conflict situations is that the Board member discloses the conflict (or potential conflict) to the rest of the Board.

The Duty of Obedience

The duty of obedience requires that Board members ensure that the Health Center remains true to its mission. In the narrow sense, this simply means making sure that the Health Center operates within the scope of the legal authority contained in the legal documents under which the Health Center is organized (Board Bylaws), as well as other Board-established policies. In the broader sense, the Board is obliged to make sure that the Health Center stays true to its purpose. To that end, the Board should periodically review the Health Center's mission statement, its organizational documents, and Board policies and procedures to make sure that the Health Center is operating as described.

P & P: #6	GOVERNANCE PROCESS Board Development & Self-Evaluation	Page 1 of 1 Effective: 10/22/12 Reviewed: 9/19/16, 2022

POLICY

The Board promotes activities to assure success as a Board team. Just as the progress of the organization is evaluated, the Board team will evaluate their performance and monitor its processes, performance, and educational needs to assure excellence in governance.

Process:

1. Under the leadership of the Board Development Committee, the Board will annually conduct a self-evaluation using an identified assessment tool.

2. The Board Development Committee will distribute a report of the results and lead discussion to interpret outcomes and make recommendations.

3. The Board will recommend specific activities with the goal of improving Board performance and identifying training opportunities. Recommendations will be incorporated in agenda planning for the coming year.

BENTON COUNTY HEALTH SERVICES
POLICY – PROCEDURE MANUAL

SUBJECT: CONFLICT OF INTEREST POLICY

SECTION: ADMIN **PROGRAM:** ALL **PAGE:** 1 OF 3

HEALTH CENTER DIRECTOR: LACEY MOLLEL **DATE:** 05/21/2025

HEALTH DIRECTOR: APRIL HOLLAND **DATE:** 05/21/2025

HEALTH CENTER BOARD CHAIR: JEFF BETHEL DocuSigned by: Jeffery Bethel 29E47A7D7A9647E... **DATE:** 05/22/2025

REVIEW BY & DATE:

PROGRAM DISTRIBUTION: ALL

Purpose

To ensure that employees of Benton County Health Services disclose issues that may be a real or apparent conflict of interest and provide a process to determine the materiality of such potential conflict of interest, along with a method of addressing any issue that is determined to be a conflict of interest. Health Services employees are prohibited from activities that would result in a personal gain because of a conflict of interest.

POLICY

Benton County Health Services staff are considered public employees under ORS 244.020 and must follow the guidelines regarding conflict of interest under that statute.

1. Definition

The Oregon Government Standards and Practices laws define “potential conflict of interest” and “actual conflict of interest”. Both relate to taking official action that may result in financial benefit or avoiding a negative financial effect on the public employee, the employee’s relative, or a business with which the employee or the employee’s relative is associated.

As the term implies, a potential conflict of interest occurs when an action potentially could affect the financial interest of the public employee, or the employee’s relatives or associated businesses.

An actual conflict occurs when such action definitely would have such an effect.

2. Actions

   Allowable actions vary depending on the employee’s role.

   Elected officials and members of the boards and commissions:

   An elected official or a person appointed to a board or commission must publicly declare a potential or actual conflict of interest before discussion, recommendation, vote, or other official action on an issue. The official must also explain the nature of the conflict. The declaration and the nature of the conflict must be noted in minutes.

   With a potential conflict of interest, an official may participate in the action once the announcement has been made.

   In the case of an actual conflict of interest, the person must:
   a) declare the actual conflict and announce its nature; and
   b) refrain from taking any official action on the issue.

   At each session or meeting at which the issue is addressed, the official must make the same public declaration. However, the official is required to make that announcement only once at each meeting, even if the issue involves a series of votes.

   If the official’s vote is necessary for the public body to achieve a quorum, the official may vote but may not discuss or debate the issue.

3. General

   An employee who is a member of a committee and may have a potential conflict of interest should not participate in the decision in cases where the potential conflict creates the appearance of bias.

4. Recording

   The announcement of a potential conflict of interest must be duly noted in the minutes of any meeting.

Compliance requires:

- Full disclosure annually, by notice in writing, shall be made to the employees' supervising manager in all real or apparent conflicts of interest.

- Any employee having a duality of interest or potential conflict of interest must not use his / her personal influence on the matter.

- No Health Services employee may participate in the discussion, selection, award, or administration of a contract supported by all or part of an award if he or she has a real or potential conflict of interest.

- Benton County Health Services employees may neither solicit nor accept gratuities, favors, or anything of monetary value from contractors or parties to subcontracts.

- Benton Health Services employees will be informed of the Conflict-of-Interest Policy annually.

Ramifications

- Employees violating any of the above-mentioned conditions may lead to disciplinary action as outlined in Benton County Policy and/or union contracts up to and including termination.

Attachment: Conflict of Interest Disclosure Statement

Conflict of Interest
Disclosure Statement

The Community Health Centers of Benton and Linn Counties (CHC) / Benton County Health Department (BCHS) encourages the active involvement of its officers, employees, and board of directors in the community. To deal openly and fairly with actual and potential conflicts of interest that may arise as a consequence of this involvement, CHC / BCHD adopts the Conflict-of-Interest Policy and requires an annual affirmation that you have read, understand, and agree with the Policy and the following Conflict of Interest Disclosure Statement. **Conflict of Interest is defined as having a vested interest that could have personal gain by doing business with CHC/BCHD, i.e., financial gain for you or a family member.**

CHC / BCHD officers, employees and board of directors are expected to use good judgment, to adhere to high ethical standards, and to conduct their affairs in such a manner as to avoid any actual or potential conflict between personal interests of an officer, employee or board member and those of the CHC / BCHD per ORS 244.020; and, must follow the guidelines regarding conflict of interest under that statute. A conflict of interest exists when the loyalties or actions are divided between the interests of CHC / BCHD and the interests of the officer, employee, or board member. Both the fact and the appearance of a conflict of interest should be avoided.

Please initial in the space at the end of **Item A** or complete **Item B**, whichever is appropriate, and sign and date the statement and return it to the HR Liaison.

A. I am not aware of any relationship or interest or situation involving my family or myself that might result in, or give the appearance of being, a conflict of interest between such family member and me and CHC / BCHD. _____ **(initial).**

OR

B. The following are relationships, interests, or situations involving me or a member of my family that I consider might result in or appear to be an actual, apparent, or potential conflict of interest between such family members or me and the CHC / BCHD _____ **(initial).**

Please list actual or potential conflict of interest relationships, including:
(Use the back of the form if necessary.)

- For-profit corporate directorships, positions, and employment,
- Nonprofit board memberships or positions,
- Memberships in organizations,
- Contracts, business activities, and investments organizations,
- Primary business or occupation, or
- Other relationships and activities not listed

I have read and understand the CHC / BCHD's Conflict of Interest Policy and agree to follow it. As an officer, employee, or board member, I will promptly inform the CHC Executive Director or the BCHD Director of any material change that develops in the information contained in this statement:

_____	_____	_____
Print or type name	Signature	Date

Community Health Centers
OF BENTON & LINN COUNTIES

BOARD POLICY & PROCEDURE

P & P: #08 **GOVERNANCE POLICY**
Officer Roles

Effective 06/2009
Reviewed: 05/2025

POLICY

The Officers of the Community Health Center Board provide leadership in assuring the Board follows the principles established in policy. No officer will have the authority to speak or act on behalf of the Board other than that authority specifically granted by the full Board. The Board Chair may represent the Board's interests when indicated. Only Board Officers may sign official documents requiring Board signature.

Accordingly:

1. Officers serve as the Executive Committee for the Board.
2. The term of office is two years, and no member may hold the same office for more than three consecutive terms. Officers' terms will be staggered to support continuity among Officers. The Chair and Secretary will be elected in even years, and Vice Chair and Treasurer in odd years.
3. The Chair's primary responsibility is to ensure the integrity of the Board's process. The Chair guides the Board to operate consistently within Board policies and represents the Board as requested outside the organization. Specifically, the Chair will:
   a) Assure the meeting discussion addresses issues within the Board's area of responsibility.
   b) Support discussion that is open, thorough, but also timely, orderly, and to the point.
   c) Foster input from individuals and organizations that have expertise and interests specifically related to Board decisions and policies.
   d) Represent the Board in sharing stated Board positions and decisions when needed and directed by the full Board.
   e) Appoint the Chair for Board committees in consultation with other Board members.
   f) Assure the Executive Director is evaluated on an annual basis according to the process outlined in these policies.
4. The Vice-Chair will serve in the absence of the Chair and perform other duties as may be assigned by the Chair or Board of Directors.

5. The Secretary reviews Board meeting minutes to present to the Board for approval and performs duties from time to time as may be requested by the Board of Directors.
6. The Treasurer serves as Chair of the Finance Committee and assures Board review of financial statements and other financial matters, and performs duties from time to time as may be requested by the Board of Directors.

P & P: # 9 **GOVERNANCE PROCESS**
Board Committee Principles

Effective: 6/29/09
Reviewed: 8/26/13, 8/15/16, 8/14/17, 2022

POLICY

Board committees will be used sparingly and in an informal capacity. When used they will be assigned to serve specific functions and will reinforce and assist the work of the whole Board and will not interfere with delegation from the Board to the Executive Director.

Accordingly:

1. Board committees are to help the Board do its job. Committees will assist the Board and Executive Director by preparing policy alternatives and implications for Board consideration and discussion. In keeping with the Board's broader focus, Board committees will not advise staff or deal with operations.
2. Board committees may not speak or act for the Board except when formally given authority with specific and time-limited purposes. Expectations and authority will be carefully stated to avoid conflict with authority delegated to the Executive Director.
3. Board committees cannot provide authority over staff; however, committees may request assistance through the Executive Director.
4. All Board committees will consist of at least one (1) Board member. The Board may appoint non-Board members to serve on committees.
5. The Board Chair may appoint committees authorized by the Board. The purpose, expectations, and time span of a committee will be defined at the time of appointment.
6. The Board has three (3) standing committees.

   Executive Committee: The primary purpose for this committee is to provide additional opportunity to set direction for Board meetings and activities when needed. The committee will be responsible for coordinating the review of Board policies and By-laws. The Executive Committee, comprised of the Board Officers, does not have authority to take action unless specifically directed by the full Board.

   Finance Committee: The primary purpose of this committee is to provide oversight and guidance to the full Board regarding the organization's financial reports and trends. The Finance Committee does not have authority to take action unless specifically directed by the full Board. The Treasurer serves as the Committee Chair. Additional financial expertise may be sought from individuals in the community invited to serve as committee members.

   Board Development Committee: The primary purpose of this committee is to assist in assuring ongoing Board training, Board recruitment, mentoring new Board members, and serving as the nominating committee in preparation for submitting names for Board membership and the slate of Officers.

P & P: # 10	**GOVERNANCE PROCESS** **Recruitment of New Members**	Page 1 of 1 Effective**:** 8/24/09 Reviewed:3/28/16 11/20, 04/24

POLICY

The Board of Directors of the Community Health Center (CHC) will actively engage in the recruitment of new members on a continual basis, ensuring:

1. A strong commitment to the mission, vision, and values of the Health Center.
2. A diverse range of perspectives.
3. Compliance with federal requirements for membership.

PROCEDURE:

1. All board members are responsible for identifying and recruiting potential candidates for nomination and approval as specified in the by-laws. The goal is to have members who actively participate in board activities.

2. The board will continuously collect names and contact information from individuals interested in joining. This information will be maintained and referenced as needed when vacancies arise. Recruitment strategies include:
    a. Invitations posted on the Health Center's website or social media platforms.
    b. Recommendations from current board members, committee members, staff, and providers, particularly those who are active patients or closely connected to the Health Center.

3. The board aims to maintain a size of 9 to 15 members to ensure adequate representation of:
    a. Consumers of Health Center services across various locations.
    b. The populations and communities served by the Health Center.
    c. Desired expertise and community representation.

4. A minimum of fifty-one percent (51%) of the board must be active patients of the Health Center. Active patients are defined as individuals who are registered patients and have accessed an in-scope Health Center services at an in-scope service delivery site within the last 24 months. They may also be the legal guardian of a dependent child or adult, or legal sponsor of an immigrant patient who could also fit the definition of an active patient. Consumer representation on the board will mirror the patient population regarding residence, financial status, age, gender, race, ethnicity, and/or national origin.

5. The remaining forty-nine percent (49%) of the board will consist of community representatives, with no more than half receiving significant income (more than 10%) from the healthcare sector.

6. Each new board member will be paired with an existing member who will serve as a mentor during their first year. The mentor will assist the new member in becoming more comfortable and effective in their role by periodically providing guidance and answering questions about the organization, its services, the community, or governance processes.

P & P No. 11	GOVERNANCE PROCESS Board Orientation	Page x of x Effective:

Executive Director

Medical Director

Board President

POLICY

To be developed

P & P No. 12	**GOVERNANCE PROCESS** **Patient & Community Input**	**Page x of x** **Effective:**

Executive Director

Medical Director

Board President

POLICY

To be developed

P & P: # 13	GOVERNANCE PROCESS Advocacy	Page 1 of 1 Effective: 04/17/172 2022

As a Federally Qualified Health Center (FQHC), the Community Health Centers of Benton and Linn Counties are a member of America's Health Center network. Health Centers are a vital part of our nation's safety net providing health care to millions of low-income people in medically underserved communities. Health Centers have proven their ability it improve health, prevent illness, and reduce health costs.

The survival of our Health Center is critically important to the health and well-being of our people and communities. Our clinics serve a higher proportion of uninsured people and individuals and families covered by Medicaid and Medicare. Adequate Medicaid payments and direct federal grant support are absolutely essential to the continued survival of Health Centers.

The current federal fiscal situation threatens not only funding for Medicaid and Medicare, but also funding for important programs like Health Centers. In this environment it is critical we make the strongest case for the vital importance of Health Centers. Participation in our state association, the Oregon Primary Care Association (OPCA) and in our national network, the National Association of Community health Centers (NACHC) has never been more vital.

To support advocacy efforts and share the stories of vitally important health services the Board and Staff of the Health Center are committed to;

- Take action to educate and inform our Board, staff, patients, community members, and others about the potential threats which may endanger our Health Center or our ability to serve our communities.
- Participate in opportunities to educate public policy makers on the importance of our Health Center, the importance of Medicaid and Medicare to our patients and clinics, and the ability of our Center to assist in expanding access, preventing illness, and reducing avoidable health care costs.
- Demonstrate that Health Centers are united in our commitment to protect the vital resources that support the care we provide to our patients, and to make the case for continued support at all levels of government and society.
- Call upon OPCA and NACHC to place the highest priority in preparing for and dealing with policies which adversely threaten health centers and the populations they serve, including educating and mobilizing our health center movement.
- Pledge our support and full participation with OPCA on the state level, and with NACHC at the national level to demonstrate to the federal and state governments that Health Centers like ours are an essential part of America's commitment to health care and an essential part of the strategy to deliver effective, efficient and high quality care.

P & P: #14	**GOVERNANCE PROCESS POLICIES**	Page 1 of 1
	Monitoring Organizational Performance	Effective: 04/2015
		Reviewed: 04/27/15, 11/20. 12/23

POLICY

To assure compliance with HRSA Health Center Program Requirements, the Health Center has systems which accurately collect and organize data for program reports. Reports are distributed, reviewed, and used to inform decision making at all levels throughout the organization. The Health Center Board of Directors has identified data elements and key reports that are important to assist them in understanding critical elements of the Health Centers work for decision making and providing strategic direction.

Accordingly, the Health Center Board will receive, review, and utilize the following identified reports.

1. **Service Area Needs Assessment:** At the end of the project period (every three years), the Health Center is required to complete a needs assessment of the service area as part of the New and Competing Service Area Competition. This provides information regarding needs and gaps within the service area. Data is used and reviewed to inform identification of target populations and gaps and needs that may influence access and scope of services. The information from this assessment is summarized, highlighted, and presented to the Board for review.

   Important source documents used for the Needs Assessment include;
   - **Census data** provides demographic information for the service area.
   - County data available through the **Community Health Assessment (CHA)** conducted by the Health Departments. Benton County and Linn County have data available on line. From the CHA, each county develops a **Community Health Improvement Plan (CHIP)**. The process is open for community input and the document is available for community review.
   - Service area data is available through **HRSA and Office of Rural Health**. Data available at those sites includes; MUA/P (Medically Underserved Area/Population), HPSA (Health Professional Shortage Areas for Medical, Mental Health, and Dental), and access barriers.
2. **UDS Trends:** The UDS (Uniform Data Set) is an annual report HRSA requires of Health Centers. Data includes; patient demographics, utilization of services by type of service, staffing, financial data, and clinical outcomes. This data is shared with the Board annually as part of strategic planning review and development.
3. **Financial Reports:** The Finance Committee and Health Center Board review financial reports monthly according to policy and process outlined in approved Board Financial policies.
4. **Quality Improvement Reports:** QI reports are provided to the Board. Information provided in the report includes; 1) patient concern, grievance, and incident report trends, 2) patient satisfaction survey results, and 3) outcome reports on high priority QI initiatives.
5. **Strategic Plan Dashboard:** The Dashboard identifies key measurable indicators that assist in tracking progress on the Strategic Plan. In addition, to the monthly narrative report provided by the Executive Director, the dashboard is provided and reviewed quarterly. Indicators may include reportable measures on access, equity, and clinical quality outcomes.
6. **Ad hoc data:** Additional data may be requested by the Board to assist in deliberation and decision-making that the Board identifies and agrees is a priority. Requests for data must be discussed at a Board meeting and requested through the Executive Director. Consideration must be given to the availability and effort required to collect and organize the data.

Community Health Centers
OF BENTON & LINN COUNTIES

BOARD POLICY & PROCEDURE

P & P: #16 GOVERNANCE PROCESS
Monitoring Executive Performance

Effective 9/24/12
Reviewed: 09/2024

POLICY

The Board will view Executive Director performance relative to organizational performance. The Board of Directors is responsible for monitoring Executive Director performance against stated expectations. Expectations are outlined in documents that include; Health Center Director Job Description, performance goals if developed, organizational values, organizational accomplishments/outcomes as described in the Strategic Plan, and other performance measures as required for funding and/or accreditation, i.e. UDS, , HRSA reviews, PCPCH accreditation, & Value Based Pay performance.

Process:

1. The Board will receive regular monitoring data by one or more methods; a) Executive Director reports, b) external reports, i.e. reports required for achieving accreditation or compliance, c) financial reports, and Health Center trend data. The Board may request additional monitoring data as defined by the Board.
2. The Board will provide informal feedback on performance throughout the year. Annually, the Board will conduct a more comprehensive assessment of performance. The following steps will be completed as part of the annual review.
   a) The Board Chair will facilitate the evaluation process.
   b) Both the County and CHC Board will conduct separate annual evaluations of the CHC Executive Director. Each party provides feedback to the other party to consider in the separate performance evaluations. Both evaluations shall be submitted to the County's Human Resources department. The evaluation is conducted annually, targeted for August. The evaluation tool will align with Benton County's Performance Management system. The same 4-point rating scale and five core competencies as the County will be used. Executive level competencies and Functional Competencies can be uniquely designed for the Health Center Director at the discretion of the Health Center Board.
   c) The Board of Directors may review the Health Center Director Job Description as needed as part of the evaluation process. Recommendations for changes will occur in collaboration with HR and the Assistant County Administrator.
   d) The Board will use the Strategic Plan as the lead monitoring tool for performance. At the end of each Strategic Plan timeframe, the Executive Director will prepare a summary of progress on the strategic plan. The Board may request additional information for review and will make the Executive Director aware of what information is requested with a reasonable timeframe for preparation of the report.

e) Progress report(s) along with the evaluation tool will be distributed to all Board members. Refer to the attachment for the evaluation tool. Selected staff will also be invited to provide feedback. Constructive feedback should be specific so that appropriate action may be taken.

f) Evaluations are returned to the Board Chair. The Chair will complete a composite report with accompanying comments. Numerical scores provided by staff and board will be tabulated separately and shared as part of the evaluation. Comments may be combined and do not need to be reported separately from staff or Board.

g) The Board Chair will review the evaluation with the full Board in Executive Session for final feedback and input.

h) The Board Chair, and other Board members as requested by the Chair, will meet with the Executive Director to present the evaluation. Should the Executive Director disagree with part or all of the evaluation, the Executive Director has the right to respond to the full Board in writing.

i) When the Board of Directors has completed their process, the Board Chair and Executive Director will meet with the Assistant County Administrator to present the evaluation and provide an opportunity for additional comments.

j) The Executive Director and Board Chair will sign the final evaluation. A copy is given to the Executive Director and the original placed in the HR file.

3. The county is responsible for recruiting any CHC Executive Director vacancy. The county shall consult with the CHC Board on special qualifications and the recruitment process. The CHC Board shall have the authority to approve or reject the selection of the CHC Executive Director candidate. Once the CHC Board and the county agrees on a candidate, the appointment will be made by the Assistant County Administrator as the appointing authority.

4. Except when in conflict with the Co-Applicant Agreement Section 1.4.2, The CHC Board shall have the authority to approve the dismissal of the CHC Executive Director from the role of Director of the Community Health Center, if such dismissal is warranted based on performance or pursuant to federal, state, or county personnel rules, and performance deficiencies. If the CHC Board votes to dismiss the CHC Executive Director, Benton County shall terminate the employment of the CHC Executive Director. The Board of Directors will inform the Board of Commissioners during any planned or emergency transition per Governance Policy – Succession Plan.

P & P: # B-17	GOVERNANCE PROCESS Succession Plan	Page 1 of 2 Effective: 12/17/18 Revised 12/2018, 01/2024

POLICY

The goal of a succession plan is to develop a pipeline of strong leaders within the organization and outline steps to take for unexpected and expected Senior Leadership transitions. Over the past several years, BCHS (Benton County Health Services) has been successful in designing an integrated system of care with a continuum of person-centered to population-based services. This effort has required a concerted focus on creating an organizational culture of integration, integrated management teams, and collaborative decision-making. The succession plan is intentionally designed to assure continuity in assuring integrated, collaborative leadership.

A. Board Readiness and Responsibilities

The Health Center Board of Directors focuses on strengthening their knowledge regarding Health Center governance and Health Resources and Services Administration (HRSA) program requirements. The Board Development Committee uses a self- assessment tool to identify strengths and opportunities for improvement. Board members are encouraged to develop leadership capabilities, assume executive committee and committee chair roles, and attend local, regional, and national board trainings.

As stated in the Cooperative Agreement between the Board of Directors and Benton County Board of Commissioners (BOC), the Board of Directors is responsible for the selection and hiring of the Health Center/Executive Director. Given the strong working relationship between the Board of Directors and BOC, it is expected there will be mutual agreement regarding the succession plan, agreement on the involvement of the BOC in the recruiting process for the Health Center Director, and open communication regarding steps taken and decision-making criteria. Responsibility for the selection, evaluation and dismissal of the CHC Executive Director is outlined in Section 1.3 of the Cooperative Agreement.

B. Leadership Readiness and Development

On-going training in senior leadership management and supervision skills will be supported to develop leadership training curriculum through a variety of options and strategies including; 1) internal training opportunities through Benton County Human Resources (HR), 2) identification of relevant training available locally or through state and regional organizations such as OPCA (Oregon Primary Care Association), NWRPCA (Northwest Regional Primary Care Association), NACHC (National Association of Community Health Centers), OPHA (Oregon Public Health Association), and 3) engaging external consultants.

C. Emergency Transition of Health Center Director

Interim Leadership: In the event, there is a sudden, unplanned vacancy in the Health Center Director position, the Board Chairperson and at least one other member of the Executive Committee, in collaboration with the Board of Commissioners Health Center liaison, and in consultation with Benton County Administrator and HR Director will appoint an interim Health Center Director within 1-3 days. Likely and capable candidates for this role will be the Health Department Director, Deputy Director of Clinical Operations, chief Finance Officer, or Medical Director. Co-leaders sharing responsibilities may also be considered for interim leadership. It's advisable to relieve them temporarily of at least some of their other responsibilities while the board and senior leadership assess options. This may require increasing responsibilities of middle management staff and administrative support staff during the interim period.

BENTON COUNTY HEALTH SERVICES
POLICY – PROCEDURE MANUAL

SUBJECT: SLIDING FEE DISCOUNT POLICY

SECTION: ADMIN **PROGRAM:** ALL **PAGE:** 1 OF 4

HEALTH CENTER DIRECTOR: LACEY MOLLEL **DATE:** 09/23/2025

HEALTH DIRECTOR: APRIL HOLLAND **DATE:** 09/23/2025

HEALTH CENTER BOARD CHAIRPERSON: JEFF BETHEL DocuSigned by: Jeffrey Bethel 29E47A7D7A9647E... **DATE:** 09/24/2025

REVIEWED BY & DATE:

PROGRAM DISTRIBUTION: ALL

POLICY:

Sliding Fee Discount Policy: The Community Health Center (CHC) shall have and offer a sliding fee discount program (SFDP), hereafter referred to as "The Program", to all its patients. The structure of The Program shall be in full compliance with Health Resources & Services Administration (HRSA) requirements and guidelines and administered in the spirit of those requirements and guidelines.

Operational Functionality: Operational functionality for how The Program is offered and administered is outlined in the Finance Billing Processes document. L:\Health\Processes\Finance\16.3 Billing - Financial Process - DRAFT 2021.pdf

BASIC PREMISE:

Governing Board Approval: The Sliding Fee Discount Policy, the CHC Financial Policy and all financial processes, to include The Program (the SFDP), are reviewed by the Community Health Center

Governing Board on a triennial basis. Board signature of this document constitutes Governing Board approval of the Sliding Fee Discount Policy, The Program and all supporting financial processes.

Access: The Health Center assures that no patient will be denied health care services due to an individual's inability to pay for such services and that any fees or payments required by the center for such services will be reduced or waived to enable the center to fulfill this assurance. Likewise, The Program is available to ALL eligible patients (insured, underinsured and uninsured), applicable to any outstanding balance resulting in a patient payment obligation.

Fees: The CHC has established a schedule of fees for all services within the scope of project as defined on HRSA form 5A, consistent with locally prevailing rates or charges (via price surveys of most frequently utilized charge codes) and has designed these fees to cover its reasonable costs or operations. The Health Center's schedule of fees are reviewed from our patient's affordability perspective and offered at rates that are considered and approved by the Health Center's patient represented Board of Directors. The discounted and nominal schedule of fees do not reflect the actual cost of the services provided.

The setting of a flat nominal charge at a level considered nominal from the perspective of the patient is based on input from the patient board members, patients, and /or review of co-pay amounts associated with Medicare and Medicaid for patients with comparable incomes. Nominal fees are not reflective of the actual cost of the service being provided.

Applicability: The Program applies to all fees within the scope of project as defined on Health Resources and Services Administration (HRSA) Form 5A Services. The Program is applied uniformly to all eligible patients that participate.

Eligibility: Patients interested in participating in The Program must apply. Eligibility for The Program is based solely on two components: the patient/family annual income and family size. This data is compared against the U.S. Department of Health and Human Services' (HHS) annual Federal Poverty Guidelines (FPG) to determine eligibility. The Program utilizes the most current FPG annually. Individuals and families with annual incomes above 200% of the current FPG are not eligible. At a minimum, patient eligibility for The Program is reviewed annually, but may be done at any time upon request by the patient.

Definitions:

Family: The CHC has defined **Family** as a group of two or more people related by birth, marriage, or adoption who reside together. All such related persons are considered as members of one family. Additionally, individuals who have lived together for at least 2 years and share family financial responsibilities and household expenses, as well as multi-generational families living together, will also be considered part of the family.

Family Size: The CHC has defined **Family Size** as the head of the household, their spouse, children, any other dependents living in the household, and any individuals who meet the extended family definition described above. We determine family size by how the patient completes the "Income Verification for

Sliding Fee Discount" form. Patients indicate how many people (in each age group) live on this income and in the home. The age categories are as follows: 0-5, 6-17, 18-64 and 65+ years of age.

NOTE: All income from each individual counted in **Family Size** must be included as income within the context of the SFDP calculation.

Income: The CHC has defined **income** as:

a. Cash or cash equivalents received for doing work - employed/self-employed
b. Cash or cash equivalents received from investments - interest/dividends/rental income/etc.
c. Cash or cash equivalents received from programs and entitlements - AFS/AFDC/Social Security/disability/worker's comp/pension/veteran/retirement plans/alimony/child support/unemployment/housing assistance, etc.
d. Other cash or cash equivalent gifts consistently received, predictably anticipated and depended upon for ongoing living support

NOTE: Student loans and the portion of educational grants applied to tuition or books do not count as household income.

Schedule of Discounts: Total fees for services are discounted to one of five flat fee encounter rates, for Medical, Lab, Pharmacy, Behavioral Health and Public Health. The discounted flat rate determined at check-in based on the type of service received and where the patient/family income level and family size is relative to the FPL. A full discount of all fees is applied to those patients / clients at or below 100% of the FPL.

Multiple Sliding Fee Discount Schedules: The CHC maintains multiple flat fee encounter rates for services within the Health Center's approved scope of project based on the level of provider rendering the service and the type of service (Medical/Mental Health/Dental). Schedules are Board approved and routinely evaluated to ensure that they do not inadvertently create a barrier to care.

NOTE: For a full list of flat fee encounter rates based on provider type and type of service, reference the most current SFSD fees document located in the Finance Department.

Nominal Charges: The CHC Board of Directors has established and implemented nominal charges by level of provider and type of service, while ensuring that patients are not limited in accessing services due to an inability to pay. Nominal charges do not reflect the true cost of a service provided and are generally considered to be of token value. Nominal charges are reviewed and may be adjusted annually by the CHC Board of Directors. Nominal charges are deemed nominal from the Board and patient's perspective based upon patient Board member input, patient input, and comparison with other regional FQHC nominal fee rates.

Services under Formal Contracted Referral Arrangements: As defined on HRSA form 5A, Column III, the CHC ensures that agreement with referral contractor states contractor will **either** discount their service by:

1) A full discount or only a nominal charge is provided for individuals and families with annual incomes at or below 100% of the current Federal Poverty Guidelines (FPG); and partial discounts are provided for individuals and families with incomes above 100% of the current FPG and at or below 200% of the current FPG, adjusted based on gradations in income levels with at least three discount pay classes.

   OR

2) Discounted in a manner such that individuals and families with incomes above 100% of the current FPG and at or below 200% of the FPG receive an equal or greater discount for these services than if the CHC's Sliding Fee Discount Schedule were applied to the referral provider's fee schedule; and individuals and families at or below 100% of the FPG receive a full discount or are assessed only a nominal charge for these services.

P & P: #18	BUDGET Financial Planning and Budgeting	Page 1 of 1 Effective: 10/28/13 Reviewed:3/28/16, 02/24

POLICY

The Board of Directors participates in financial planning and budgeting for the financial success of the Health Center. The Health Center Board of Directors recommends and consults with the Board of Commissioners in budget planning.

Accordingly:

To accomplish the goals for **financial planning**, the Board of Directors will:
1. Make recommendations to ensure the long-term financial viability of the Health Center.
2. Assure adequate resources to maintain or increase the array and level of services provided and the number of people served by the Health Center.
3. Evaluate prior period actual data and use conservative estimates in financial planning.
4. Consider the capital needs of the organization and be an advocate in identifying and securing capital needs within the county infrastructure.
5. Consider allowances for uncertainties.
6. Routinely monitor actual performance to budget, understand variances, and participate in planning corrective action when indicated.

Budgeting Process: The Health Center will follow the County budgeting process. The Health Center Board of Directors will be involved in the development and provide preliminary approval of the budget which is then submitted to the Board of Commissioners for final approval.

P & P: #19	MONITORING FINANCIAL PERFORMANCE Financial Oversight	Page 1 of 2 Effective: 10/28/13 Reviewed: 4/11/23

POLICY

The Board of Directors (BOD) provides financial oversight of the Health Center to assure compliance with HRSA Program Expectations and support sustainability in financial performance while operating within County government. The Health Center Board of Directors makes recommendations and/or consults with the Board of Commissioners as appropriate in the development and implementation of Health Center BOD financial policies.

General Financial Policy: The Health Center operates within Benton County's financial systems to assure compliance with sound financial practices and safeguard assets. The Board of Directors provides financial oversight in monitoring financial performance. The Finance Committee of the Board is responsible to carefully review financials on a monthly basis and make recommendations as appropriate to the full Board for review, approval, and recommended action.

Financial Management: The Health Center ensures awarded Health Center Program federal funds are not expended for restricted activities

General Billing Policy: The Health Center will provide financial policy information to all clients as they access services, and will prominently display policy information in the client waiting areas.
The Health Center provides insurance billing services as a courtesy to clients with the goal of ensuring timely billing and payment. CHC expects full client and guarantor cooperation in providing necessary information and releases to support billing. Patients under eighteen years of age must have a parent/legal guardian as their guarantor for services, unless they meet the definition of age of consent, are confidential, or are legally emancipated. Clients may request assignment of a confidential status to prevent phone calls, insurance Explanation of Benefits (EOB), statements, or other information going to the client's telephone or address.

Sliding Fee Scale (SFS): Services are provided in accordance with a client's ability to pay as defined by the federal poverty guidelines. A sliding fee discount schedule based on federal guidelines using income and family size is reviewed and approved periodically by the Board of Directors. Verification of income is required when applying for a SFS discount. A nominal fee is required for all services provided by the FQHC in compliance with federal mandate (42 CFR Part 51c.303(f)) and is not subject to the SFS discount.

Collection Policy: Clients are fully responsible for balances due after applying eligible discounts. To reduce financial barriers to care, payment plans are available. Business processes are in place that further define the evaluation and management of accounts, as well as the pre-collection and collection process.

Grant Application & Budget: Health Center BOD reviews and approves non-compete HRSA 330 grant application and budget annually.

The Board of Directors reviews, approves and makes recommendations to the Board of Commissioners for final approval in the following areas.

Fee Setting: The Health Center establishes and annually reviews fees for services provided. Fees are determined based on consideration of the following factors; 1) RVU's by procedure, 2) actual Health Center costs for providing the service, and 3) local/regional market rates.

Financial Budget: Health Center prepares and monitors a biennial budget operating within Benton County's budgetary system to assure financial sustainability.

Grant Application & Budget: Health Center BOD reviews, approves and forwards a recommendation to the County Board of Commissioners for new or competing HRSA 330 grant applications and budgets as needed.

P & P: #20 **MONITORING FINANCIAL PERFORMANCE** Page 1 of 1
Reserve Policy: Operating Reserve Effective: 11/2008
Reviewed: 3/28/16, 09 2019, 06, 2023

POLICY

It is in the interest of the Health Center to support sustainability based on Health Center performance while operating within County government. The Health Center will demonstrate financial responsibility by establishing and maintaining an operating reserve that provides mutual benefit for the Health Center and County.

This policy provides definitions and criteria for establishing, managing, and using reserves. Reserves are addressed through two concepts: contingency and operating reserves. This policy further describes Operating Reserves and cash management.

OPERATING RESERVE

Definition: Operating reserve is the amount of assets available to use to support operations in the event of an unanticipated loss of revenue or increase in expenses.

Operating Reserve Target: 90 days

Calculating Operating Reserve: Calculation of operating reserve includes:

+ Current cash balance
+ 45% of the current Accounts Receivable balance

÷ Divided by the average daily **net** operating expense; which is calculated as the prior 3 months of total operating expense (including County overhead, Department overhead and facility fees) less 3 months of HRSA **base grant** revenue

Cash Balance: Cash balances are reported monthly in the financial statements prepared by County Finance and Health. Cash will fluctuate based on the timing of entries and may exhibit significant swings from month to month. Monitoring monthly changes in cash balances over time is the best reflection of cash trends in a fiscal year.

Monitoring Operating Reserve: The following will be monitored to assure financial performance meets the established expectations and actions are taken should performance fall below established targets.

- Financials are reviewed monthly by the Finance Committee and Board of Directors
- The 90 day operating reserve balance is calculated and included in the quarterly financial report prepared by BCHS Finance Director and reviewed by the Health Center Board of Directors Finance Committee

Expenditures that were not identified in the budget must be considered and discussed carefully before committing to the expense to assure that operating reserve remains within the targets established. Approval for a new expenditure is required and must go through the supplemental budget process. Justification for the expenditure, and new revenue and/or funding to support the additional costs must be addressed in the supplemental budget request.

Operational Response Plan: It is recommended a response plan be in place that outlines operational steps that would occur in the event the reserve balance drops below the 90 day target. The first set of action items may be a combination of cost saving and revenue generating measures. The action steps will become more urgent as the reserve balance decreases. The response plan is developed by Health Center leadership and presented to the Board of Directors Finance Committee for approval.

P & P: #20a **MONITORING FINANCIAL PERFORMANCE** Page 1 of 2
Reserve Policy: Contingency Effective: 11/2008
Reviewed: 3/28/16, 09/19
Revised: July 2023

POLICY

It is in the interest of the Health Center to support sustainability based on Health Center performance while operating within County government. The Health Center will demonstrate financial responsibility by establishing and maintaining an operating reserve that provides mutual benefit for the Health Center and County.

This policy provides definitions and criteria for establishing, managing, and using reserves. Reserves are addressed through two concepts: contingency and operating reserves. This policy further describes contingency.

CONTINGENCY

Definition: Oregon budget rules for public entities define contingency as an amount appropriated in anticipation that some operating expenditures will become necessary that cannot be foreseen and planned in the budget.

Contingency Cost Center: There are three Health Center cost centers within the County accounting system established for contingency. These are restricted "contingency" funds designated in the biennial budget, and are available only for use by the Health Center including integrated in-scope BCHS (Benton County Health Services) services.

The three contingency cost centers in the Health Center budget are 521-90-25-101, which is primary care and oral health for Benton County, 521-34-25-101, is Benton County in-scope behavioral health, and 522-90-25-100 is Linn County.

Contingency Target: The Health Center Board of Directors (BOD) established a target of 90 days operating expense. This includes the overall operating expense of all in-scope services: medical, dental, and behavioral health.

Evaluation of Budgeted Contingency: The contingency balance will be reviewed as part of the biennial budgeting process. The recommendation to decrease or add to contingency will occur as part of the budget process.

Operating expenses will be evaluated to identify if there has been any change. The Health Center Board will include in the strategic planning and budgeting process identification of potential large capital expenditures in excess of the Capital Improvement Plan base (currently $15,000), and consideration of whether contingency funds will be needed for implementing or sustaining programs or services.

Consideration will also be given to whether there is an opportunity to add to contingency based on positive financial performance and operating reserve above the target. Recommendations to move funding from operating cash to contingency will be made by the Finance Committee and approved by the Health Center Board of Directors.

Use of Contingency Funds: Funds budgeted as contingency can only be moved from contingency to an expenditure via an appropriation transfer resolution approved by the County Board of Commissioners. These funds are intended to be used for one-time expenditures. Use should be considered carefully against the stated priorities. If use of contingency is recommended, it should include consideration for how contingency funds will be replaced.

Priorities for Use of Contingency

1. Contingency balances in 521 accounts should be for priorities in Benton County, and funds in 522 should be used in Linn County.
2. Capitol/Infrastructure needs (equipment, technology, capital projects such as buildings or renovation) that will support enhanced revenue capacity over time or improved patient experience and outcomes.
3. To preserve direct service and the staffing required to support efficient delivery and maximum provider capacity when a program is operating at a loss, while plans are being developed and implemented to assure long-term sustainability of a program. The use of contingency to support operational needs should not be more than 6 months.
4. Use of contingency may be considered for start-up of services or programs but the service should be self-sustaining through revenue, outside financial support, or operating cash within 4-6 months.

Decision-making Process: Access to contingency funds requires Health Center Board and BOC approval. The use of Health Center contingency funds should be considered in the context of the value to the integrated service delivery model of primary care, behavioral health, and oral health. The recommended process is the Health Center Director, and if proposing the use of Behavioral Health contingency the Health Department Director, present the request to the Board of Director's Finance Committee. After Finance Committee review, their recommendation is presented to the Board of Directors for their action. If supported by the Board of Directors it must go the Board of Commissioners (BOC) for final approval.

Performance Management and Quality Improvement Framework for The Community Health Centers of Benton and Linn Counties

2023 – 2025

To: CHC Board Members

Funded by The U.S. Department of Health and Human Services Health Resources and Services Administration (HRSA), and as a recognized federal employer covered under the Federal Tort Claims Act (FTCA), Health Centers are required to implement a quality improvement (QI) and quality assurance (QA) program.

The CHC Board reviews and approves the CHC Performance Management and Quality Improvement Framework every three years. The last CHC Board review and approval occurred in 2020.

Approval / Endorsement

Approved by the Community Health Centers of Benton and Linn Counties Board of Directors

DocuSigned by:
Jeffrey Bethel
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Signature

03/29/2024
Date

Contents

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Performance Management and Quality Improvement Framework

1 Purpose

The purpose of the Community Health Centers of Benton and Linn Counties (CHC) Performance Management and QI Framework (PMQIF) is to provide context and guide processes for performance excellence, QI activities, and training at the Community Health Centers of Benton and Linn Counties.

Policy Statement: Our PMQIF stands as a cornerstone in our organizational framework, deliberately designed to advance us toward the realization of the objectives outlined in our Strategic Plan. Within it, we conduct both organizational-level ("Big QI") and program/project-level ("little qi") initiatives to close gaps in disparity, achieve the best possible health outcomes, and to make effective and efficient use of resources.

At the core of our mission is our unwavering commitment to patient-centered care. The PMQIF serves as a dynamic tool to enhance and optimize healthcare delivery, ensuring that every aspect of our many services align with the needs and preferences of our patients and communities.

There is also an underlying emphasis on the development of a healthy organizational culture in this plan. Filled with activities that necessitate innovation, collaboration, learning, and continuous process improvement, this framework includes ingredients essential to the long-term health of the culture within our clinics.

Furthermore, components within this framework contribute to organizational fiscal vitality by requiring regular analysis of operational efficiency, cost-effectiveness, service utilization, and resource utilization. Regular assessment of these components allows leadership to be thoughtful about stewardship and allocate resources in a manner that promotes high return on investment.

Lastly, as we strive to cultivate thriving communities, the PMQIF serves as a catalyst for community engagement, preventive care initiatives, and outreach programs, reinforcing our commitment to holistic well-being beyond the confines of our clinic walls. In essence, the PMQIF is the strategic linchpin that propels BCHS toward a future where patient-centricity, a robust organizational culture, fiscal resilience, and flourishing communities harmoniously converge.

As we embark on this journey of continuous improvement, we recognize that success relies on the collective efforts of our dedicated staff, CHC Board of Directors, the support of our communities, and strategic collaborations with community partners. Through the implementation of this PMQIF, Benton County Health Services (BCHS) reaffirms its commitment to delivering healthcare that not only meets the needs of today but will also evolve to exceed the expectations of tomorrow. Together, we will shape a healthier and more resilient future for the communities we proudly serve.

2 Guiding Principles

Benton County has a strong history of promoting collaborative approaches to achieving better health for the community and for patients/clients who receive services from the Benton County Health Department and/or Community Health Centers of Benton and Linn Counties. Organizationally, BCHS approaches strategic and operational planning as a collaborative process across the organization. As a result, this "framework" was intentionally developed for and adopted by all staff working under the umbrella of Benton County Health Services.

CHC Guiding Principles:

- QI work as systems and processes
- Focus on patients
- Focus on being part of the team
- Focus on use of the data

Underlying Principles:

- Alignment of performance improvement and quality improvement with mission, vision, and values of BCHS
- Commitment to a collaboratively planned, systematic and organization-wide approach to improving organizational performance
- Collaborative approach to improvement that includes clinical and administrative leadership, the staff at all levels, clients and community members
- Transparency that leads to accountability to BCHS clients, regulatory and oversight bodies – including the CHC Board – as well as other community stakeholders
- Commitment to improving outcomes, processes and capacities at every level in the organization
- Staff involvement in project selection, design, and implementation
- Training investment to assure equipped, competent improvement teams
- Sharing and learning from improvement project successes and failures

Factors to Consider:

Adaptive leadership, culture, and governance: CHC Individuals and teams work in a culture that supports aptitude and dedication to make continuous improvements. CHC realizes that individual efforts alone won't result in prioritized, sustained quality improvement. Successful quality improvement initiatives require senior leadership support and an adaptive learning culture committed to data-driven quality improvement. Quality work and continuous improvement is everyone's role. All levels of the organization receive performance management communication and are empowered to share innovative approaches to continuous improvement.

Analytics: Analytics is an essential ingredient for sustained quality improvement and plays an important role in each phase of the quality improvement lifecycle (plan, do, study, and act), from determining trends, to measuring a baseline, and understanding the problem, to determining if the resulting change

was an actual improvement. CHC uses analytics to help determine opportunities for improvement based on the discovery, interpretation, and communication of meaningful patterns in data.

Evidence and consensus-based best practices: Developing and integrating evidence- and consensus-based best practices is foundational to CHC quality improvement, however it isn't enough; CHC's also prioritize automating ways to measure how consistently the best practices are being used and their impact on outcomes.

Adoption: CHC approach to adoption includes language like:

- "Here's why we want you to use this best practice."
- "We're going to measure your use of this best practice."
- "We're going to share the correlation of this best practice to outcomes with you so we can learn together and continuously deliver quality, affordable care."

Financial alignment: CHC financial incentives and payment models must align with quality improvement initiatives. If CHC is being paid one way but measuring performance another way, then its financial payment approach doesn't properly align with its quality improvement goals.

A Note about Innovation

In addition to improvement ideas, innovation is encouraged and fostered at BCHS. BCHS is committed to the Benton County Innovation Program that can be found on the intranet. The objective is small, incremental innovations that add up. A culture that fosters disruptive innovation is going to be more entrepreneurial, more outwardly focused on new markets, technologies, and business models.

Definitions

Aim statement is a written, measurable, and time-sensitive description of the accomplishments an improvement team expects to make from its improvement efforts. The Aim Statement answers the question: "What are we seeking to accomplish?"

Big QI refers to improvement initiatives that are identified in an annual QI plan and that have organization-wide or cross-functional, interdisciplinary scope.

Little qi includes program-level initiatives and may include some cross-functional initiatives. Personal improvement goals ("**i-qi**") are intended to tie to both "Big QI" and "little qi" projects.

Capacity means the ability of a work group, program, or organization to carry out its mission and essential services. This ability is made possible by access resources (capitol, staff, expertise, etc.). Having capacity means, for example, that you have sufficient staff, training, facilities, and finances, among other things. Available organizational capacity is a critical predictor of an organization's ability to effectively implement and sustain new programs or services.

DMAIC is a data-driven quality strategy used to improve processes. The five phases in the DMAIC model are: **D**efine the problem, **M**easure performance, **A**nalyze for root cause, **I**mprove by addressing the cause, **C**ontrol the improved process for future performance.

Lean Six Sigma is a combined business management strategy to improve quality. "Lean" and "Six Sigma" are complementary strategies. **Lean** focuses on improving the efficiency of a process by distinguishing value-added steps from non-value-added steps and eliminating waste so that every step adds value to the process. **Six Sigma** focuses on reducing variability in a process and is built on a five-phase framework referred to as DMAIC.

Outcome means a change, or lack of change, in the health of a person or population that is related to a clinical or public health intervention, respectively. Outcomes can be of three types:

> **Health Status:** A change, or lack of change, in physical or mental status.
> **Social Functioning:** A change, or lack of change, in the ability of an individual to function in society.
> **Consumer Satisfaction:** The response of an individual to services received from a provider or program.

Process means the sequence of activities completed by an individual or groups – or to, for, or with individuals or groups – as part of the *provision* of public health services. Process means all the things we do in public health practice; for example, conducting educational classes, performing a test or procedure, investigating a complaint, crunching data, or meeting with community groups.

Performance Management is the practice of actively using performance data to improve processes, outcomes, and capacities. PM includes setting performance standards, as well as measuring, improving, and reporting performance.

Plan-Do-Study-Act (PDSA) is an iterative four-stage problem-solving model for improving a process or carrying out change. PDSA stems from the scientific method (hypothesize, experiment, evaluate). A fundamental principle of PDSA is iteration. Once a hypothesis is supported or negated, executing

the cycle again will extend what one has learned. PDSA is like DMIAC, minus the long-term monitoring for increased process control.

Quality Assurance focuses on systematic monitoring and evaluation of programs, services, and outcomes, to assure compliance with requirements of federal, state, grantors, and accrediting agencies.

Quality Improvement is an integrative process that links people, knowledge, structures, processes and outcomes to enhance quality throughout an organization. The intent is to improve the level of performance of key processes and outcomes within an organization. It is designed to create a culture of shared learning and cooperation where both data and team knowledge are used to improve:

- access to our services
- quality of our care, enhancing service delivery and clinical outcomes
- operational efficiency
- outreach and prevention activities
- patient and employee satisfaction

Quality Improvement Plan (QIP) identifies specific areas of current operational performance for improvement within the agency. These plans can and should cross-reference one another, so a quality improvement initiative that is in the QIP may also be in the Strategic Plan.

Quality Methods build on an assessment component in which a group of selected indicators [selected by an agency] are regularly tracked and reported. The data should be regularly analyzed and shared using visual management tools. Key process indicators show whether agency goals and objectives are being achieved and can be used to identify opportunities for improvement. Once a goal is selected for improvement, the agency develops and implements interventions, and re-measures to determine if interventions were effective. These quality methods are frequently summarized at a high level as the Plan/Do/Study/Act (PDSA) cycle.

Quality Tools: are designed to assist a team when solving a defined problem or project. Tools will help the team get a better understanding of a problem or process they are investigating or analyzing. Some basic QI tools will be available in an accessible electronic format at some future time.

Strategic Planning and Program Planning and Evaluation: Generally, Strategic Planning and Quality Improvement (Big QI) occur at the level of the overall organization, while Program Planning and Evaluation are program specific activities that feed into the Strategic Plan and into Quality Improvement. Program evaluation alone does not equal Quality Improvement; program evaluation data must be used to inform process improvement activities, and those activities must be measured, monitored, revised as needed.

3 Acronyms

BCHS	Benton County Health Services
BCHD	Benton County Health Department
BEE	Benton Employee Engagement (Intranet)
CAHPS	Consumer Assessment of Healthcare Providers & Systems
CCO	Coordinated Care Organization
CHCBLC	Community Health Centers of Benton and Linn Counties
DMAIC	Define, Measure, Analyze, Improve, Control
EHR	Electronic Health Record
HP2030	Healthy People 2030
HRSA	Health Resources and Services Administration
i-QI	Individual, personal improvement goals
OAR	Oregon Administrative Rules
PCPCH	Patient Centered Primary Care Home
PDSA	Plan-Do-Study-Act
PM	Performance Management
QA	Quality Assurance
QI	Quality Improvement
QIP	Quality Improvement Plan
QSC	Quality Steering Committee
SMART	Specific, Measurable, Attainable, Relevant, Timely
UDS	Uniform Data System
USPSTF	U.S. Preventative Services Task Force
WIC	Women, Infants and Children

4 Overview of BCHS Performance Management and Quality Improvement

Annually the CHC reviews data and assesses performance. Performance is analyzed and assessed to identify strengths and weaknesses. Opportunities for improvement are identified. Objectives are developed by the CHC and are prioritized and translated into goals that align with and are sometimes included as a CHC Strategic Priority (Big ‘QI’). The objectives are translated into performance measures that cascade into program-level (Little ‘qi’) and individual-level quality improvement action plans across the organization.

Managers and staff identify measures related to their specific objectives taking into consideration resources and current processes in place. Plans and processes are executed and measured using small improvement cycles. Performance is measured, analyzed, and used to drive decisions for additional actions. Improvement activities are shared to learn from both successes and failures. Successful improvement strategies are used to spread improvement to other areas of the organization.

5 Methodology

BCHS uses an approach to quality improvement that is consistent with performance management strategies. The following four components provide a framework for BCHS quality improvement.

Performance Standards are generally accepted, objective standards of measure such as a rule or guideline against which an organization's level of performance can be compared. They are used to set a level of performance that is desired or expected.

Performance Measurement is the regular collection and reporting of data to track work produced and results achieved. Capacities, processes, or outcomes may be measured.

Improvement of outcomes and processes is based on analysis of quantitative and qualitative data.

Reporting, monitoring, and sharing of performance indicators and improvement results are monitored and shared with leadership, staff, community partners, clients, regulatory groups and other stakeholders.

Figure 1: Turning Point Performance Management System

5.1 Performance Standards

Standards set a level of performance that is desired or expected. In public health and primary care, standards may describe population health status, client health status, client care, utilization of services, and agency systems, and infrastructure. BCHS identifies standards for core areas including:

Population/Client Focus:

- health outcomes for individuals and populations
- access to/utilization of services
- opportunities to make choices that lead to a long, healthy life
- per-capita cost of care

Organizational/Operational Focus:

- leadership and governance
- workforce environment, engagement, capability, and development
- work processes
- financial performance

Quality Indicators

Standards are available from sources such as Health Resources and Services Administration (HRSA) Uniform Data Set (UDS), Oregon Health Authority, Patient Centered Primary Care Home (PCPCH), etc. CHC also benchmarks against similar organizations.

Quality indicators may include:

- population health indicators
- clinical standards
- benchmarking against external agencies
- regulatory standards set by oversight agencies
- accreditation standards
- expectations of clients and staff

5.2 Performance Measurement

The measurement and monitoring of performance and quality indicators provides a basis for understanding how well BCHS is delivering high-quality and cost-effective services to our clients. By assessing our performance, BCHS gains insight into what is working well and where changes are needed in order to optimize program efficiencies and effectiveness. Performance measurement provides a way to report transparently to our staff, our patients, and to external stakeholders outside of BCHS. In evaluating performance, BCHS measures outcomes, processes, and capacities against internal and external benchmarks. Frequency of measurement is dependent on the purpose of the measure. Performance may be assessed:

Annually	to determine if improvement initiatives have met their goals; to track trends over time; to identify gaps; and develop the next QI Plan and set realistic goals for improvement
Semi-annually	to monitor improvements continuously and determine whether they have met their goals; and to identify areas where additional QI activity may be required
Quarterly	to monitor improvements continuously and determine whether they have met their goals; and to identify areas where additional QI activity may be required
Monthly/Weekly	to determine if a QI test of change is successful or whether adjustments are needed to achieve improvement; to monitor incremental improvements over time; and to measure stability of a process over time

Incident Management / Risk Management: BCHS has a specific policy and procedure related to Incident Reporting (see "Incident Response and Reporting". Incidents are monitored daily and reported on a quarterly basis to the Key Management Staff, Quality Steering Committee (QSC), and CHC Board of Directors. Staff members are trained on when and how to complete incident reports. Issues that need immediate attention are addressed immediately; in addition, trends are monitored and shared with staff.

Client Concerns: Clients are given the opportunity to express any concern or complaint they may have. BCHS has a "Client Complaint and Grievance" policy and procedure that describes how patients may file formal grievances. Staff are encouraged to work together with clients to resolve concerns and/or to provide both a Client Concern form and assistance completing the form. Client Concerns are reviewed, staff provides support to address the client concern, and internal systems and protocols are reviewed. System improvement opportunities are tracked, monitored, and systems/protocols are updated as needed.

Patient Feedback and Experience of Care: Patients are routinely asked to rate their experience using a nationally recognized Consumer Assessment of Healthcare Providers & Systems (CAHPS)-like survey tool. Survey results are analyzed and shared with staff and the CHC Board of Directors on a quarterly basis.

Policies and Procedures: Internal policies and procedures are reviewed and updated at least every three years. Current policies and procedures are made available to staff on The Benton County

Employee Engagement Intranet (BEE). Staff are notified of new policies and policy revisions by email or through management staff review of policy with staff.

Clinical Standards of Care and Protocols: CHC practitioners have 24-7 access to evidence-based recommendations for patient care through subscription to UpToDate. In addition, CHC practitioners access recommendations for clinical preventive services through online U.S. Preventive Services Taksforce (USPSTF) resources. Clinical practice agreements used by the pharmacy, family planning guidelines, and standing orders provide additional sources of clinical standards of care.

Peer Review: Physician-led peer reviews are performed on a quarterly basis to evaluate the quality and performance of care, provide direct feedback to the practitioners, as well as review and analysis to identify areas of excellence and improvement opportunities. Mental health professionals review the work of their colleagues on a semi-annual basis and provide feedback on overall client care as well as appropriate documentation of care. A summary of each peer review process is documented and reported to the CHC Board of Directors.

Chart Review: Chart review in primary care is completed by the CHC Medical Director as a part of annual staff performance evaluation process. The mental health professional peer review process incorporates some components of chart review. Dental charts are reviewed on an ongoing basis to ensure chart completeness and follow through with referrals.

Clinical/Health Quality of Care: CHC measures utilization and clinical outcomes and bases its performance measures on Uniform Data System (UDS), Patient Centered Primary Care Home, Oregon Coordinated Care Organization (CCO) performance metrics, and other evidence-based best practices. Other program areas such as Women, Infants and Children Program (WIC), family planning, communicable disease, environmental health, behavioral health, and public health measure performance against nationally recognized standards and measures for their respective programs.

Operational Performance Metrics: Organizational performance metrics are in development and include financial performance metrics, as well as other indicators of organizational performance.

Employee Engagement: Staff are surveyed every other year using the Gallup Q12 survey. Basic needs, individual contributions, teamwork, and growth are all assessed at the team and program level. Results are shared and activities are constructed/conducted to address opportunities for improvement identified with the globally recognized assessment tool.

6 Project Identification, Prioritization, and Initiation

6.1 "Big QI"

The Quality Improvement Plan (QIP) identifies specific areas of current operational performance for improvement. The QIP is reviewed and updated on an annual basis to reflect priorities in both the population/client and the organizational focus areas (see *Performance Standards* above). Selection and prioritization of "Big QI" initiatives is led by the Quality Steering Committee (QSC) and is guided by the principles described below (*Prioritization*).

Expected outcomes for each of the selected priorities are identified by the program areas that are involved in making the improvement. Oversight responsibilities of senior leadership and the QSC add an element of accountability for setting goals that are both realistic and challenging. When the QIP is complete with initiatives and goals, the QIP is reviewed and approved by the CHC Board.

Approved "Big QI" initiatives cascade to department and inter-departmental initiatives aimed at operationalizing "Big QI" directives. At the department and program-level, strategies are identified and communicated to help achieve initiatives identified in the QIP. Aim statements are documented using SMART principles (specific, measurable, attainable, relevant, timely). Specific actions, resources and performance indicators are identified for the program-level initiatives; baselines are established as a basis for evaluating the degree of improvement.

6.2 "Little qi"

Performance and quality improvement are encouraged at all levels in the organization and are not limited to the "Big QI" initiatives. "Little qi" activities include interdepartmental or multi-disciplinary representation in most instances. "Little qi" does not indicate the size of a project, rather, it is an indicator of smaller initiatives that are not at an organization level. "Little qi" initiatives may address gaps identified by audits, compliance with Oregon Administrative Rule (OAR)s, accreditation requirements, and other regulatory and/or compliance requirements. "Little qi" efforts are generally managed at the program or service level as a self-contained project.

Opportunities for process improvement identified at the unit, department, or service level, which do not involve other areas, are acted upon using systematic process improvement techniques within the department. Departmental initiatives are prioritized based upon the process's relevance to the department's mission, impact upon client/staff safety and care or other department-specific factors. As with other projects, project leads are encouraged to establish quality, cost, or service level targets as appropriate for the improved or redesigned process. Leads will establish time frames for completion and use QI improvement tools and methods. Leads may work with leadership to allocate resources for project completion.

QSC encourages staff-driven improvement ideas and allows improvement initiatives to be tested and implemented without formal involvement of the QSC. The QSC is available to provide guidance and support and actively engages in helping to prioritize initiatives when intervention is needed.

To effectively manage organizational resources and keep communication flowing, management staff will regularly share improvement project ideas, project updates, and new project information with their peers, with leadership, and among staff. All managers are encouraged to document their improvement initiatives via PDSA or Define, Measure, Analyze, Improve, Control (DMIAC) so they can easily be tracked, accounted for, and shared with governing bodies as needed.

6.3 Prioritizing Improvement Opportunities

As an organization that values innovation and learning, there are an abundance of new ideas and opportunities competing for limited resources. Establishing clear priorities is essential to achieving

BCHS' vision of "*Healthy People, Strong Communities*." A variety of prioritization tools are available on the Internet including paired comparison analysis, decision matrix analysis, action priority matrix, and Pareto analysis. An appropriate tool will be selected to guide prioritization of organization-wide opportunities for improvement.

Improvement initiatives are prioritized based on several factors including:

- Impact on client-centered values (safety, care, access, outcomes, satisfaction)
- Impact on health equity
- Alignment with the mission, vision, and values of BCHS, BCHD and CHCBLC
- Scope and extent of the process in question
- High risk, problem prone outcomes or process, or one where variation has historically been a problem
- Extent to which the improvement is a requirement of regulatory or oversight bodies
- Availability of constrained resources (data, time, staff, money, skill, etc.)

6.4 Project Initiation

Senior leadership leads the way for "Big QI" projects by publicly endorsing and supporting the initiatives, articulating how the initiatives align with organizational values, allocating resources, and removing barriers as needed. The project lead and team will develop a Project Charter that includes the following.

- Identify the project vision and objectives
- Define the complete scope of the project
- List all the critical project deliverables
- State the customers and project stakeholders
- List the key roles and their responsibilities
- Create an organizational structure for the project
- Document the overall implementation plan
- List any risks, issues, and assumptions

"Little qi" projects can be initiated by any staff member with the approval of their supervisor. Staff is encouraged to document improvement projects on a PDSA worksheet available on The BEE. PDSA worksheets can be provided on an informational basis to the QSC, to develop awareness of various work groups operating within the organization and to identify the potential of coordination of similar efforts across work units. The QSC may initiate formation of a "little qi" project to fill an identified need or strategic initiative. If there is a question as to whether a work group should be chartered as an organization level group, the issue should be brought to the QSC for a decision.

7 Reporting, Monitoring and Sharing

BCHS is committed to transparency and using data to measure and monitor the quality of outcomes, processes and capacities. Capacity for collecting, validating, reporting, interpreting and using data for improvement is under development.

Performance indicators selected to measure performance of small tests of change are reported and monitored by quality improvement teams with a frequency relevant to the test and determined by the improvement team. Program-level and team-level goals that feed into accomplishing "Big QI" goals are monitored at the program- or team-level. Reporting and monitoring will be shared with the QSC at its quarterly meeting.

Indicators selected to track broad "Big QI" initiatives are reported and monitored by improvement teams, operational leadership teams, with advisory groups and boards, and with the Quality Steering Committee (QSC). Progress is reported to and monitored by the QSC on a quarterly and annual basis and reported to the CHC Board on a regular basis.

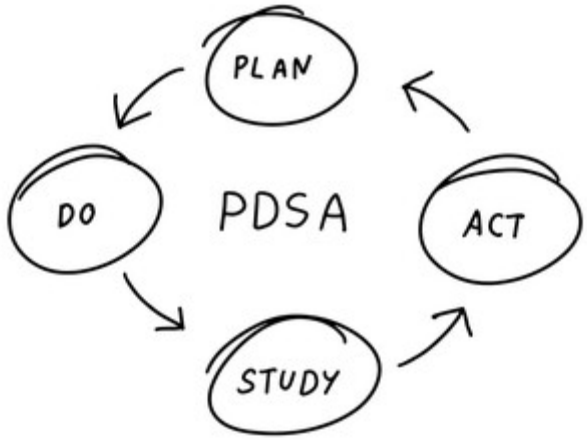
Results of process improvement initiatives will be communicated as appropriate throughout the organization in an effort to share ideas, gain a better understanding of relevant processes, encourage collaboration, instill concepts of continuous improvement into the organizational culture, and to stimulate creative and innovative improvement initiatives.

As BCHS deepens its capacity to collect, validate and report data and increases acceptance of the value of data for shining a light on improvement opportunities and successes, the process of reporting, monitoring and sharing will become more robust. This will include development of a quality dashboard that includes a comprehensive set of measures or indicators tied to client and organizational performance requirements.

8 Quality Improvement Model: PDSA and DMAIC

There are several accepted methodologies for making improvement outcome, process and/or capacity improvements. Using a methodology ensures consistency in approach and that critical steps are not missed. No one method is best for everyone or all situations. Two models used most by Benton County Health are PDSA and Six Sigma DMAIC.

PDSA: We have adopted the widely recognized Plan-Do-Study-Act (PDSA) model for managing process improvement. The PDSA model provides a structured framework for iterative testing and refinement of processes. Empowering and encouraging our teams to employ this tool helps foster a culture of continuous improvement within our organization.



Plan: The first phase of the PDSA cycle involves planning, where we identify the specific process that requires improvement, define clear improvement objectives, and establish a plan of action. In our health centers, this phase typically involves collaboration among multidisciplinary teams, including administration, healthcare providers and their Care Team, and support staff. Together, we will articulate the goals of the improvement initiative, set measurable targets, and outline the strategies to achieve them.

Example: If our goal is to reduce patient wait times in the clinic, our plan may involve streamlining the check-in process, optimizing appointment scheduling, and enhancing communication between different job roles.

Do: The "Do" phase involves implementing the planned changes on a small scale, allowing us to observe their impact and gather valuable data. This step is crucial for identifying potential issues, refining the process in real-time, and minimizing the risks associated with full-scale deployment.

Example: To reduce patient wait times, we may implement a revised check-in process for a specific clinic or time period. This small-scale implementation allows us to assess the practicality and effectiveness of our process changes before a full-scale implementation across all clinics.

Study: In the "Study" phase, we collect and analyze data to evaluate the outcomes of the implemented changes. This analysis helps us understand whether the modifications achieved the desired results and provides insights into any unexpected consequences. The focus is on measuring key performance indicators and assessing the impact on patient satisfaction, staff efficiency, and overall workflow.

Example: We will then analyze the data gathered from the small-scale implementation and compare its effect on patient wait times, feedback surveys, and staff input. This analysis will help us determine if the revised check-in process led to a meaningful reduction in wait times and/or improved overall satisfaction.

Act: Based on the findings from the study phase, the "Act" phase involves making informed decisions about whether to standardize, adjust, or abandon the changes. Successful elements of the improvement initiative can be integrated into standard operating procedures, while unsuccessful aspects can be modified or discarded. The lessons learned from each cycle feed back into the planning phase for the next iteration of improvement.

Example: If the revised check-in process proves successful in reducing wait times and enhancing patient satisfaction, we may decide to implement it across all clinics. If certain aspects need refinement, we will make the necessary adjustments and re-enter the PDSA cycle.

By embracing the PDSA approach, CHCBLC will not only enhance our ability to address specific challenges but will also foster a culture of continuous improvement. This iterative and evidence-based methodology ensures that changes are implemented thoughtfully, with a focus on achieving measurable improvements in patient care, operational efficiency, and overall organizational excellence. Through the PDSA cycle, our health center is poised to adapt and thrive in the dynamic landscape of healthcare, delivering the highest standard of care to our community.

DMAIC: As an extension to the PDSA, the Six Sigma DMAIC model is used to further guide improvement efforts. The DMAIC model guides the process through a similar five phases, but also adds an element of sustainability or control:

- **Define**: Develop a clear project charter that identifies processes to be improved that are relevant to customer needs and that will provide significant benefits to the hospital.
- **Measure**: Determine the baseline and target performance of the process, define key input and output variables and validate the measurement system.
- **Analyze**: Use data to find the root cause of the problem; to understand and quantify their effect on process performance.
- **Improve**: Identify process improvements to optimize process outputs and reduce variation.
- **Control**: Document, monitor and assign accountability for sustaining gains made by the process improvements.

Additional Lean tools may be used to drive out waste, improve quality, reduce cost, and eliminate variation.

9 Governance, Structure, Roles, and Responsibilities

Everyone has a role in BCHS's performance management and quality improvement efforts.

BCHS recognizes the interest of and valuable contribution of its stakeholders in performance and quality improvement planning, as well as ongoing implementation of those plans. The structure used to support quality improvement reflects BCHS' commitment to engaging our clients, staff and community partners in continuous improvement and a collaborative, systems approach to quality.

- The Community Health Centers of Benton and Linn Counties Board of Directors have oversight responsibility and authority for the QA/QI activities for the CHC's. The CHC Board of Directors is ultimately accountable for the quality of care provided at the CHC's. The CHC Board reviews and approves the Performance Management and QI Framework a minimum of every three years, receives and acts upon reports related to the QI Program, and assures the availability of resources and systems to support QI activities.
- The primary responsibility for managing CHC's QA/QI efforts is assigned to the CHC Medical Director with operational support provided by the Chief Operating Officer, and the QI & Data Services Manager.
- The directors of Benton County Health (BCHD) and the Community Health Centers (CHC) have charged all staff with the responsibility to engage in actions that contribute to a culture of quality.
- The Quality Steering Committee (QSC) sets the strategic direction for high-level (Big QI) quality activities at BCHS in alignment with CHC and HD strategic plans. The QSC provides guidance and oversight for carrying out Health Services aligned QA/QI initiatives. The QSC identifies and monitors measures of organizational performance which may include financial and administrative measures when there is alignment across CHC and HD initiatives.
- Key Management Team members are responsible for supporting QI efforts and for promoting, training, challenging and empowering BCHS employees to participate in the practices and processes of QI.
- Clients and community partners may be involved during the assessment process through meetings, surveys, key informant interviews, focus groups, email and/or social media. Their input is integrated into planning.

9.1 Oversight Roles and Responsibilities

CHC Board of Directors and BC Board of Commissioners have oversight responsibility and authority for the QA/QI activities for the Community Health Center and Public Health Department, respectively. As such, the CHC Board of Directors and Benton County Board of Commissioners:

- review a summary of performance improvement activities and outcomes on an annual basis
- provide feedback and suggestions on the needs of the community
- approve allocation of resources when appropriate to implement needed system changes to achieve the highest possible outcomes
- approve and participate in implementation of key governance processes that are the most important to the safety and excellence in health outcomes of the people we serve

- assure that there is adequate opportunity for input by community members served by the two Departments

Quality Steering Committee members are responsible for helping to create a quality improvement culture. In this culture, employees use quality improvement principles and tools in their day-to-day work, with support and guidance from leadership. Members of the QSC are not directly responsible for managing project activities, but provide guidance and oversight for those who do.

This includes:

- encouraging quality improvement at all levels in the organization and showing genuine interest in improvement initiatives
- actively supporting collaboration among and across departments
- recommending program and process improvements
- serving as executive sponsors for improvement projects
- encouraging use and adoption of data-driven performance measures
- analyzing measured outcomes and making evidence-based recognitions and recommendations
- responding to specific requests for QSC assistance
- identifying and reviewing implementation issues
- helping balance conflicting priorities and resources
- encouraging and facilitating investment in development of quality improvement capability and capacity
- recognizing and celebrating both individual and team accomplishments
- conducting a quarterly quality performance review and preparing an annual report

In addition to QI activities, the QSC oversees systematic monitoring and evaluation of programs and services to assure compliance with requirements of federal, state, grantors, and accrediting agencies with regard to quality. The QSC may delegate day-to-day responsibility for QI activities but ultimately is accountable for:

- reporting, tracking, monitoring and investigating incidents (see policy on “Incident Response and Reporting”)
- responding to complaints and grievances
- assuring staff are credentialed
- conducting clinical record reviews

Health Department advisory committees and the Health Center governing board serve as extensions of the QSC, providing a richer representation of the community in providing guidance for QI activities.

9.2 Leadership and Staff Roles and Responsibilities

Quality improvement is the responsibility of all staff. QI roles and responsibilities described below are represented in position-specific competencies.

All Staff

- Apply QI principles and tools to daily work.
- Participate in QI project work as assigned or agreed upon by supervisor.
- Develop an understanding of basic QI principles & tools through QI orientation and training.
- With program manager, identify program areas for improvement and suggest improvement actions to address identified projects; evaluate project ideas using established criteria including alignment with organizational goals and project prioritization methods.
- Identify QI training needs and coordinate training through supervisor.

Program Managers/Management Staff

- Develop and document improvement strategies that address the initiatives identified in the annual QI plan (Big QI); test improvement strategies; collect, analyze and review performance data results for the initiatives; implement and spread changes.
- Lead change with respective program teams and encourage appropriate use and application of QI tools and methods.
- Monitor and report progress on Big QI projects.
- Coordinate with Improvement Manager to identify projects or processes to improve and assist with development of QI project proposal.
- Develop and document program-specific improvement plans to comply with OARs, accreditation requirements, and all other regulatory and/or compliance requirements.
- Document QI activities and efforts.
- Identify staff training needs, participation in QI training, and competency with identified QI competencies. Identify staff for quality advisor team and/or advance QI training opportunities.
- Apply QI principles and tools to daily work.

Quality Improvement & Data Services Manager

- Lead, coordinate, support, and guide organization-level quality improvement.
- Lead development of an annual QI Plan with input from senior leadership, managers, and staff; advisory groups/boards; and community improvement planning partners.
- Assist program managers with program-level improvement planning.
- Collaborate with appropriate leadership to integrate QI principles into policies/protocols (e.g. job descriptions/competencies, performance review, training; policy, procedure, and process development).
- Provide technical assistance to QI projects at all staff levels of BCHS.
- Encourage documentation of QI activities and projects (aim, objectives, measures, planning/implementation, and QI project results).
- Identify continuing education resources.
- Provide quarterly written updates on core projects to Quality Steering Committee.
- Serve in an advisory capacity in addressing problems encountered by QI project teams and QI advisors/team leads.

- Identify and promote strategies to develop "culture of QI" (e.g., change management, creativity theory).
- Apply QI principles and tools to daily work.

Quality Improvement Teams

- Provide QI expertise and guidance for QI project teams.
- Provide QI training to new and existing staff.
- Assist program managers in development of program level QI activities.
- Advocate for QI and encourage a culture of learning and QI among staff.
- Apply QI principles and tools to daily work.

Leadership Staff

- Provide leadership for organizational vision, mission, strategic plan and direction related to performance improvement and quality improvement efforts.
- Facilitate involvement of key stakeholders in PI/QI activities including management- and staff-level employees; advisory groups and board members; and community partners.
- Promote a learning environment and be a champion for QI among staff, clients/patients, advisory groups/board members, and community partners.
- Assure all staff has access to resources to carry out QI projects and training.
- Apply QI principles and tools to daily work.

10 Performance Management and Quality Improvement Training

Training is essential to developing and maintaining a culture of quality. The goal of training is long-term adoption and integration of performance management (PM) and quality improvement (QI) into day-to-day work.

Orientation to PM and QI will be developed for new employees. The goal of orientation is to (a) communicate the organizational commitment to PM/QI, (b) introduce some key concepts and terminology, (c) describe Big QI and little qi in the BCHS context, and (d) identify next steps and resources for more involvement with QI.

Training opportunities are offered to staff and management in a variety of formats and on a variety of PM/QI topics including meeting facilitation, performance management, quality improvement tools and methods (e.g. PDSA, Lean/DMAIC, rapid cycle improvement, model for improvement), using data for improvement, and change management. Guiding principles for training include (a) using just-in-time instruction to bridge didactic with engaged learning and (b) transfer of training as a way to spread and effectively apply new knowledge. Training methods include self-study, instructor-led training using internal and external instructors, online training, workshops/ conferences, coaching, and project-focused/hands-on training.

Training needs will be solicited from managers and staff by the systems improvement manager. Training will be developed or training sources identified to meet organizational needs.

Intermediate- and advanced-level training will be offered to interested staff and particularly to QI-Team members to develop their skills to lead other staff in QI efforts. Training will include both conceptual and experiential learning. Additionally, boards and advisory group members will be introduced to PM/QI principles as needed.

11 Change Management

Understanding and managing change are essential to effectively building a culture of quality. "In order for a quality improvement process to bring about real, sustainable business improvements, it is imperative that managers at all levels of the organization have the ability and willingness to deal with the tough issues associated with implementing major change. They must be capable of guiding their organization safely through the change process." BCHS is committed to understand and manage change using proven change management principles. Peter Senge's concepts of a learning organization and John Kotter's change model are used as guiding principles for staff as they lead change.

John Kotter's change model takes both head and heart into consideration. "The core of the matter is always about changing the behavior of people, and behavior change happens in highly successful situations, mostly by speaking to people's feelings. This is true even in organizations that are very focused on analysis and quantitative measurement." Kotter's eight-step change model is summarized below with additional explanation available online.

1. **Increase urgency** – Help others see the need for change; make objectives real and relevant.
2. **Build the guiding team** - Get the right people in place with the right emotional commitment, and the right mix of skills and levels.
3. **Get the vision right** – Create a vision and strategy to help direct the change effort; focus on emotional and creative aspects necessary to drive service and efficiency.
4. **Communicate for buy-in** – Make sure as many as possible understand and accept the vision and the strategy.
5. **Empower action** - Remove obstacles, enable constructive feedback and lots of support from leaders - reward and recognize progress and achievements.
6. **Create short-term wins** - Set aims that are easy to achieve - in bite-size chunks. Follow through with those achievements. Finish current stages before starting new ones.
7. **Never let up** - Foster and encourage determination and persistence - ongoing change - encourage ongoing progress reporting - highlight achieved and future milestones.
8. **Make change stick** – Articulate the connections between the new behaviors and organizational success, and develop the means to ensure leadership development and succession. Weave change into culture.

12 Record Keeping and Confidentiality

BCHS' policies on Confidentiality of Medical Records states that medical records are protected under both Oregon and federal law. It is the policy of BCHS to protect client health information in accordance with Federal and State privacy and security regulations. All information shall be confidential and shall be disclosed only to authorized persons in accordance with Oregon and federal law. Policies related to confidentiality of client records are regularly updated, posted on the BEE, and staff are trained annually.

Any client specific information generated by the Quality Steering Committee may be shared in accordance with HIPPA regulations. Violation of this confidentiality may result in disciplinary action if it involves staff, and/or removal from participation in the Quality Management Committee or sub-committee.

Meeting Minutes: The QSC will document business conducted at meetings. Standing Sub-Committees are required to document business conducted at meetings. Time-limited, ad-hoc workgroups or other sub-committees will document business as requested.

13 Demonstration of Compliance

The Community Health Centers of Benton and Linn Counties demonstrate their compliance with the HRSA Quality Improvement/Quality Assurance System requirements by fulfilling all the following:

- The health center has a board-approved policy(ies) that establishes a QI/QA program (see ***Quality Assessment and Performance Improvement*** policy). This QI/QA program addresses the following:
  - The quality and utilization of health center services (see ***Peer Chart Review Process, Power BI, annual UDS reporting***);
  - Patient satisfaction and patient grievance processes (see ***Patient Experience of Care and Satisfaction Surveying Process***); and
  - Patient safety, including adverse events (see ***Incident Reporting and Investigation Process***).
- The health center designates an individual(s) to oversee the QI/QA program established by board-approved policy(ies). This individual's responsibilities would include, but would not be limited to, ensuring the implementation of QI/QA operating procedures and related assessments, monitoring QI/QA outcomes, and updating QI/QA operating procedures (**Quality Improvement and Data Services Manager, Medical Director, and Health Information Management Compliance Officer**).
- The health center has operating procedures or processes that address all of the following:
  - Adhering to current evidence-based clinical guidelines, standards of care, and standards of practice in the provision of health center services, as applicable (see ***Peer Chart Review Process***);
  - Identifying, analyzing, and addressing patient safety and adverse events and implementing follow-up actions, as necessary (see ***Incident Reporting and Investigation Process***);
  - Assessing patient satisfaction (see ***Patient Experience of Care and Satisfaction Surveying Process***);
  - Hearing and resolving patient grievances (see ***Client Complaint/Grievance Procedure***);
  - Completing periodic QI/QA assessments on at least a quarterly basis to inform the modification of the provision of health center services, as appropriate; and (***Monthly Clinical Oversight and Leadership workgroup***)

  - Producing and sharing reports on QI/QA to support decision-making and oversight by key management staff and by the governing board regarding the provision of health center services (***Monthly Quality Metrics and Quarterly BOD presentations***).
- The health center's physicians or other licensed health care professionals conduct QI/QA assessments on at least a quarterly basis, using data systematically collected from patient records (see ***Peer Chart Review Process***), to ensure:
  - Provider adherence to current evidence-based clinical guidelines, standards of care, and standards of practice in the provision of health center services, as applicable; and
  - The identification of any patient safety and adverse events and the implementation of related follow-up actions, as necessary.
- The health center maintains a retrievable health record (for example, the health center has implemented a certified Electronic Health Record (EHR)) for each patient, the format and content of which is consistent with both Federal and state laws and requirements (***OCHIN Epic***).
- The health center has implemented systems (for example, certified EHRs and corresponding standard operating procedures) for protecting the confidentiality of patient information and safeguarding this information against loss, destruction, or unauthorized use, consistent with Federal and state requirements (***OCHIN Epic, mandatory annual HIPAA training***).

Appendix A: Performance Review Calendar

Performance is reviewed on a regular basis at intervals described below. Strategies to improve processes/outcomes and correction action activities are taken to both mitigate risk and to improve the quality of care and outcomes for clients. Performance activities and results are summarized and reported.

Topic	Responsible	Frequency	Reported to
Incident Management	Compliance Manager	Daily with quarterly reporting	QSC, CHC Board
Client Concerns	Compliance Manager	Daily with quarterly reporting	QSC, CHC Board
Client Satisfaction	QI & Data Services Manager Communication & Patient Engagement Coordinator	Quarterly, annually	QSC, CHC Board, Management teams, Staff, Advisory Groups, Quality Teams, OPCA
Risk Assessments (Security, HIPAA, Compliance)	Compliance Manager	As applicable, quarterly, and Annual reporting	QSC, CHC Board, Management teams, Staff, Advisory Groups, Quality Teams
Policies & Procedures	Compliance Manager	Annually (review/audit)	QSC, CHC Board, Management teams, Staff
Program-Specific Performance (Non-Clinical)	Program Managers	Varies by program	Management Teams, Staff, Advisory Groups, Quality Teams
Operational Management Performance	Chief Operations Officer Chief Financial Officer Program Managers	Daily, weekly with monthly, quarterly, and annual reporting	QSC, CHC Board, Management teams, Staff, Advisory Groups, Quality Teams
Clinical Standards of Care and Protocols	CHC Medical Director MH Medical Director	Daily with quarterly reporting	QSC, CHC Board, Management teams, Staff, Advisory Groups, Quality Teams
Clinical Outcomes (incl. UDS, CCO, PCPCH measure review)	CHC Medical Director QI & Data Services Manager Program Managers	Weekly, Monthly with Quarterly and Annual Reporting	CHC Board, Management teams, Staff, Advisory Groups, Quality Teams
Peer Review	CHC Medical Director Behavioral Health Medical Director	Quarterly (Primary Care) Semi-Annually (Mental Health)	CHC Board
Chart Review Primary Care Mental Health Dental	Compliance Manager CHC Medical Director MH Program Manager Oral Health Manager	Annually Annually Semi-Annually Semi-Annually	QSC, CHC Board, Staff QSC, CHC Board, Staff QSC, CHC Board, Staff QSC, CHC Board, Staff
Credentialing	QI & Data Services Manager	2x year	CHC Board

Appendix B: Quality Improvement Calendar

Dedicated Quality Improvement activities are conducted throughout the year to strategically select and/or monitor the progress towards Big QI objectives.

Function	Responsible	Frequency
Quality Steering Committee	QI & Data Services Manager	Every other month
Incident and Client Concern	Compliance Manager	Monitor daily, report quarterly
Patient Experience	QI & Data Services Manager	Monitor daily, report quarterly
Staff Engagement	Leadership & Management Team	Survey every 2 years, Monthly
QI Planning (next fiscal year)	Management Team, QSC, QI Advisors	Annually
QI Plan Approval (next fiscal year)	QSC	Annually
QI Plan – Performance Metrics	QSC	Every other month
HRSA Site Visit	Community Health Centers	Every 3 years
PCPCH Accreditation	Community Health Centers	Every 2 Years
NCQA Accreditation	Community Health Centers	Annually
IHN VBP Performance Review	Community Health Centers	Annually

Appendix C: Mission, Vision, Values

Our mission, vision, and values are the guiding force in our quality improvement work; They outline our purpose and commitment to delivering unparalleled value our patients, our staff, and the communities we serve.

Mission
Community Health Centers of Benton and Linn Counties provide a medical home that promotes and supports health and wellness.
We accomplish this by -

- Bringing together medical, dental, mental health, and addiction services
- Acknowledging that health care is a right and offering care that is inclusive and available to anyone
- Providing services at clinic locations in Benton and Linn Counties
- Working together with patients/consumers/clients to have them involved in decisions and actions to improve their health
- Coordinating community partnerships to provide a broader range of services than can be offered by the health center alone
- Intentionally committing to being a leader in changing health care delivery by modeling an integrated health home that provides access to quality care

Vision
Healthy People, Strong Communities

Values
Values were developed through a process that included input from all employees of Benton County Health Services (BCHS; which includes the Health Department and the Health Center). These shared values are reflected in our service to patients as well as our work environment and are defined as follows:

- BCHC values innovation as a tool for positive change and will be proactive in strategically utilizing opportunities to advance the health of our community
- Our staff and services demonstrate a client centered approach that is timely, respectful, and involves the client.
- BCHS is committed to improving the health of all residents in our community.
- BCHS values high functioning, multi-disciplinary teams accomplished by supporting individuals in professional growth, encouraging their contributions as experts in their areas of work, and demonstrating equality and respect among all team members.
- Successful partnerships reflected internally among staff and programs, and externally with community and state stakeholders are critical to achieving our goals.
- BCHS values diversity as demonstrated in our staff and culturally appropriate services.
- BCHS demonstrates excellent stewardship of human & financial resources.

Item	Revision Description	Date	Approved By
Initial Approval	Original development of the Performance Management and Quality Improvement Framework Document	2016	CHC Board
Revision	**HRSA Feedback required the following changes:** Page 1: added "context" for the "Framework" Pages 7 & 8: added "Scope" section to delineate specific areas of performance measurement that HRSA and FTCA identifies as required (peer review, chart review, clinical performance measures, etc.) Page 14: added statement that clearly identifies CHC Medical director as the person accountable for CHC QI/QA program Page 19: supplemented the existing statement on confidentiality Page 21: added a new Appendix that delineates responsibility and frequency for measuring and reporting performance measures; this aligns with the newly-added "Scope" section (pp. 7-8) Page 24: under revision – Activity Calendar	10/2016	CHC Board
Revision	**3-year Review:** Revised the document to focus specifically on CHC Performance Management and QI processes separately from Health Department Performance Management and QI processes. This means that references to HD specific quality requirements were removed. Health Services (CHC and HD) align on Performance Management and QI concepts and principles related to tools and creating a culture of QI. Health Services works collaboratively to determine opportunities for integration related to the 2040 Thriving Communities Strategic Plan. The CHC and HD have two separate Performance Management & QI Plans specific to their programs. Replaced Health Systems Improvement Manager with Data & Analytics Manager throughout Replaced Section "Endnotes" with "References" and removed endnotes. Removed specific tools from the framework, and referred to the location where QI Tools are placed for staff. Page 3: Removed QSC from Approval/Endorsement Signatures. The QSC is not responsible for approving the Performance Management and QI Framework. The QSC is responsible for promoting and implementing the components of the Framework Page 5: Added CHC Quality Improvement Purpose and Values statements. Added clarification to Guiding Principles, including four key principles - QI work as systems and processes - Focus on patients - Focus on being part of the team - Focus on use of the data Page 8: Added Factors to Consider which include: - Adaptive leadership, culture, and governance - Analytics - Evidence- and consensus-based best practices - Adoption (Spread) - Financial alignment Added "A Note About Innovation" Page 20: Updated Appendix A Page 21: Updated Appendix B Page 22: Added Appendix C	1/27/2020	CHC Board
Revision	**3-year Review:** Document reformatted with emphasis on creating consistency Updated Policy Statement to link PMQIF to Strategic Plan Updated Acronyms Updated Turning Point Performance Management Systems graphic Standardized references to "Little qi" Revised Quality Improvement Model section Added Gallup G12 Survey on Employee Engagement Added section 14 – Demonstration of Compliance	11/20/2023	

BENTON COUNTY HEALTH SERVICES
POLICY – PROCEDURE MANUAL

SUBJECT: CREDENTIALING AND PRIVILEGING

SECTION: ADMIN **PROGRAM:** ALL **PAGE:** 1 OF 12

HEALTH CENTER DIRECTOR: LACEY MOLLEL **DATE:** 06/23/2025

HEALTH DIRECTOR: APRIL HOLLAND **DATE:** 06/23/2025

HEALTH CENTER BOARD CHAIR: JEFF BETHEL **DATE:**

REVIEW BY & DATE:

PROGRAM DISTRIBUTION: ALL

Purpose

Benton County Health Services (BCHS) will ensure that health practitioners (defined as LIPs, OLCPs, and OCSs) are properly credentialed and privileged and possess the skills and competency required to provide the service(s) they were hired to perform.

It is the goal of the credentialing program to credential an effective and efficient panel of practitioners able to provide high-quality, safe, and integrated services to BCHS clients. To achieve this goal, the credentialing program uniformly collects, evaluates, and maintains information and documentation regarding the professional experience and qualifications of its practitioners.

Scope

This policy applies to all public health and health center practitioners at all sites, including employees, contracted staff, locum tenens, and interns providing behavioral health, dental, medical,

mental health, direct patient care, public health, or substance abuse services. Practitioner types in scope include, at minimum, MDs, DOs, PhDs, DDSs, PsyDs, PAs, NPs, RNs, PharmDs, MAs, Behaviorists, QMHPs, QMHAs, LCSWs, CADCs, peer providers, and dental hygienists. Staff who are licensed as a Registered Environmental Health Specialist in accordance with Oregon Revised Statutes (ORS) 700 are tracked by the Environmental Health Manager.

Definitions of Key Credentialing and Privileging Terms

The following definitions and acronyms apply to this policy:

Credentialing. The process of assessing and confirming the qualifications of a licensed, certified, or other healthcare practitioner.

BCHS Credentialing. Credentialing is intended specifically to meet BCHS requirements.

CVO. Credentialing verification organization. Certain responsibilities involved in the credentialing process may be delegated to a CVO on a contractual basis.

Insurance Credentialing. Credentialing is intended to meet the requirements of individual third-party payers.

Licensed or certified healthcare practitioner. An individual is required to be licensed, registered, or certified by the state in which a health center is located. Licensed or certified healthcare practitioners include, but are not limited to, physicians, dentists, registered nurses, and others required to be licensed, registered, or certified (e.g., lab technicians, social workers, medical assistants, dental hygienists, and nutritionists). The definition varies depending on legal jurisdiction. Licensed or certified healthcare practitioners can be divided into two categories:

- **Licensed independent practitioners (LIP)**. Any practitioner permitted by law and by the organization to provide care and services, without direction or supervision, within the scope of the practitioner's license and consistent with individually assigned clinical responsibilities. In the State of Oregon, LIPs include physicians, dentists, nurse-practitioners, nurse-midwives, or any other individual permitted by law (and the health center) to provide care without direction or supervision. Health centers should determine which individuals meet the definition of licensed independent practitioners based on law and the health center's policy.
- **Other licensed or certified practitioners (OLCP)**. An individual who is licensed, registered, or certified but is not permitted by law to provide client care services without direction or supervision. Examples include, but are not limited to, physician assistants, social workers, lab technicians, medical assistants, and dental hygienists.
- **All Staff Providing Clinical and Enabling Services (OCS)**: Other clinical staff are health center employees, individual contractors, students, or volunteers. Examples of other clinical staff include: medical/dental assistants or community health workers in states, territories, or jurisdictions that do not require licensure or certification.

Office of Inspector General (OIG). OIG has the authority to exclude individuals and entities from federally funded health care programs pursuant to section 1128 of the Social Security Act (Act) (and from Medicare and State health care programs under section 1156 of the Act) and maintains a list of all currently excluded individuals and entities called the List of Excluded Individuals/Entities (LEIE). Anyone who hires an individual or entity on the LEIE may be subject to civil monetary penalties (CMPs).

Mandatory exclusions: OIG is required by law to exclude from participation in all federal health care programs individuals and entities convicted of the following types of criminal offenses: Medicare or

Medicaid fraud as well as any other offenses related to the delivery of items or services under Medicare, Medicaid, SCHIP or other State health care programs; patient abuse or neglect; felony convictions for other health care-related fraud, theft, or other financial misconduct; and felony convictions relating to unlawful manufacture, distribution, prescription or dispensing of a controlled substance.

Benton County runs an OIG on all Benton Health Services staff according to CMS guidelines 42 CFR 455.436.

Primary source verification. Verification by the original source of a specific credential to determine the accuracy of a qualification reported by an individual healthcare practitioner. Examples of primary source verification include, but are not limited to, direct correspondence with the educational institution or healthcare organization, telephone or electronic correspondence, or reports from CVOs. The Educational Commission for Foreign Medical Graduates, the American Board of Medical Specialties, the American Osteopathic Association's Physician Database, or the American Medical Association Masterfile may also be used as primary source verification for education and training.

Privileging. The process of authorizing a licensed or certified healthcare practitioner's specific scope and content of patient care services. Privileging is performed in conjunction with an evaluation of an individual's clinical qualifications and/or performance and is specific to particular locations.

Secondary source verification. Verification by methods other than by a primary source. Examples include, but are not limited to, the original credential, a notarized copy of the credential, or a copy of the credential when the copy is made from an original source by approved health center staff.

General Policy

It is the policy of BCHS that the credentialing program conforms to the standards of regulatory agencies, including Oregon Administrative Rules and HRSA requirements of the FTCA coverage program, as well as to accrediting organizations such as the National Committee for Quality Assurance (NCQA). BCHS staff are credentialed according to the highest level of health service the individual provides.

Specific goals of the credentialing/privileging program are to:

- Verify the professional qualifications of all practitioners who provide health-related services for BCHS.
- Provide an efficient and consistent credentialing method to meet standards for licensed or certified health care practitioners as well as non-licensed clinical staff.
- Ensure there is no discrimination against any practitioner seeking qualifications as a participating provider.
- Ensure the confidentiality of practitioner credentialing data.
- Ensure that credentialed practitioners remain appropriately qualified to provide services that include review of any data on practitioner performance obtained through processes (including peer review), quality improvement, client satisfaction, chart audits, supervision, and performance evaluation.
  - **Life support/CPR training:** Copies of CPR/BLS certificates are maintained in the credentialing file. Certification training is offered to staff at no cost throughout the year. CPR and/or BLS certification are obtained at initial credentialing and each recredentialing cycle.

- Assure that no licensed or certified staff are excluded from participation in federally funded programs.

Health Center Policy (meets the requirement of 42 U.S.C. 233(h)(2))

Ultimate approval authority for Community Health Center (CHC) practitioners is vested in the CHC governing board, which may review recommendations from either the Medical Director or a joint recommendation of the medical staff (including the Medical Director) and the Health Center Director.

Alternatively, the governing board may delegate this responsibility, via resolution or bylaws, to an appropriate individual or committee to be implemented based on approved policies and procedures, which include methods to assess compliance with these policies and procedures.

In its November 24, 2008, board meeting, the governing board of the Community Health Centers of Benton and Linn Counties granted authority to the Credentialing Committee (Committee). This authority allows for monitoring of credentialing and privileging through the Committee. The CHC Board will become involved only in the event of an appeal. Credentialing activities will be included in the Medical Director's Report.

Credentialing Committee

The external Credentialing Committee is a committee that meets monthly to:

- Review and approve practitioner credentials
- Review and approve privileges
- Evaluate the effectiveness of the credentialing and privileging program
- Review and recommend credentialing and privileging policies and procedures

The Committee has the authority to approve, provisionally approve, deny, or limit an applicant's request to provide services within the scope of their practice at BCHS. The final recommendations are then provided to BCHS for final action.

The internal Credentialing Committee reviews recommendations and acts on them appropriately. This committee consists of:

- Community Health Center Director
- Health Department Director
- Medical Director of Behavioral Health
- Medical Director of Community Health Center

Delegation of Credentialing Activities

BCHS may contract with a Credentials Verification Organization (CVO) for specific credentialing and recredentialing functions, although BCHS retains the ultimate right and responsibility for these functions. (See Appendix A for CVO contractual requirements.)

Initial and Recredentialing Verification

Prior to providing health-related services, practitioner credentials shall be verified.

It is the policy of BCHS that individuals complete a BCHS credentialing and privileging process as appropriate to their position at the time of hire, prior to provision of patient care, and every two years thereafter. Determination that an LIP, OLCP, or OCS meets the credentialing requirements shall be stated in writing by BCHS' Medical Director and/or Credentialing Committee.

As a condition of credentialing and recredentialing, staff shall act consistently with the Health Services' mission statement and written corporate compliance plan.

Licensed Independent Practitioner (LIP) Credentialing

LIP credentialing requires the primary source verification of the following:

1. Current licensure
2. Relevant education, training, and experience (e.g., medical school, internship(s), residency(s), board certifications)
3. Current competence
4. Health, fitness, or the ability to perform the requested privileges. This can be determined by a statement from the individual that is confirmed either by the director of a training program, chief of staff/services at a hospital where privileges exist, or by a licensed physician designated by BCHS
5. Background Checks

LIP credentialing also requires secondary source verification of the following:

1. Government-issued picture identification
2. DEA registration (as applicable)
3. Immunization and PPD status
4. Life support training (as applicable)
5. Hospital admitting privileges (as applicable)

BCHS shall also query the National Practitioner Data Bank (NPDB) (as applicable) for LIPs.

Other Licensed or Certified Practitioner (OLCP) Credentialing

OLCP credentialing requires primary source verification of the individual's license, registration, or certification, and background checks. Secondary source verification will be done on the following:

1. Education, training, and experience
2. Registration and certifications
3. Government-issued picture identification
4. Drug Enforcement Administration registration (as applicable)
5. Immunization and PPD status
6. Life support training (as applicable)
7. Health, fitness, or the ability to perform the requested privileges. This can be determined by a statement from the individual that is confirmed either by the director of a training program,

chief of staff/services at a hospital where privileges exist, or by a licensed physician designated by BCHS

All other licensed and certified personnel will have verification of her/his license renewal done every two years during annual evaluations of performance, which ensures the employee is competent to perform the duties in the job description.

BCHS shall also query the National Practitioner Data Bank (NPDB) (as applicable) for OLCPs.

All Staff Providing Clinical and Enabling Services (OCS):

OCS credentialing requires primary source verification for background checks.

OCS credentialing requires secondary source verification on the following:

1. Government-issued picture identification
2. Education, training, and experience (if applicable)
3. Immunization and PPD status
4. Life support training (as applicable)
5. Health, fitness, or the ability to perform the requested privileges. This can be determined by a statement from the individual that is confirmed either by the director of a training program, chief of staff/services at a hospital where privileges exist, or by a licensed physician designated by BCHS
6. Letter of Good Standing (if applicable)

OCS practitioners receive annual evaluations of performance, which ensure the employee is competent to perform the duties in the job description.

BCHS shall also query the National Practitioner Data Bank (NPDB) (as applicable) for OCS.

Privileging

Privileging is a second phase, or competency phase, of the credentialing process, and is the process of authorizing a licensed or certified practitioner's specific scope and content of services. The competence of all licensed or certified practitioners is reviewed at hire and subsequently at least biennially to coincide with the recredentialing process. Each licensed or certified practitioner is privileged specific to the services being provided in each delivery setting. Privileges are requested by the practitioner, forwarded to the Medical Director for recommendation, and approved by the Credentialing Committee.

A practitioner providing clinical services for BCHS shall be entitled to exercise only those privileges specifically granted by the Credentialing Committee or as otherwise described in this policy. The process and procedures for demonstrating competence, as well as delineation for which privileges are granted, are described in "Standardized Procedures to Monitor Proficiency of Practice" and "Services for which Privileges are Granted."

Initial Privileging

For LIPs, initial granting of privileges involves completion of the credentialing process and demonstration of current competence through primary source verification, including peer references, professional practice review data, and/or other relevant information; or, in the case of

residency-trained physicians, verification of appropriate training. This information is forwarded to the medical director to be presented to the Credentialing Committee for approval.

Newly hired LIPs will be monitored while performing invasive procedures in accordance with guidelines described in "Standardized Procedures to Monitor Proficiency of Practice."

Initial granting of privileges for other licensed or certified healthcare practitioners requires secondary source verification of the individual's competence to perform the duties described in the job description.

Renewal of Credentials and Privileges

Credentials and privileges of practitioners will be reviewed for renewal, at a minimum, every two years. Similar to the initial granting of credentials and privileges, the necessary information shall be forwarded to the medical director to be presented to the Credentialing Committee for approval. The Committee is empowered to make a decision to renew credentials and privileges or to recommend changes to a practitioner's status.

Renewal of credentials and privileges of LIPs requires primary source verification of the following:

- Expiring or expired credentials
- Peer review results for the two-year period
- Relevant performance improvement information
- Periodic redetermination of privileges, and the increase or curtailment of same, shall be based upon the criteria set forth in BCHS' "Services for Which Privileges are Granted." The process lists and describes the delineation of privileges and reviews volumes required to retain privileges.

Renewal of privileges for other licensed or certified practitioners requires secondary source verification of the individual's competence to perform the duties described in the job description.

Modification of Privileges (Adding or Revoking Privileges)

Practitioners may submit a request for modification of clinical privileges at any time. Requests to add or modify privileges must be accompanied by the appropriate documentation that supports the practitioner's assertion of competence (i.e., advanced educational or clinical practice program, clinical practice information from other institution(s), references, etc.). Requests for modification of privileges will be processed in the same manner as initial privileges and in accordance with "Standardized Procedures to Monitor Proficiency of Practice" and "Services for which Privileges are Granted."

Right to Review and Correct Credentialing Information

BCHS will notify practitioners of their right to review information obtained to evaluate their credentialing application. Credentialing and re-credentialing will be done in a non-discriminatory manner. (See "Credentialing and Privileging Right to Review Process," Appendix B.) This process will also include notifying the practitioner in the event that credentialing information obtained from other

sources varies substantially from that provided by the practitioner. The practitioner has the right to correct erroneous information submitted by another source and inquire regarding their credentialing or re-credentialing status.

Duty to Notify

Practitioners have a duty to promptly notify BCHS of each of the following:

1. denial, reduction, voluntary or involuntary revocation, limitation, or suspension of his or her professional license or DEA registration, any reprimand or other disciplinary action taken by any state or federal governmental agency relating to his or her professional license, or the imposition of terms of probation or limitation by any state;
2. denial, application withdrawal, voluntary or involuntary loss, reduction, change of membership category, relinquishment or suspension of staff membership, or voluntary or involuntary loss, limitation, reduction, or suspension of clinical privileges at any hospital or other health care institution, whether temporary or permanent, including all suspensions;
3. voluntary or involuntary cancellation, loss, or change of professional liability insurance coverage;
4. receipt of a quality inquiry letter, an initial sanction notice, notice of proposed sanction or of the commencement of a formal investigation, or the filing of charges regarding health care matters by a Medicare quality improvement organization, the Department of Health and Human Services, or any law enforcement agency or health regulatory agency of the United States or of any state;
5. any proposed or actual exclusion from any federally funded health care program, any notice to the individual or representative of proposed or actual exclusion, or any pending investigation of the individual from any health care program funded in whole or in part by the federal government, including Medicare and Medicaid;
6. receipt of notice of the filing of any suit against the member or submission of adversity to the Wisconsin Injured Patients and Families Compensation Fund alleging professional liability in connection with the treatment of any patient;
7. settlement of a claim by a payment from an insurance company (or by the Practitioner or any other party) or any agreement that results in a release from liability being given by a patient to the Practitioner;
8. any criminal conviction or pending criminal charges, including but not limited to, any findings by a governmental agency that the Practitioner has been found to have abused or neglected a child, or patient, or has misappropriated the property of any patient;
9. Removal from a managed care organization's provider panel for quality-of-care reasons or unprofessional conduct;
10. any notification by any quality improvement organization or a third-party payer reimbursement program concerning any utilization or quality of care review or sanction imposed; and
11. any circumstance(s) or change in circumstance(s), including, but not limited to, health status that would materially affect the ability to perform essential functions of the Medical Staff or to exercise the clinical privileges granted, or that may put patients or staff at risk.

Maintenance of Confidentiality

BCHS will maintain a confidential credentials file for each practitioner. Access to credentialing files is limited to authorized personnel only. Electronic records are maintained on a network drive; access is limited to appropriate personnel using secure logins to the network. Staff receive appropriate training on protecting the confidentiality of protected information, including credentialing files, and sign a confidentiality agreement affirming they will protect confidential data. Practitioner information reviewed by the Committee is maintained in a secure area and is accessible only to staff with a

direct need to access this information. If a CVO is utilized, part of the contract will outline confidentiality expectations that will be followed.

Monitoring Practices and Services

Between re-credentialing cycles, BCHS monitors practitioner practices and services. If BCHS identifies any concern related to services or practice, BCHS may take action up to and including suspension of privileges and/or removal of credentialed status.

Suspension/Removal of Privileges and/or Credentialed Status

When a concern or issue has been raised about a LIP, OLCP or OCP practitioner's ability to provide safe clinical care (whether or not due to their physical and/or emotional state) and/or professional conduct or competence, the Medical Director, or his/her designee, shall make sufficient inquiry to determine that any concern or question raised merits further review. The Medical Director shall report their findings to the Credentialing Committee. The Credentialing Committee will review the case and make a decision regarding the practitioner's competence and/or privileges.

While a practitioner's professional competence or conduct is under review by the Medical Director and/or Credentialing Committee, the practitioner may be placed on administrative leave pending completion of the investigation and final determination.

BCHS can initiate an immediate termination in the event of:

- Knowledge of a client's imminent harm by a practitioner.
- Action by a recognized regulatory agency, such as license suspension or revocation, or CMS sanction.

Whenever a practitioner's credentials and/or privileges are limited, revoked, or in any way constrained, BCHS must, in accordance with state and/or federal laws or regulations, report those constraints to the appropriate state and federal authorities, and/or databases, such as the National Practitioner Databank. In addition, BCHS must notify Benton County Human Resources and any respective bargaining unit.

Credentialing and Privileging Decisions

If credentialing or clinical privileging is denied, limited, or discontinued, non-represented, licensed independent practitioners have the right to appeal. (See "Credentialing and Privileging Appeals Process," Appendix C.) Credentialing and privileging decisions for all other BCHS credentialed staff are governed by the principles and rules described in their respective collective bargaining agreements.

Version History

Previous Version Date, 3/31/2014

Appendix A – Contracted Credentials Verification Organization (CVO)

Appendix B – Credentialing and Privileging Right to Review Process

Appendix C – Credentialing and Privileging Appeals Process

Appendix A - Contracted Credentials Verification Organization (CVO)

BCHS may gather some of its credentialing information from a CVO. BCHS establishes a level of confidence in the information provided by the CVO by evaluating the following:

1. The CVO makes known to BCHS what data and information it can provide.
2. The CVO provides documentation to BCHS describing how its data collection, development, and verification processes (es) are performed.
3. BCHS is provided with sufficient, clear information on database functions that includes any limitations of information available from the CVO (for example, providers not included in the database), the time frame for CVO responses to request information, and a summary overview of quality control processes related to data integrity, security, transmission accuracy, and technical specifications.
4. BCHS and CVO agree on the format for the transmission of credentials information about an individual from the CVO.
5. BCHS can easily discern which information, transmitted by the CVO, is from a primary source and which is not.
6. For information transmitted by the CVO that can expire (for example, licensure, board certification), the date the information was last updated from the primary source is provided by the CVO.
7. The CVO certifies that the information transmitted to the user accurately represents the information obtained by it.
8. BCHS can discern whether the information transmitted by the CVO from a primary source is all the primary source information in the CVO's possession pertinent to a given item or, if not, where additional information can be obtained.
9. BCHS can engage the quality control processes of the CVO (when necessary) to resolve concerns about transmission errors, inconsistencies, or other data issues that may be identified from time to time.

Appendix B - Credentialing and Privileging Right to Review Process

All BCHS practitioners have the right to review information obtained by BCHS to evaluate their credentialing and/or re-credentialing application. This includes information obtained from any outside primary source such as the National Practitioner Data Bank, Healthcare Integrity and Protection Data Bank, malpractice insurance carriers and the Composite State Board of Medical Examiners, and other State board agencies. This does not allow a provider to review references, personal recommendations, or other information that is peer-reviewed and protected.

Should a practitioner believe any of the information used in the credentialing/re-credentialing process to be erroneous, or should any information gathered as part of the primary source verification process differ from that submitted by a practitioner, they have the right to correct any erroneous information submitted by another party. It is the responsibility of the practitioner to initiate and obtain corrections to primary source information.

To request the release of such information, a written request must be submitted to the BCHS Credentialing Department. Upon receipt of this information, the practitioner will have seven days to provide a written explanation, via certified letter, detailing the error or the difference in information to BCHS.

Upon receipt of notification from the practitioner, BCHS will re-verify the primary source information in dispute. If the primary source information has changed, corrections will be made immediately to the practitioner's credentialing file. The practitioner will be notified in writing, via certified letter, that the correction has been made to his/her credentialing file. If, upon review, primary source information remains inconsistent with the practitioner's notification, BCHS will notify the practitioner via certified letter. The practitioner may then provide proof of correction by the primary source body to BCHS Credentialing staff via certified letter within ten working days. Credentialing staff will re-verify primary source information if such documentation is provided.

In addition, practitioners/providers have the right to request the status of the practitioner’s credentialing and or recredentialing application by calling the Credentialing Department or submitting a request via email or fax.

Appendix C: Credentialing and Privileging Appeals Process

New credentialing applicants who are declined participation for reasons, such as quality of care or liability claims issues, have the right to request reconsideration of the decision in writing within ten days of formal notice of denial. All written requests should include additional supporting documentation in favor of the applicant's reconsideration for BCHS.

Reconsiderations will be reviewed by the Credentialing Committee at a specially scheduled meeting, but in no case later than 60 days from the receipt of additional documentation. The final decision will be made within the 60-day period.

The applicant will be sent a written response to his/her request within two weeks of the Committee's decision.

Current non-represented, licensed independent practitioners (LIPs) whose participation is suspended, reduced, or terminated shall have the right to appeal the decision in writing within fourteen days of receipt of the formal notice. Credentialing and privileging decisions for all other BCHS credentialed staff are governed by the rules and principles described in their respective collective bargaining agreements.

For a formal appeal of the suspension or termination of privileges, non-represented LIPs must send a written reconsideration request to BCHS, for the attention of Credentialing:

Benton County Health Services

Attn: Credentialing

P. O. Box 579

Corvallis, OR 97302

The written request should describe the reason(s) for requesting reconsideration and include any supporting documents. This reconsideration request must be postmarked within thirty days of receipt of the suspension or termination letter to comply with the appeal process.

BCHS will follow County Personnel Policy Rule 20 to govern disputes/grievances related to suspension, reduction, or termination of privileges. The Personnel Policy is available to staff electronically and/or can be provided at the request of the practitioner. In the case of non-represented contracted practitioners, BCHS will also follow all provisions of the employment agreement. Credentialing and privileging decisions for represented LIPs will be governed by the principles described in their respective labor agreements as well as by their employment agreement.

P & P: # 23	Clinical Oversight Policy Approach to the Provision of Patient Care	Page 1of 4 Effective:10/14 Reviewed: 2/16 Revised 12/16/19, 11/2023

POLICY

As a Federally Qualified Health Center (FQHC), the Community Health Centers of Benton & Linn Counties actively pursues excellence in patient-centered, team based, integrated service delivery. Services are designed to achieve the mission, vision, and values of the organization. The Health Center assures all services are compliant with HRSA legal and regulatory requirements.

Accordingly

1. Mission, Vision, Values

Mission: Community Health Centers of Benton and Linn Counties provide a medical home that promotes and supports health and wellness.

We accomplish this by;

- Bringing together medical, dental, mental health, and addiction services
- Acknowledging that health care is a right and offering care that is inclusive and available to anyone
- Providing services at clinic locations in Benton and Linn Counties
- Working together with patients/consumers/clients to have them involved in decisions and actions to improve their health
- Coordinating community partnerships to provide a broader range of services than can be offered by the health center alone
- Intentionally committing to being a leader in changing health care delivery by modeling an integrated health home that provides access to quality care

Vision: Healthy people, strong communities

Values: Values were developed through a process that included input from all employees of Benton Health Services (the Health Department and the Health Center). These shared values are reflected in our service to patients as well as our work environment and are defined as follows:

- ***Client Centered*** Our staff and services demonstrate a client centered approach that is timely, respectful, and involves the client
- ***Diversity*** Values diversity as demonstrated in our staff and culturally appropriate services
- ***Health Equity*** Committed to improving the health of all residents in our community
- ***Innovation*** Value innovation as a tool for positive change and be proactive in strategically utilizing opportunities to advance the health of our community
- ***Multi-Disciplinary Teams*** Values high function, multi-disciplinary teams accomplished by supporting individuals in professional growth, encouraging their contributions as experts in their areas of work, and demonstrating equality and respect among all team members
- ***Partnerships*** Successful partnerships reflected internally among staff and programs, and externally with community and stat stakeholders are critical to achieving our goals
- ***Stewardship*** Demonstrates excellent stewardship of human and financial resources

2. **Administrative Leadership**

- The Board, administration, management, and staff work collaboratively to improve **access**, promote health **equity**, provide high **quality** health outcomes, through affordable, efficient care, and sustainable **costs**.
- Health Center leadership works integrally with the Health Department to assure integration, collaboration, and coordination of planning and service delivery across all Health Services programs
- The Health Center supports a strong Quality Improvement infrastructure to assure continuous improvement.
- Decisions are based on careful data review and analysis.
- Leadership is actively involved in evaluating, supporting, and promoting an organizational culture that supports and leads health care transformation innovation.
- Staff are encouraged and supported to be actively involved in innovation and improvements.
- The Health Center recognizes the importance of being actively involved in community activities that contribute toward improving the quality of life in the community.

3. **Approach to Patient Care Delivery**

- Services are designed to address the documented needs of vulnerable populations and identified gaps in community services/resources.
- The care delivery model is designed to demonstrate a high functioning Patient Centered Primary Care Home (PCPCH). We strive to achieve maximum accreditation as Patient-Centered Primary Care Homes by meeting the Key Standards for Recognition) *Refer to attachment for the PCPCH Key Standards* A priority is placed on relationships with the patient and patient engagement; incorporating their interests, needs, and expectations, and working with them to establish and achieve their goals for health.
- The Health Center designs services that integrate with the local health care delivery system, and works collaboratively to increase effectiveness and minimize duplication.
- Patient services are provided through an organized and systematic process designed to ensure the delivery of safe, effective, and timely care in an atmosphere that promotes respect and caring.
- Services will include a strong focus on outreach and prevention to reduce the incidence of health problems, support early identification of health issues, and identify and assist vulnerable populations in accessing care.
- Patient care encompasses the recognition of both disease and health. It includes patient education and advocacy, and recognizes the unique physical, emotional and spiritual needs of each person.

4. Continuity Of Care

- The Health Center promotes and supports continuity of care between patients and providers. Patients are assigned to a primary care provider (PCP). Every effort is made to assure the patient sees the same provider for prevention, follow-up, and acute visits. When that is not possible, patients are scheduled with a provider from the same Care Team.
- The Health Center assures access to hospitalization through relationships with the local hospitals. Hospitals provide a copy of the discharge summary to the primary care provider upon discharge through the Electronic Health Record.
- The Health Center coordinates access to specialists and diagnostic services for patients when needed. For uninsured patients there is an agreement with Samaritan Health System to discount the cost of specialists' assessment and diagnostic services. The Health Center utilizes a formal tracking system to monitor referrals made to specialists and services not provided by the Health Center. Documentation of specialty referrals and procedures are received and noted in the patients file.
- After hours coverage is provided by a 24-hour nurse triage service. Documentation is provided to the Health Center regarding any calls received and the action recommended. Follow-up will occur with the patient when indicated.

5. Integration of Services

The Health Center is an integral component of the broader framework of Benton County Health Services with a shared commitment to deliver a full range of services from population health to person-centered care. We provide our patients and community access to a full spectrum of services from prevention, healthy environment, health equity, and engagement of at risk population's strategies; to direct service delivery that integrates primary care, mental health, dental services, and care coordination.

The importance of a collaborative multidisciplinary team approach, which takes into account the unique knowledge, judgment and skills of a variety of disciplines in achieving desired patient outcomes, serves as a foundation for integration. Open lines of communication exist between all programs providing patient care and support services within the organization, to ensure provision of patient care that is effective, efficient, and rendered at the same level to the entire patient population.

6. Quality Improvement Activities

The Health Center utilizes a Quality Improvement (QI) program to promote continuous performance improvement. It is expected all staff and care teams are engaged in improvement activities. Patient feedback and input is an important component of the QI process. Feedback is encouraged through a variety of methods. A Patient Experience of Care survey is conducted each quarter. Client comment/concern cards are also available at all sites.

7. Staff Excellence

Innovation and excellence in care are supported and encouraged by administration, but success in achieving goals is accomplished through high performing, engaged and empowered staff. All staff are appropriately licensed, credentialed and privileged. Staff competency is regularly assessed, with active training and support for improvement. Annual performance reviews will include mutual goal setting to assure all staff has the opportunity to work toward and achieve personal growth goals as well as contribute to the overall goals for the organization.

To facilitate effective relationships, problem solving is encouraged at every level of the organization. Administration maintains an open-door policy that serves as a model for all personnel to openly and constructively discuss issues and seek mutually acceptable solutions. Managers, Supervisors, and Team Leads have the authority to mutually solve problems and seek solutions within their sphere of influence.

PCPCH Key standards for recognition

- **Accessible:** Care is available when patients need it.
- **Accountable:** Clinics take responsibility for the population and community they serve and provide quality, evidence-based care.
- **Comprehensive:** Patients get the care, information and services they need to stay healthy.
- **Continuous:** Providers know their patients and work with them to improve their health over time.

- **Coordinated:** Care is integrated and clinics help patients navigate the health care system to get the care they need in a safe and timely way.

- **Patient & Family Centered:** Individuals and families are the most important part of a patient's health care. Care should draw on a patient's strengths to set goals and communication should be culturally competent and understandable for all.

Community Health Centers
OF BENTON & LINN COUNTIES

BOARD POLICY & PROCEDURE

P & P: #24 **SERVICES & HOURS OF OPERATION**
Scope of Services

Effective 10/2014
Reviewed: 09/2024

POLICY

The Community Health Centers of Benton and Linn Counties serves people in need of healthcare, with a focus on a model of care that is meaningful for vulnerable populations. These services are available across Benton and Linn Counties. The Health Center provides patient-centered, team-based, integrated services including primary care, mental health, dental care, and public health services.

Integrated services are provided for infants to seniors, across the lifespan. We aim to provide culturally responsive and appropriate care. We focus on prevention through our public health services and orientation and engage patients in all aspects of their care.

The Patient Centered Primary Care Home (PCPCH) model and Value Based Care environment underpins a focus on excellence in service delivery and improved health outcomes. A particular focus on vulnerable populations includes historically marginalized communities, children, low-income people, and seniors.

Accordingly

1. **Approach to designing Scope of Services**

   Services at the Health Centers are designed with consideration for age, identity, and health conditions of the community served by the organization. The primary care focus includes management of chronic conditions, prevention services, and the influences of physical, mental, and oral health, as well as social determinants of health. Outreach, education, patient self-management, and care coordination are important components in the design of services.

2. **Primary Care services**

   The Health Center provides all HRSA (Health Resources and Services Administration) required primary, preventive, and enabling services. Core services support the mission of the Health Center and build on existing expertise in providing interdisciplinary, culturally competent care.

The primary care services provided directly include

a) Health services related to **primary care, pediatrics, and reproductive health** including acute care, and management of chronic conditions

b) Diagnostic **laboratory** services

c) **Screening and preventive** services including cancer screening, well-child services, immunizations, vision and hearing screenings

d) **Referrals** to community providers include specialty providers, diagnostic testing, and social services

Services provided through agreements include

a) **X-ray** through an agreement with Samaritan Health Services. These services are provided at a discounted rate. Other diagnostic procedures are also available through the arrangement.

b) The Health Center assures access to **hospitalization** through relationships with the Samaritan Health Services hospital system. Hospitals provide a copy of the discharge summary to the primary care provider via health information exchange systems upon discharge.

c) The Health Center works with Samaritan Health Services to ensure access to **specialists** when needed. The Health Center utilizes the electronic health record to monitor referrals made to specialists and services not provided by the Health Center. Documentation of specialty referrals and procedures are received and noted in the patient's electronic health record.

d) **After-hours** coverage is provided by a 24-hour nurse triage service. Documentation is provided to the Health Center regarding any calls received, along with the action recommended for follow-up from Health Center staff, when indicated.

e) The Health Center has an agreement with **Children's Farm Home** to provide primary care services to the children in residence. A provider is on-site at the Farm Home, as needed.

3. Family Planning services

Family Planning services are provided according to the rules and regulations outlined by the state and federal funding that the Health Centers received. The focus of the Family Planning program is to ensure access to services that promote sexual health, plan pregnancy, and reduce the incidence and spread of sexually transmitted infections.

4. School Based Health Center services

The Lincoln Health Center and Monroe Health Center have state designation as School Based Health Centers (SBHC). SBHCs offer primary care services either within or on the grounds of a school. Our two SBHCs serve the school population and the community's surrounding area. Additional outreach and collaboration occur directly with the schools to provide outreach, screening, health promotion and education, and triage and assessment.

5. Pharmacy services

The Health Center has a contract and collaborative relationship with Oregon State University (OSU) College of Pharmacy to offer an on-site pharmacy at the Benton Health Center. The Health Center participates in the 340B program to provide medications to patients of the Health Center at a reduced cost and 340B revenue us used to stretch scare federal funding resources for operating the Health Centers. Pharmacy staff also assist patients in accessing free medications through pharmaceutical companies Prescription Assistance Programs.

Pharmacists participate on teams offering clinical pharmacy services like patient education, medication management, and prescription reconciliation.

6. Mental Health services

a) Adult Mental Health program: Supports people diagnosed with mental health conditions. The full range of community mental services is provided including psychiatric services, medication management, out-patient therapy, and intensive case management. Prevention, health education, and wellness activities are supported in the program.

b) Substance Use Disorder Services program: Provides outpatient alcohol and drug use assessment, treatment, education, and counseling in individual and group sessions. Additionally, they coordinate with primary care to provide medications for opioid use disorder treatment.

c) Children and Families program: Provides mental health care coordination and wrap-around services for children with mental health diagnoses. This includes wraparound services, Outpatient services, School-Based Mental Health, and stabilization services.

7. Dental Services

a) Boys & Girls Club Dental services: In collaboration with the Boys & Girls Club of Corvallis, the Health Center provides dental treatment to children and pregnant women. Services include hygiene, restorative, dental emergency, preventive dental, and oral health education.

b) Children's Prevention services: Dental staff provides screening and assessment in the schools across Benton and Linn Counties, at health screening events, and with

community-based organizations. Fluoride varnish, silver diamide fluoride, and sealants are available at these locations.

c) ***Outreach and education:*** The Health Center utilizes a Dental Coordinator to arrange outreach to targeted populations and assist people in accessing dental services in the community. The Coordinator and dental staff attend community events such as health fairs to raise awareness regarding oral health. Staff also provides oral health education for community agencies that serve high-risk populations.

d) Adult prevention and restorative care: Dental Hygienists provide prevention services for adults on-site at medical clinics with a primary focus on bringing adult dental prevention services to rural communities. Screening and cleaning are performed, referrals for dental treatment are provided as needed. The target population is medical patients with a chronic disease like diabetes and heart disease, as well as those who are underserved such as veterans.

8. Support services

a) Care Coordination/Case Management: Registered Nurse Care Coordinators, Behavioral Health Consultants, Referral Coordinators, and Health Navigators play a role in coordinating care. They assist in facilitating access to internal program services, and coordinate and assist in accessing specialty, diagnostic, and other health services in the community. Health Navigators assess and assist patients to access public health insurance, as well as other community programs, such as financial support, social services, housing, and education.

b) Health education: Focus on health education and patient self-management are built into the services we provide. Handouts and materials provided are reviewed for cultural relevance and literacy levels.

c) Outreach: The Health Center supports outreach to identified populations and communities to assisting improved access to Health Center services.

d) Interpretation/Translation: The Health Center offers options to assist in addressing language barriers. The Health Center recruits for bilingual positions at all levels of the organization. Emphasis for bilingual staff occurs at the front desk, reception, and medical assistants, and whenever possible nurses, and providers. Large numbers of our Health Navigation staff are bilingual and bicultural.

Health Center staff use translation and interpreter services, as well as on-site interpreters, when needed.

e) ***Transportation:*** The Health Center utilizes transportation options provided by Medicaid for all covered patients. Cab arrangements are available, when needed, if other transportation options are not available. Health Center staff assists with

transportation for clients, at times, as well. Home visits are offered, when needed, to overcome transportation barriers.

9. **Location and Hours of Operation:** Hours are established to support accessibility for patients. Primary care clinics assure hours beyond traditional 8 – 5 in compliance with PCPCH (Patient Centered Primary Care Home) accreditation standards. The Board of Directors has the authority and responsibility to approve the Health Center's services, location, and hours of operation of all the Health Center sites.

P & P: #25	STRATEGIC PLAN Strategic Planning Process	Page 1 of 2 Effective:2/23/15 Reviewed: 6/18/18, 03/24

POLICY

One of the most important responsibilities of the Health Center Board is setting the course for the organization through the Strategic Planning process. The Board establishes and monitors goals and objectives through a formalized approach to strategic planning. This ensures the long-term sustainability of health center actions and that the health center works to meet the needs of the community.

PROCESS

1. ***Purpose & Intent for the Strategic Plan***
   - Define performance goals to achieve the health center's mission and vision
   - Ensure that the patient voice and community perspective is integrated into the overall strategy
   - Define and respond to the healthcare needs of the target and patient population
   - Assure the financial well-being of the health center
   - Guide strategic and operational decision-making and action
   - Align resources and strategic focus to support and promote internal capacity and be responsive to the current healthcare environment
   - Improve the value of the organization to its patients and the community
2. ***Health Center Board Responsibilities***
   - Take a leadership role in developing the planning process
   - Participate in making decisions about the plan
   - Formally approve the strategic plan
   - Assure that the plan is used to guide strategic and operational decisions
   - Evaluate the organization's progress in meeting the plan's goals and objectives
   - Ensure that the plan is updated as time and changing conditions warrant
3. ***Frequency of Planning:*** The Board will review and update the strategic plan annually. At least every three (3) years the Board will conduct a more thorough, facilitated strategic planning process.
4. ***Approach for Preparing for Facilitated Planning Process***

   Documents, data, and elements to be considered in identifying the focus for planning will include;
   - Progress on a current strategic plan
   - Review of Quarterly Dashboard report for any identified trends/concerns
   - Health Center trends patient demographics, review of sites and services, operational priorities
   - Review of target populations and community need
   - Current and/or anticipated local, state, and national trends that impact the healthcare environment
   - The Board will decide on options to coordinate strategic plan work- this may include a Strategic Planning Committee, or a request to work with staff and outside facilitators for the process, review, and development of the document. If a facilitator is desired, the Board will work with staff to identify and contract with the person who will serve in that capacity. The Board will work with the staff and facilitator to plan the approach and key focus areas for a planning retreat.
   - The Board will discuss the need/desire to include additional perspectives in the planning process. Consideration should be given to how others such as key community members and target population advocates, are to be prepped to ensure they are able to offer the desired input. Key staff may also be invited to participate in planning retreats.

- The Board, staff, and consultants will identify logistics like format (planning retreat, small group work, setting aside time in Board meetings), date and timeline, agenda, and desired outcome for identified activities. Staff will assist in coordinating logistics as requested by the Board.

5. Development & Approval Process for Strategic Plan

- The composition of the Strategic Plan should include outcomes that may have a broader time frame (2-3 years), and strategies. Strategies should be action items that are to be completed within a one-year timeframe. Strategies should be measurable, and/or produce a deliverable result.
- Consideration will be given to identify, where possible, what will be the Board's work and what is staff's responsibility, to complete and report progress to the Board.
- The Board will establish outcomes and the intent of strategies; staff will be involved in the development of measurable strategies, particularly those related to staff work.
- The Board will formally approve the Strategic Plan at a regularly scheduled Board meeting.

6. Monitoring & Review

- The Health Center Director or relevant staff will periodically update the Board on the outcomes and strategies of the current strategic plan.
- Additional data is provided to the Board as requested and needed.