COASTAL HEALTH & WELLNESS

GOVERNING BOARD

9850-A.106 Boardroom Emmett F. Lowry Expressway, Texas City

AGENDA
Thursday, October 27, 2022 – 12:30 PM

CONSENT AGENDA: ALL ITEMS MARKED WITH A SINGLE ASTERICK (*) ARE PART OF THE CONSENT AGENDA AND REQUIRE NO DELIBERATION BY THE GOVERNING BOARD. ANY BOARD MEMBER MAY REMOVE AN ITEM FROM THIS AGENDA TO BE CONSIDERED SEPARATELY.

PROCEED TO BOTTOM OF THIS DOCUMENT FOR APPEARANCE & EXECUTIVE SESSION GUIDELINES

In accordance with the provisions of the Americans with Disabilities Act (ADA), persons in need of a special accommodation in order to participate in this proceeding should, within two (2) days prior to the proceeding, request necessary accommodations by contacting CHW's Executive Assistants at 409-949-3406, or via email at trollins@gchd.org or ahernandez@gchd.org

ANY MEMBERS NEEDING TO BE REACHED DURING THE MEETING MAY BE CONTACTED AT 409-938-2288

REGULARLY SCHEDULED MEETING

Meeting Called to Order
Pledge of Allegiance

Item #1..... Comments from the Public

***Item #2 ACTION**..... Agenda

***Item #3 ACTION**..... Excused Absence(s)

*Item #4 **ACTION**..... Consider for Approval Minutes from September 29, 2022 Governing Board Meeting

*Item #5 **ACTION**..... Consider for Approval Minutes from October 13, 2022 Governing Board QA Meeting

*Item #6 **ACTION**..... Consider for Approval Quarterly Investment Report

*Item #7 **ACTION**..... Consider for Approval Quarterly the Coastal Health & Wellness 2022-2023 Environment of Care Plans

a) Equipment Assessment Plan 2022-2023
b) Equipment Management Plan 2022-2023
c) Fire Safety Management Plan 2022-2023
d) Hazardous Materials and Waste Management Plan 2022-2023
e) Safety Management Plan 2022-2023
f) Security Management Plan 2022-2023
g) Utilities Management Plan 2022-2023

*Item #8 **ACTION**..... Consider for Approval the Coastal Health & Wellness Risk Management Report for the Quarter Ending September 30, 2022

*Item #9 **ACTION**..... Consider for Approval Coastal Health & Wellness After Hours Policy Submitted by Ami Cotharn

*Item #10 **ACTION**..... Consider for Approval Revisions to the Coastal Health & Wellness Credentialing and Privileging Policy Submitted by Ami Cotharn

Item #11**ACTION**.....Coastal Health & Wellness Updates
a) Update on COVID-19 Submitted by Executive Director
b) Operational Updates/Coastal Wave Submitted by Chief Operating Officer
c) Dental Updates Submitted by Dental Director

Item #12**ACTION**.....Consider for Approval Preliminary September 2022 Financial Report Submitted by Trish Bailey

Item #13**ACTION**.....Consider for Approval Quarterly Visits and Analysis Report Including Breakdown of New Patients by Payor Source for Recent New Patients Submitted by Ami Cotharn

Item #14**ACTION**.....Consider for Approval the Quarterly Compliance Report for the Period Ending September 30, 2022 Submitted by Wendy Jones

Item #15**ACTION**.....Consider for Approval Coastal Health & Wellness Quality Assurance Performance Improvement Plan 2022-2023 "QAPI" Submitted by Jason Borillo

Item #16**ACTION**.....Consider for Approval Coastal Health & Wellness Title V Child Health & Dental Eligibility Policy Submitted by Jennifer Koch

Item #17**ACTION**.....Consider for Approval Consumer Board Member Cynthia Darby to serve on the Appointing Committee Submitted by Samantha Robinson

Item #18**ACTION**.....Consider for Approval Nominee Courtni Tello, RDH, DDS to fill the Community Representative/Interim Vice Chair Position through June 2023

Item #19.....RCM Quality Project Update Submitted by Ami Cotharn

Item #20.....Comments from Board Members

Adjournment

Next Regular Scheduled Meeting: November 10, 2022

Appearances before the Coastal Health & Wellness Governing Board

The Coastal Health & Wellness Governing Board meetings are conducted under the provisions of the Texas Open Meetings Act, and members of the public that wish to address the Board about an item presented on the agenda shall be offered three minutes to do so. The Board cordially requests that individuals desiring to make a such a statement notify the Board of their intention by writing their name on the sign-in sheet located at the Boardroom's main entrance.

A citizen desiring to make comment to the Board regarding an item not listed on the agenda shall submit a written request to the Executive Director by noon on the Thursday immediately preceding the Thursday of the Board meeting. A statement of the nature of the matter to be considered shall accompany the request. The Executive Director shall include the requested appearance on the agenda, and the person shall be heard if he or she appears.

Executive Sessions

When listed, an Executive Session may be held by the Governing Board in accordance with the Texas Open Meetings Act. An Executive Session is authorized under the Open Meetings Act pursuant to one or more the following exceptions: Tex. Gov't Code §§ 551.071 (consultation with attorney), 551.072 (deliberation regarding real property), 551.073 (deliberation regarding a prospective gift or donation), 551.074 (personnel matters), 551.0745 (personnel matters affecting Coastal Health & Wellness

advisory body), 551.076 (deliberation regarding security devices or security audits), and/or 551.087 (deliberations regarding economic development negotiations). The Presiding Officer of the Governing Board shall announce the basis for the Executive Session prior to recessing into Executive Session. The Governing Board may only enter into Executive Session if such action is specifically noted on the posted agenda.

Governing Board
October 2022
Item#3
Excused Absence

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Governing Board
October 2022
Item#4
Consider for Approval Minutes from September 29, 2022
Governing Board Meeting

Coastal Health & Wellness
Governing Board
September 29, 2022

Board Members:

Samantha Robinson
Dr. Southerland (zoom)
Kevin Avery
Rev. Walter Jones
Donnie VanAckeren
Ivelisse Caban
Cynthia Darby
Elizabeth Williams
Clay Burton
Sharon Hall
Flecia Charles
Sergio Cruz

Staff:

Dr. Keiser, Executive Director
Dr. Choi, Medical Director
Ami Cotharn, Chief Operations Officer
Hanna Lindskog, Dental Director
Trish Bailey, GCHD, CFO
Tiffany Carlson
Neal Pathak
Jonathan Jordan
Mary Jones
Virginia Lyle
Judie Olivares
Pisa Ring
Pamela Britton
Jennifer Koch
Tikeshia Thompson-Rollins
Anthony Hernandez

Excused Absence: Dr. Thompson
Unexcused Absence: Miroslava Bustamante, and Victoria Dougharty

Items#1 Comments from the Public
There were no comments from the public.

Items#2-5 Consent Agenda
A motion was made by Elizabeth Williams to approve the consent agenda items two through five. Cynthia Darby seconded the motion, and the Board unanimously approved the consent agenda.

Item#6 Informational Report
- Notification of Board Resignation

Samantha Robinson, Board Chair, thanked Dr. Southerland, Vice Chair, for her dedicated services to Coastal Health and Wellness Governing Board and the Citizens of Galveston County from 2021-2022.

Item#7 Coastal Health & Wellness Updates
a) Update on COVID-19 Submitted by Executive Director
b) Operational Updates/Coastal Wave Submitted by Chief Operating Officer
c) Dental Updates Submitted by Dental Director

Dr. Keiser, Executive Director, updated the Board on COVID-19 & Monkeypox.

Ami Cotharn, Chief Operating Officer, presented the September 2022 Coastal Wave.

Ami Cotharn, Chief Operating Officer, updated the Board on clinical operations.

New Hire
- Six positions filled this month.
  - Four Patient Access Specialist positions filled
  - One Phlebotomist position filled
  - One Medical Assistant position filled

Outreach

- Five outreach events scheduled for the month.
  - Health Fair Texas A&M Galveston
  - Pregnant and Parenting Teen Forum – Galveston
  - Gulf Coast Water Authority Health Fair
  - Combined Arms Veteran Food Drive
  - Community Conversations w/Mayor – Texas City

Hanna Lindskog, updated the Board on dental services in the Coastal Health & Wellness Clinic:

- The dental clinic continues to follow CDC's Interim Infection Prevention and Control Recommendations for Healthcare Personnel which has a section dedicated to Dental Facilities. We are wearing N95 respirators for all aerosol generating procedures.
- The College of the Mainland is continuing to develop their Dental Hygiene Program. We had an Advisory Board meeting on August 31st, 2022, which Dr. Lindskog attended. Items discussed included: delegation to hygienists, nitrous oxide, mission statement, program goals and program learning outcomes. The program expects the accreditation process to take at least one year.
- The current wait list is at 823 people, which is 149 more than reported last month. We identified a way to simplify the wait list with NextGen to remove the possibility of duplicate entries and the patient services team will begin transitioning the wait list to NextGen this week. In the month of August, we completed 75 comprehensive exams on new patients which is a 33% increase from July. We continue to offer new patients acute appointments to address immediate needs so that no one in pain is waiting. We had a total of 221 Acute visits in the month of August, which was also a 31% increase compared to July. 56 of those patients were either new to our clinic or had not been here in over 3 years. In the month of August, 122 extractions (23% increase compared to July) and 248 restorative procedures (54% increase compared to July) were completed. These large increases in services provided are partly due to absence of providers in July due to sick leave.
- We had our first meeting for the NNOHA Teledentistry Collaborative on September 7th. This is a virtual collaborative and several dental clinic staff members are participating including one of our full-time dentists (Dr. Shetty), the Dental Director, and Dental Assistant Supervisor. Our first meeting focused on the Texas State Dental Board rules as they pertain to teledentistry as well as team introductions. The next collaborative meeting is scheduled for October 5th.
- We had our Ryan White Oral Health Care Grant audit scheduled for yesterday and today. They finished early yesterday. We do not have the final report yet, but there were not any findings.
- Staffing: We currently have one dental assistant vacancy
- As previously reported, we will be attending City of Texas City Senior Program at Nessler Park on October 21st (dental presentation and handout for Seniors – Dr. Lindskog)

Item#8 Consider for Approval August 2022 Financial Report Submitted by Trish Bailey

Trish Bailey, Chief Finance Officer, presented August 2022 Financial Report. A motion to accept the financial report as presented was made by Rev. Jones. Ivelisse Caban seconded the motion and the Board unanimously approved.

Item#9 Consider for Approval HRSA 5C Form "Other Activities" Submitted Ami Cotharn

Ami Cotharn, Chief Operating Officer, asked the Board to consider for approval HRSA 5C form "other activities".

- Home Visits
- Immunizations
- Health Fairs
- Health Education
- Non-Clinical Outreach

- Portable Clinical Care

Donnie VanAckeren informed the Board Galveston County Food Bank operates Tuesday through Friday with Tuesday's being there busiest day and sees about 250 families per day. Ami suggested holding a registration on site. Samantha Robinson, suggested keeping the Board updated on the calibration with Galveston County Food Bank. A motion to accept the HRSA 5C form as presented was made by Sharon Hall. Ivelisse Caban seconded the motion and the Board unanimously approved.

Item#10 Update on Texas Chiropractic College Collaboration Plan Submitted by Ami Cotharn

Ami Cotharn, Chief Operating Officer, updated the Board on the Texas Chiropractic College Collaboration Plan. Ami informed the Board that we are working on getting the faculty credentialed and should be up and running in the next three to four weeks.

Item#11 RCM Quality Project Update Submitted by Ami Cotharn

Ami Cotharn, Chief Operating Officer, updated the Board on the RCM Quality Project.

Item #12 Comments from Board Members

No comments

The meeting was adjourned at 1:59p.m.

_____	_____
Chair	Secretary/Treasurer
_____	_____
Date	Date

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Governing Board
October 2022
Item#5
Consider for Approval Minutes from October 13, 2022
Governing Board QA Meeting

Coastal Health & Wellness Governing Board

Quality Assurance Committee Meeting
October 13, 2022

BOARD QA COMMITTEE MEMBERS:
Kevin Avery- Consumer Member

EMPLOYEES PRESENT:
Ami Cotharn (Chief Operations Officer), Dr. Choi (Medical director), Hanna Lindskog, DDS (Dental Director), Jason Borillo (Director of Innovation and Clinical Quality), Pisa Ring (Patient Services Manager), Wendy Jones (Compliance & Risk Management Officer), Tyler Tipton (Public Health Emergency Preparedness Manager) Anthony Hernandez (Executive Assistant II) and Tikeshia Thompson-Rollins (Executive Assistant III)

(Minutes recorded by Tikeshia Thompson-Rollins)

ITEM	ACTION
Patient Access / Satisfaction Reports Quarterly Access to Care Report Quarterly Patient Satisfaction Report	**Quarterly Access to Care Report** • Quarterly report (July, August, and September) reviewed. Current no show rate is 27%. **Call Center Queues** • Call Back feature added to queues on 9/16/2022 • Numbers are from 7/1/2022 – 9/23/2022; IT is working with vendor for current numbers. **Ways to lower no-show rate** • Effective November 1st all Medical Providers appointments will be 20 minutes. • Some Providers will be moved from Galveston back to Texas City so that we have more appointments available in Texas City and patients won't have to wait 4-6 weeks for an appointment. **Quarterly Patient Satisfaction Report** • Survey went live on October 4th. Pisa will work on and bring to the next QA Board committee meeting.
Clinical Measures Quarterly Report on UDS Medical Measures in Comparison to Goals	**Medical Quality Review Measures** • UDS measures were reviewed. Jason and Dr. Choi will work on the below three areas and bring back to the QA Board Committee in January. ➢ Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents ➢ Childhood Immunization Status ➢ HIV Linkage to Care
Quality Assurance/Risk/Management/ Emergency Management Reports a) Quarterly Risk Management Report b) Dental Quarterly Summary c) Quarterly Emergency Management Report	**Quarterly Risk Management Report** • Report reviewed. ➢ Wendy reported the hand-hygiene for July, August, and September and they were at 99%. This information will be added to the quarterly report. **Dental Quarterly Summary** • Summary reviewed and Dr. Lindskog will continue to bring report to the committee on a quarterly basis. **Quarterly Emergency Management Report** • Tyler reviewed the Emergency Management Report gave an update on trainings and plans that occurred during the quarter.

Plans and Policies **2021-2022 Environment of Care Plans** a) Equipment Assessment Plan 2022-2023 a. Equipment Management Plan: 2022-2023 b. Fire Safety Management Plan: 2022-2023 c. Hazardous Materials and Waste Management Plan: 2022-20223 d. Safety Management Plan: 2022-2023 e. Security Management Plan: 2022-2023 f. Utilities Management Plan: 2022-2023 **Quality Assurance Performance Improvement "QAPI"**	**2021-2022 Environment of Care Plans** • All Environment of Care Plans were reviewed and will be presented to the Governing Board 10/26/2022 for approval. **Quality Assurance Performance Improvement "QAPI"** • Quality Assurance Performance Improvement Plan 2022-2023 was reviewed and will be presented to the Governing Board 10/26/2022 for approval.

Next Meeting: January 12, 2023

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Governing Board
October 2022
Item#6
Consider for Approval Quarterly Investment Report

Coastal Health & Wellness
Investment Report
For the period ending September 30, 2022

Coastal Health & Wellness	Money Market Account		
	Jul	Aug	Sep
Beginning Balance	6,161,994	5,879,611	7,047,304
Deposits	140,000	1,560,000	975,000
Withdrawals	(425,000)	(395,000)	(450,000)
Interest Earned	2,618	2,692	3,418
Ending Balance	$5,879,611	$7,047,304	$7,575,721
Current Annual Yield	0.50%	0.50%	0.60%
Previous Quarter Yield (04/2022 - 06/2022)	0.40%	0.40%	0.41%

Tex Pool Investments		
Jul	Aug	Sep
26,504.68	26,538.96	26,587.70
-	-	-
-	-	-
34.28	48.74	52.72
$26,538.96	$26,587.70	$26,640.42
1.52%	2.16%	2.41%
0.30%	0.62%	1.00%

Summary	Interest Earned	Avg Balance	Yield
October 1, 2021 to December 31, 2021	6,714	6,683,321	0.06%
January 1, 2022 to March 31, 2022	6,635	6,746,910	0.06%
April 1, 2022 to June 30, 2022	6,671	6,639,153	0.13%
July 1, 2022 to September 30, 2022	8,864	6,494,542	0.32%
YTD Totals	$28,883	$6,640,982	0.57%

Coastal Health & Wellness	Q1	Q2	Q3	Q4	YTD Comparison
Interest Yield Year to Year Comparison	**Oct 1-Dec 31**	**Jan 1-Mar 31**	**Apr 1-Jun 30**	**Jul 1-Sep 30**	**Total as of 9/30**
FY2019	0.43%	0.47%	0.47%	0.46%	**1.37%**
FY2020	0.40%	0.36%	0.21%	0.20%	**0.97%**
FY2021	0.19%	0.14%	0.05%	0.05%	**0.38%**
FY2022 (Current year)	0.06%	0.06%	0.13%	0.32%	**0.57%**

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Governing Board
October 2022
Item#7
Consider for Approval Quarterly the Coastal Health & Wellness 2022-2023 Environment of Care Plans

a. Equipment Assessment Plan 2022-2023
b. Equipment Management Plan 2022-2023
c. Fire Safety Management Plan 2022-2023
d. Hazardous Materials and Waste Management Plan 2022-2023
e. Safety Management Plan 2022-2023
f. Security Management Plan 2022-2023
g. Utilities Management Plan 2022-2023

Coastal Health & Wellness
Galveston County's Community Health Center

Effective: 08/01/2018
Last Approved: 10/2021
Expires: NA

EQUIPMENT ASSESSMENT PLAN

All equipment acquired for use by Coastal Health & Wellness will be evaluated for and assigned an Equipment Management Assessment Score (EMAS) by the applicable departmental director (e.g. Medical Director, Dental Director, Nursing Director, Laboratory Director or Director of Dental Assistants) or designee from the department in which the equipment will be used. In completing this process, the applicable director or designee will fill out an EMAS form for each piece of equipment at the time in which it is received and before it is commissioned, which shall then be forwarded to the Risk and Safety Coordinator. The Healthcare Compliance Specialist will be responsible for retaining a copy of the form.

The EMAS system is designed to classify the risk rating of equipment in the most objective possible manner by assigning each piece of equipment an aggregate rating, utilizing the following formula: Function + Risk + Required Maintenance + Equipment Incident/Inherent Risks.

Contingent upon the assigned EMAS, clinical equipment will be categorized into one the following four classifications, which will dictate the standard of attention and care devoted to it.

High Risk: EMAS (22 – 25):

This equipment is given the highest priority for testing, calibration and repair, and is classified as "High Risk." All staff and personnel who use the equipment shall be notified of its High Risk classification by their department director. Should this equipment ever malfunction or fail, it must immediately be decommissioned, fixed in accordance with the manufacturer's recommendation, and certified by a third-party inspector prior to being redeployed for use. Per EC.02.04.01, although the term "High Risk" includes all life support equipment, it applies more broadly to encompass other items that are technically not necessary to support life ***but that would put the patient or staff member at risk if it fails***.

Medium Risk: EMS (19 – 21)

This equipment is noted as "Medium Risk." Every effort will be made to test, calibrate and repair this equipment, but only after it's ensured that all High Risk equipment requirements have been fulfilled. Formal written procedures for operating this equipment will be created only if deemed necessary by the applicable department head. Should this equipment ever malfunction or fail, it must immediately be decommissioned and fixed in accordance with the manufacturer's recommendation.

Low Risk: EMS (12 – 18)

This equipment is considered "Low Risk." Every effort will be made to test, calibrate and repair this equipment, but only after High and Medium Risk equipment requirements have been fulfilled. In the case of failure or malfunction, Low Risk should be fixed in accordance with the manufacturer's recommendation, unless suggested otherwise by the applicable department head.

Minimal Risk: EMS (less than 12)

Equipment with an EMAS of 11 is constituted as "Minimal Risk," and will thus receive be viewed as lower priority. This equipment will still be checked at least annually for hazards and/or faults by department heads, designees or the Healthcare Compliance Specialist. Equipment requiring specific or professional testing shall be performed via outside contractors in accordance with manufacturer's recommendations.

EQUIPMENT MANAGEMENT ASSESSMENT SCORING CRITERIA

All clinical equipment must be assigned a risk classification by utilizing the formula set forth below.

The four primary categories for assessment are:

1. Equipment function;
2. Physical risks associated with equipment;
3. Equipment maintenance requirements; and
4. Equipment incidents and inherent risks.

To determine the classification of each item, primary evaluation categories have been broken down into subgroups with specific subgroup characteristics. Each subgroup has been assigned a numerical value for each characteristic.

Values from each primary evaluation category are added to arrive at an overall assessment score, which is used to determine the risk classification for each piece of equipment.

1. Equipment Function:

Therapeutic

a. Life Support…….. 10
b. Surgical and Intensive Care……. 09
c. Physical Therapy and Treatment 08

Diagnostic

Surgical and Intensive Care Monitoring……. 07
Additional Physiological Monitoring and Diagnostic…….06

Analytical

Analytical Laboratory……... 05
Laboratory Accessories……..…04
Computer and Related……03

Miscellaneous

Patient Related and Other…….. 02
Non-Patient Related…….. 01

2. Physical Risk
   a. Patient Death……05
   b. Potential to Cause Severe Injury..05
   c. Potential to Cause Minor Injury...04
   d. Inappropriate Therapy or Misdiagnosis…….. 03
   e. No significant Risks…….01

3. Maintenance Requirement
   a. Extensive……..05
   b. Above Average……04
   c. Average……03
   d. Below Average……02
   e. Minimal……01

4. Equipment Incidents and Inherent Risks
   a. Very High Inherent Risks ……05
   b. High Inherent Risks……. 04
   c. Average Inherent Risks……03
   d. Minimal Risks……. 02
   e. No Significant Risks…….01

EQUIPMENT INFORMATION FORM

Name/Type of Equipment: _____

Manufacturer: _____

Department: _____

EMAS Calculation:

[FUNCTION] + [RISK] + [MAINTINANCE] + [INCIDENTS/RISKS] = EMAS

[ ] + [ ] + [ ] + [ ] = _____

Priority Classification:

High Risk (22 – 25 points)	[ ]	Low Risk (12 – 17 points)	[ ]
Medium Risk (18 – 21 points)	[ ]	Minimal Risk (11 points or less)	[ ]

Additional Notes: _____

_____

_____

_____

Completed By (print): _____ Title: _____

Signature: _____ Date: _____

Please return a completed and signed copy of the form to the Risk and Safety Coordinator for retention.

Coastal Health & Wellness
Serving, Healing, Caring

Effective: 10/28/2021
Last Approved: 08/2020
Expires: 09/2022

ENVIRONMENT OF CARE
Equipment Management Plan: –2022-2023

I. PURPOSE

The Equipment Management Plan (the "Plan") is established to provide a safe and secure environment for all patients, staff, and other individuals who enter Coastal Health & Wellness ("CHW") facilities. The Equipment Management Plan describes the framework to manage all medical, dental and laboratory equipment used by CHW staff. This Plan is written in accordance with Joint Commission standards EC.02.04.01 and EC.02.04.03

II. OBJECTIVES

a. To promote safe and effective use of medical equipment used for the diagnosis, treatment, and monitoring of patient care; and
b. To proactively mitigate risk through timely preventive equipment maintenance, servicing and calibration.

III. RESPONSIBILITIES

a. The Joint Commission Committee (the "Committee") shall:

1. Review sentinel events related to any aspect outlined in the Equipment Management Plan and, as necessary, propose and implement follow-up regulations which shall be no less stringent than those designated by the manufacturer for each type of equipment utilized by Coastal providers;
2. When applicable, develop new procedures and guidelines for medical equipment deemed necessary to ensure optimal levels of patient safety and care, and remain consistent with changes in The Joint Commission Environment of Care standards along with relevant regulatory updates established by other applicable authoritative agencies and/or the equipment's manufacturer;
3. Select and implement procedures and controls to achieve objectives of the Equipment Management Plan; and
4. Review the Equipment Management Plan as deemed necessary, and no less than once annually (see Section V. Annual Evaluation).

b. The Procurement Agent shall:

1. Assist in maintaining a current Equipment Inventory Log, to be retained in a protected shared drive accessible solely by pertinent staff, of selected items which shall include, amongst other elements, each piece of equipment's Equipment Management Assessment Score ("EMAS"), if applicable;
2. Coordinate the acquisition of equipment in conjunction with the Medical Director, Dental Director, Laboratory Director, Director of Dental Assistants, or the Nursing Director ("Department Directors") and/or designees;
3. When requested, assist the Department Directors or designees prior to the purchase of equipment to determine if said equipment meets all requisite safety requirements and includes appropriate warranties, satisfies manufacturers' suggestions for inspection, etc.;
4. Ensure that all received equipment classified as high-risk, or of which requires any form of maintenance or inspection, or that has an electrical cord, is inspected and approved upon delivery;
5. Update the Equipment Inventory Log to include new equipment;
6. When applicable, remove discarded or decommissioned equipment from the Equipment Inventory Log; and
7. In accordance with manufacturers' suggested maintenance schedules for all equipment on the inventory log, work in conjunction with Department Directors and the Healthcare Compliance Specialist to monitor, track and arrange for appropriate servicing.

c. The Medical Director, Dental Director, Laboratory Director, Director of Dental Assistants or the Nursing Director (the "Department Directors")shall:

1. Assist the Procurement Agent during the selection and acquisition of equipment, and advise the Procurement Agent regarding pertinent specifications for acquisitions;
2. Complete an EMAS form for all equipment which poses *ANY* form of risk, and furnish a completed copy of the form to the Healthcare Compliance Specialist;
3. Monitor equipment within their respective department and notify the Procurement Agent of all third-party maintenance, inspection and servicing required to be performed on applicable equipment; and
4. Notify and work in conjunction with the Healthcare Compliance Specialist to produce equipment malfunction reports and, if necessary, appropriate follow-up procedures.

d. The Healthcare Compliance Specialist shall:

1. Document and track any and all incidents, such as equipment failures or user errors;
2. In conjunction with the Procurement Agent, coordinate hazard notices and recalls;

3. Work with the Procurement Agent to maintain an updated Equipment Inventory Log;
4. Assist the Procurement Agent in ensuring that all received equipment classified as high-risk, or of which requires any form of maintenance or inspection, or that has an electrical cord, is inspected and approved upon delivery and annually thereafter;
5. During monthly Environmental Safety Assessments, verify that equipment requiring certain inspection or maintenance is not overdue;
6. Oversee compliance with the Equipment Assessment Plan and ensure a valid EMAS is retained for each piece of applicable equipment;
7. With the ~~Chief~~ Compliance and Risk Management Officer, report all significant findings, discrepancies, observations, and noted opportunities for improvement and recommendations to the Committee for review and consideration.

e. <u>All staff, personnel, and volunteers shall</u>:

1. Follow the policies, procedures, and guidelines approved by the Committee and the Coastal Health & Wellness Governing Board;
2. Immediately submit an incident report to his/her supervisor and the Healthcare Compliance Specialist for any event related to equipment malfunction;
3. Ensure that equipment which malfunctioned is tagged and removed from the floor until repaired; and
4. Immediately submit an Equipment Malfunction Report to his/her supervisor and the Procurement Agent.

f. <u>Incoming Equipment Inspection Procedure</u>:

The Procurement Agent shall:

1. Work with the Department Directors to ensure facilitation of equipment inspections before equipment is commissioned for use; and
2. Notify the manufacturer and/or distributor of any encountered issue, and supply the manufacturer with documentation explaining the problem.

g. <u>Equipment Inventory Log</u>

1. The Equipment Inventory Log shall identify equipment by type, serial number, location, department of oversight, frequency of recommended maintenance checks, and, if applicable, comments related to equipment failure history.
2. Items may be added to or removed from the Equipment Inventory Log by the Procurement Agent, Healthcare Compliance Specialist, or designee.

h. Regular Inspection, Testing, & Maintenance:

1. Inspections, testing and maintenance shall be completed in accordance with the manufacturer's suggestion for all equipment, unless specifically designated in a more stringent capacity by the applicable Department Director; and
2. When required to be performed by a third-party, maintenance checks shall be arranged by the Procurement Agent and/or the Healthcare Compliance Specialist.

i. Documentation of Maintenance & Testing:

1. All maintenance, servicing and testing of equipment will be documented in the Equipment Inventory Log, which shall denote the activity performed and the required date of follow-up.
2. Equipment denoted in the Equipment Inventory Log classified as high-risk, or of which requires any form of maintenance or inspection, or that has an electrical cord shall be denoted accordingly to ensure appropriate periodic maintenance and corrective work orders can be tracked.
3. The Procurement Agent, Healthcare Compliance Specialist and Department Directors will be jointly responsible for ensuring such documentation is retained.

j. Hazard Notices & Recalls:

1. Equipment recalls and hazard notices received must immediately be forwarded to the Healthcare Compliance Specialist for proper handling and action.
2. Recalled equipment shall be tagged and immediately removed from service until certified safe via repair or replaced entirely.

k. Safe Medical Device Act of 1990 (amended in 1996):

1. The Safe Medical Device Act of 1990 requires that device users report incidents to the device manufacturer when the facility determines a device's malfunction, at least in part, has or may have caused or contributed to the death or serious injury or illness of an individual. The facility must also send a copy of the report to the FDA in the case of death. Such reports will be drafted by the primary user and/or supervisor of the applicable machine and shall provide detailed information on medical device failures that may have caused or are suspected of causing serious illness, injury or death.
2. Such reporting measures will be conducted by the Chief Operating Officer in conjunction with the Compliance and Risk Management Officer

l. Equipment Failures & User Errors:

The following steps will be followed in the event of an equipment failure:

1. Staff will follow written procedures when medical equipment fails, including using emergency clinical interventions and back-up equipment.
2. Any defective equipment will be tagged and removed from service immediately and will remain out of service until the equipment is commissioned by a certified party as having been returned to its proper operating condition or until the piece of equipment has been replaced.
3. All equipment failures will be reported as an incident report and sent to the Compliance and Risk Manager Officer and Equipment Malfunction Report is to be completed and, in the report, will include the error/failure date, location of the equipment, cause or affected area, resolution and follow-up. The report will be retained by the Healthcare Compliance Specialist and Procurement Agent.
4. The Procurement Agent and Compliance Risk Manager Officer will work collaboratively to have all documented problems corrected.
5. Once the problem is corrected, the equipment will be returned to service. Equipment that cannot be repaired will be disposed of in accordance with applicable procedures.
6. In the event a problem was caused by user error, the user(s) will be retrained on the operation and use of the equipment by the Department Director or otherwise qualified trainer.

m. Orientation & Education:

1. As a part of initial employee orientation and periodic continuing education, as required, staff will be provided by their supervisors with training that addresses:
    i. Capabilities, limitations and special applications of equipment;
    ii. Basic operating and safety procedures for equipment use;
    iii. Emergency procedures in the event of equipment failure;
    iv. Information/skills necessary to perform assigned maintenance responsibilities; and
    v. Processes for reporting equipment problems, failures and user errors.
2. Staff will periodically undergo competency assessments to determine if proficiency levels for operating equipment have been maintained. For equipment that requires documented training, staff may not utilize the equipment until documentation of successful training has been produced and a competency, if applicable, has been completed.
3. Trainings and competency assessments are to be tracked and enforced by Department Directors, or their designee.

IV. PERFORMANCE MONITORING

The following processes may be used to identify, monitor, evaluate, report, and reduce

safety risks identified by individuals or the organization. Such processes shall include, but not be limited to:

1. Reviewing Incident Reports and trends related to equipment issues;
2. Reporting equipment failures in accordance with the Safe Medical Devices Tracking Act; and
3. Documenting observed competence by medical equipment users.

V. ANNUAL EVALUATION

a. The annual review is used as an opportunity to develop or modify programs, plans, and policies; identify and implement additional or more effective controls; and enhance employee orientation and training.

b. The Committee keeps the Equipment Management Plan current by reviewing the plan at least annually (e.g. one year from the date of the last review, plus or minus 30 days) and making necessary modifications based on the results of the evaluation and changes to policies, regulations, and standards.

c. In performing the annual review, the Committee shall utilize a variety of sources to improve inspection and audit results, accident/incident reports, and other forms of tracking reports. The Committee may also review and seek input from alternative sources of relevance including leadership, management, staff, personnel, volunteers and third parties.

d. The annual review will include assessment of the Plan's scope, objectives, performance, and effectiveness.

VI. PERFORMANCE OBJECTIVES: –2022-2023

Performance Objective/Goal	**Performance Measure/Indicator**
Ensure documentation of observed competence by medical equipment users.	100% of staff received documented training on equipment critical to job performance as designated by supervisor.
Managing r i s k through prompt preventive maintenance checks and calibration.	95% preventive maintenance and calibration completed by due dates (100% for high-risk equipment).
Product safety alerts and recall notices are documented and reported the Procurement Agent, Executive Management and Department Directors Managers	100% of received recall and safety alert notices are documented and the information dispersed within two days of receipt.

Performance Objective/Goal	Performance Measure/Indicator
Ensure EMAS forms remain current.	100% of applicable new equipment must have an EMAS on-file and be added to the Equipment Management Log before the equipment is used.

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ENVIRONMENT OF CARE
Fire Safety Management Plan: –2022-2023

I. PURPOSE

The Fire Safety Management Plan (the "Plan") has been implemented to mitigate fire hazards, maintain an environment conducive to accessible egress, prevent potential injuries and safeguard property from any and all fire related threats. This Plan describes the framework used to manage fire risks and improve safety performance, and applies to all Coastal Health & Wellness facilities, employees, patients, contractors, volunteers, students, and visitors, and conforms to all mandates set forth by The Joint Commission standard EC.02.03.01.

II. OBJECTIVES

a. To minimize the chances of a fire;
b. To minimize the risk of injury in the occurrence of a fire; and
c. To ensure staff receives appropriate fire education and training.

III. RESPONSIBILITIES

The Joint Commission Committee (the "Committee") and the Healthcare Compliance Specialist are responsible for developing, implementing, and monitoring this Plan.

a. The Committee shall:

1. Review sentinel events and make recommendations regarding fire hazards and threats;
2. Develop procedures and guidelines consistent with the Coastal Health & Wellness Governing Board approved Emergency Operations Plan as they pertain to fire safety;
3. Implement and monitor approved policies, procedures, guidelines and recommendations in accordance with the Plan;
4. Respond appropriately when conditions involving potential fire hazards arise which may pose a foreseeable threat to life, human health and/or Coastal Health & Wellness property; and
5. Review the Fire Safety Management Plan as deemed necessary, but no less than at least once annually (see *Section V. Annual Evaluation*).

b. The Healthcare Compliance Specialist shall:

1. Conduct monthly proactive risk assessments to monitor compliance with the Fire Safety Management Plan;
2. Work with building landlords and maintenance associates to conduct fire drills annually;
3. Educate staff on fire-related policies, procedures and rules pertinent to their respective worksites and job duties;
4. Ensure exits remain unobstructed and appropriately identified;
5. Search for deficiencies, hazards, unsafe practices and other conditions that could either cause a fire or impede egress;
6. Investigate, track, and trend relevant incident reports; and
7. Present monthly reports about significant findings, discrepancies, observations, noted opportunities for improvement, and recommendations to the Committee for review and consideration.

c. All staff, personnel, and volunteers shall:

1. Follow applicable policies, procedures, and guidelines pertaining to fire safety as determined by the Committee;
2. Prohibit smoking of any form within fifty (50) feet of CHW facilities, in accordance with the Drug-Free Workplace policy;
3. In case of an emergency, follow steps set forth by the Fire Response Plan, and the Emergency Operations Plan;
4. Assist patients and visitors to safe areas of refuge during building evacuations; and
5. Submit an incident report to his/her supervisor within one (1) business day from the occurrence of any fire related event, which includes any incident that may have but did not result in the manifestation of an actual fire.

d. Landlord/Maintenance Associates/Contractor

1. Coastal Health & Wellness does not own either of the facilities at which it has a practice; rather, these buildings are both leased. The Texas City site is located in the Mid-County Annex, which is owned and maintained by the County of Galveston. The Galveston clinic is located at the Island Community Center, which is owned and maintained by the Galveston Housing Authority.

2. Landlords for these respective properties are responsible for inspecting, testing and documenting fire safety equipment, and maintaining facilities in accordance with applicable fire safety codes. Additionally, landlords shall furnish the Healthcare Compliance Specialist with documentation of any inspections, maintenance activities, tests or certificates relevant to fire safety mechanisms.

e. Unobstructed Egress:

All means of egress shall remain free from obstructions or impediments to allow for unhindered use in the case of a fire or other emergency in which evacuation is required. The Healthcare Compliance Specialist routinely monitors all means of egress and, if necessary, resolves non-compliant issues immediately.

f. Fire Drills:

1. The Healthcare Compliance Specialist, with the assistance of facility landlords and maintenance associates, conducts and documents fire drills on an annual basis;
2. Fire drills are conducted annually (one year from the date of the last drill, plus or minus 30 days) at each of the two facilities;
3. All CHW staff is required to partake in fire drills; and
4. Results of fire drills are analyzed by the Healthcare Compliance Specialist, who notifies the Committee of any deficiencies or opportunities for improvement.

g. Fire Extinguishers:

1. On a monthly basis, the Healthcare Compliance Specialist inspects all fire extinguishers located on CHW premises and documents his/her findings.
2. A third-party inspects and conducts preventative maintenance on all fire extinguishers located on CHW premises annually.

IV. PERFORMANCE MONITORING

The following processes may be used to identify, monitor, evaluate, report and reduce safety risks identified by individuals or the organization. This includes, but is not limited to:

a. Documenting and evaluating fire drills and training;
b. Ensuring that building and maintenance checks are being facilitated by landlords and maintenance associates;
c. Ensuring that fire safety training is provided to all staff annually, and educating staff whenever possible to remain current with the Fire Response Plan*;* and
d. Periodically inspecting the clinic faculties and grounds to determine if any safety risks are present.

V. ANNUAL EVALUATION

a. The annual review is used as an opportunity to develop or modify programs, plans, and policies; identify and implement additional or more effective controls; and enhance employee orientation and training.
b. The Committee keeps the Plan current by reviewing it at least annually (i.e. one year

from the date of the last review, plus or minus thirty-days) and making necessary modifications based upon the results of the evaluation and changes to policies, regulations, and standards.

c. In performing the annual review, the Healthcare Compliance Specialist works with the Committee to review inspection and audit results, incident reports that could have potential fire safety implications, and other applicable tracking and evaluation reports. The Committee may also use other forms of review and input from relevant sources such as leadership, management, staff, personnel, and volunteers.

d. The annual review includes the assessment of the plan's scope, objectives, performance, and effectiveness.

VI. PERFORMANCE OBJECTIVES: –2022-2023

Performance Objective/Goal	**Performance Measurement/Indicator**
Exit doors unobstructed.	100% of egress paths and doors shall remain entirely clear.
Storage (boxes, etc.) not less than 18" below sprinkler heads.	100% of sprinkler heads will remain at least 18" above any potential obstructions.
Unobstructed electrical panels in clinic areas and storage closets	100% of paths leading to and adjacent to electrical panels shall remain entirely unobstructed.

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ENVIRONMENT OF CARE

Hazardous Materials and Waste Management Plan: –2022-2023

I. PURPOSE

The Hazardous Material and Waste Management Plan (the "Plan") describes the framework used to reduce dangers associated with hazardous materials and waste, and to manage activities to mitigate the risk of potential injuries and/or loss to property. This plan applies to all Coastal Health & Wellness ("CHW") facilities, employees, patients, contractors, volunteers, students, and visitors, and conforms to all required measures as set forth by Joint Commission standard EC.02.02.01.

II. DEFINITIONS:

a. **Biohazardous Waste:** Waste that has the risk of carrying infectious diseases.
b. **Other Potentially Infectious Material (OPIM), which include:**
   1. The following human body fluids: semen, vaginal secretions, cerebrospinal fluid, synovial fluid, pleural fluid, pericardial fluid, peritoneal fluid, amniotic fluid, saliva in dental procedures, any bodily fluid that is visibly contaminated with blood, and all bodily fluids in situations where it is difficult or impossible to differentiate between them;
   2. Any unfixed tissue or organ (other than intact skin) from a human (living or dead); and
   3. HIV containing cell or tissue cultures, organ cultures, and HIV or HBV containing culture medium or other solutions.

III. OBJECTIVES

a. To manage critical information related to the safe use, storage, and disposal of hazardous chemicals retained in inventory; and
b. To ensure staff is adequately knowledgeable regarding procedures which define the proper handling of hazardous materials and waste.

IV. RESPONSIBILITIES

The Joint Commission Committee ("the Committee") shall:

1. Review sentinel events and make pertinent recommendations related to any events involving or potentially involving hazardous materials and/or waste;
2. Develop procedures and guidelines pertinent to specific events consistent with those set forth by The Joint Commission, the Coastal Health & Wellness

Emergency Operations Plan, and other authoritative guidelines;
3. Implement, train, and monitor approved policies, procedures, guidelines, and recommendations in accordance with the Hazardous Material and Waste Management Plan;
4. Respond appropriately when conditions involving hazardous material or waste arise which may pose an immediate threat to life, human health and/or Coastal Health & Wellness property; and
5. Review the Hazardous Material and Waste Plan as deemed necessary, but no less than at least once annually (see *Section V. Annual Evaluation*).

b. The Healthcare Compliance Specialist shall:

1. Conduct monthly proactive risk assessments via the Environmental ~~Risk~~, Safety and Compliance Analysis ("E~~R~~SCA") to monitor compliance with the Hazardous Material and Waste Management Plan;
2. Identify deficiencies, hazards, unsafe practices, and potentially adverse impacts of any hazardous waste existing on or around Coastal Health & Wellness premises;
3. Educate staff on policies, procedures and rules pertinent to hazardous materials and waste that may affect their respective worksites and job duties;
4. Annually audit and, when necessary, update Safety Data Sheet ("SDS") binders for all CHW departments;
5. Respond punctually and appropriately when observations pertaining to hazardous materials arise which may pose an immediate threat to life, health and/or property; and
6. When applicable, report significant findings, discrepancies, observations, noted opportunities for improvement, and recommendations to the Committee for review and consideration.

c. Coastal Health & Wellness employs a certified Radiation Officer whose duties include:

1. Annually reviewing and monitoring radiation safety procedures for compliance in accordance with the rules and regulations set forth by the Texas Department of State Health Services and other regulatory bodies;
2. Reviewing and monitoring radiation safety procedures for compliance in accordance with the rules and regulations set forth by the Texas Department of State Health Services and other regulatory bodies, immediately upon Coastal' s acquisition of any equipment with the ability to produce radiation and in accordance with manufacturer's guidelines thereafter; and
3. Ensuring that radiation safety badges are consistently maintained by requisite personnel.

d. The Infection Control Nurse shall:

1. Annually facilitate the following trainings:

a. Personal Protective Equipment (clinical staff);
b. Blood Borne Pathogens (clinical staff);
c. Hazardous Waste Disposal (clinical staff);
d. Mask Wearing (all staff); and
e. Hand Hygiene (all staff).

2. Present infection control reports, which incorporate hazardous waste prevention metrics, monthly to the Committee and quarterly to the Governing Board Quality Assurance Committee.

e. <u>All staff, personnel, and volunteers shall</u>:

1. Follow the policies, procedures and guidelines pertaining to any hazardous materials and/or waste as approved by the Committee;
2. Remain familiar with and, when applicable, adhere to all procedures delineated in the Coastal Health & Wellness Governing Board Approved Emergency Operations Plan as they pertain to hazardous materials and waste; and
3. Annually complete a Hazardous Communication training.

f. <u>Safety Data Sheets (SDS)</u>:

1. SDS manuals shall be stored in yellow and red binders conspicuously affixed to the wall in all clinical areas and will contain an accurate inventory of all chemicals used in the respective areas.
2. The chemicals listed in the SDS binders are reviewed by supervisors and department heads annually, or whenever items are added to or removed from the chemical inventory. A follow-up audit to verify SDS inventory is performed twice annually by the Healthcare Compliance Specialist.
3. Employees shall receive orientation on the use of SDS binders and chemical safety training from their direct supervisor as part of mandatory employee training, which shall be completed within thirty (30) days of the employee beginning work. Employees shall be precluded from using hazardous materials until the mandatory training has been completed and documented.
4. Each department will develop and train employees regarding procedures for handling hazardous materials. These procedures shall include, but not be limited to, the proper use of personal protective equipment such as gloves and masks, and the proper means by which hazardous waste should be disposed of.

g. <u>Oxygen and Gas Cylinders</u>:

1. All oxygen and gas cylinders will be secured in a container in order to prevent the cylinder from falling over; and
2. Oxygen and gas cylinders shall NEVER be stored near heat or open flames.

h. <u>Eyewash Stations</u>:

1. Eyewash stations shall be maintained in readily accessible areas for all Coastal Health and Wellness personnel at both the Texas City and Galveston clinics.
2. Supervisors or designees will test the eyewash stations weekly by conducting a "bump test," to ensure proper operation of each station's functionality and will log the results of such tests accordingly. Test results will be logged in a binder located within the applicable department.
3. Supervisors or designees will flush each eyewash station on a weekly basis.

i. Medical and Infectious Waste:

1. Liquid or semi-liquid blood or OPIM; contaminated items that would release blood or other potentially infectious materials in a liquid or semi-liquid state if compressed; items that are caked with dried blood or other potentially infectious materials and are capable of releasing these materials during handling; contaminated sharps; and pathological and microbiological wastes containing blood or other potentially infectious materials must be discarded in an appropriate red biohazard bag or container.
    a. This includes, but is not limited to, used sharps, slides and slide covers contaminated with bodily fluids, vaccine ampoules and vials that have been used, and blood-soaked dressing or other blood-soaked materials.
    b. Urine is not considered OPIM unless it is contaminated with blood.
    c. Needles, syringes, contaminated slides, blood-filled test tubes, and glass ampoules and vials are to be disposed in red plastic sharps containers.
2. Sharps containers and used red bags must be placed in a red bag-lined transport box stored in a designated locked closet identified with the biohazard symbol (the Hazardous Waste Storage Room).
3. **Dental amalgam is not considered infectious and is disposed of by being suctioned into traps, which are periodically replaced.** Each dental operatory contains amalgam separators.
4. Coastal Health & Wellness currently contracts with Stericyle to remove and dispose of medical waste from its facilities.

j. Spill Procedures:

1. Standard precautions should be followed when a spill occurs, and the area should be blocked off from public access until it is entirely cleaned, and the affected area is deemed safe to return by the department supervisor, Infection Control Nurse or Healthcare Compliance Specialist.
2. Staff should clean spills or leaks of most products in accordance with directions of the manufacturer of the spilled substance. In the absence of such directions, staff should immediately barricade the area and notify the department supervisor.
3. Blood should be cleaned using appropriate PPE and approved virucidal disinfecting agents.

4. Hazardous material incidents involving radiological, chemical or biological contaminants may require evacuation of the facility. Employees will follow procedures as outline in the Coastal Health & Wellness *Emergency Operations Plan* during such circumstances.

V. PERFORMANCE MONITORING

The following processes may be used to identify, monitor, evaluate, report, and reduce hazardous risks identified by individuals or the organization. This includes, but is not limited to:

a. Investigating, identifying, and reporting incidents related to hazardous materials;
b. Reviewing incident reports and implementing new policies and procedures to prevent future adverse incidents; and
c. Periodically inspecting the clinic faculties and grounds to determine if any hazards are present.

VI. ANNUAL EVALUATION

a. The annual review, which includes the assessment of the Plan's scope, objectives, performance, and effectiveness is used as an opportunity to develop or modify programs, plans, and policies; identify and implement additional or more effective controls; and enhance employee orientation and training.
b. The Committee maintains the Hazardous Material and Waste Management Plan by reviewing the plan at least annually (i.e. one year from the date of the last review, plus or minus 30 days) and making necessary modifications based on the results of the evaluation and changes to regulatory laws, policies and standards.
c. While performing the annual review, the Committee should use a variety of sources such as inspection and audit results, incident reports and other statistical information and tracking reports. The Committee may also use other forms of review and input from relevant sources such as management, staff, personnel, and volunteers.

VII. PERFORMANCE MEASURES: 2021 – 2022

Performance Objective/Goal	**Performance Measure/Indicator**
Manage critical information related to the safe use, storage, and disposal of hazardous chemicals available to staff.	95% SDS binders correctly maintained at work area determined through biannual audit of SDS binder.
Ensure staff is knowledge on segregation of hazardous waste at the point of generation is effective to control the potential for exposure or spills during collection, transport, storage, and disposal.	100% of staff handling biohazardous waste receive training for handling, packaging, and preparation of biohazardous material for transport within thirty (30) days of hire through online DOT training.

Performance Objective/Goal	Performance Measure/Indicator
Ensure spill kits are maintained in each department where hazardous chemicals/waste spills can occur.	100% of clinical staff receive training on the appropriate use of spill kits relating to chemical/biohazardous spills within thirty (30) days of hire conducted during orientation training to departments.

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ENVIRONMENT OF CARE
Safety Management Plan: 2022-2023

I. PURPOSE

The Coastal Health & Wellness ("CHW") Safety Management Plan ("the Plan") has been established to provide a safe, functional, and effective environment for all patients, staff, and other individuals in order to optimize the outcome of patient services. The Plan describes the framework used to reduce physical hazards, and to reduce the risk of injuries to individuals and loss to property. This plan applies to all CHW facilities, employees, patients, contractors, volunteers, students, and visitors, and conforms to all requirements set forth under The Joint Commission Standard EC.04.01.01.

II. OBJECTIVES

a. Ensuring staff awareness and performance of pertinent safety topics through education and training; and
b. Mitigating safety risks by promptly identifying and resolving perils.

III. RESPONSIBILITIES

a. The Joint Commission Committee (the "Committee") shall:

1. Review sentinel events pertaining to potential safety issues occurring at CHW facilities or elsewhere, and make recommendations for prevention or improvement;
2. Develop procedures and guidelines related to safety management issues that are consistent with or integrate the Coastal Health & Wellness Governing Board approved Emergency Operations Plan;
3. Implement and monitor approved policies, procedures, guidelines and recommendations in accordance with the Safety Management Plan;
4. Investigate and track incident reports and workers' compensation claims to identify potentially trending safety issues;
5. Respond appropriately when conditions involving potential safety risks arise which may pose a foreseeable threat to life, human health and/or Coastal Health & Wellness property; and
6. Review the Safety Management Plan as deemed necessary, but no less than at least once annually (see *Section V. Annual Evaluation*).

b. The Healthcare Compliance Specialist shall:

1. Conduct a monthly risk assessment, the Environmental ~~Risk~~ Safety and Compliance Assessment ("E~~R~~SCA"), to monitor adherence to pertinent components of the Safety Management Plan;
2. Identify deficiencies, perils, unsafe practices, and practices potentially adverse to the promotion of safety in and around CHW facilities;
3. Educate staff on safety related policies, procedures and rules pertinent to their respective worksites and job duties;
4. Intervene when conditions immediately threaten life or human health, or threaten damage to CHW property;
5. Report monthly on significant findings, discrepancies, observations, noted opportunities for improvement, and recommendations to the Committee for review and consideration; and
6. Manage product and equipment safety recalls.

c. <u>All staff, personnel, and volunteers shall</u>:

1. Immediately notify appropriate personnel when environmental conditions pose a potential threat to human life, health or damage to CHW property;
2. Follow the policies, procedures, and guidelines approved by the Committee; and
3. Submit an Incident/Injury Report ~~Form~~ to through the Health Districts e-communication chain "CHW Incidents within twenty-four (24) hours of any event related to potential illness, injury or "near misses" to any person(s) occurring on CHW premises, or any property loss or damage.

IV. PERFORMANCE MONITORING

The following processes may be used to identify, monitor, evaluate, report, and reduce safety risks identified by individuals or the organization. This includes, but is not limited to:

a. Investigating, identifying and reporting incidents and trends related to occupational illnesses or injury and/or property loss or damage.

b. Reviewing and monitoring incident reports and workers' compensation claims to create activities that limit perils, with a goal to reduce risk of occupational illness or injury and/or property loss or damage.

c. Periodically inspecting clinic facilities and grounds to determine if any safety risks exist; and

d. Constantly monitoring and reporting cleanliness of the facility.

V. ANNUAL EVALUATION

a. The annual review is used as an opportunity to develop or modify programs, plans, and policies; identify and implement additional or more effective controls; and enhance employee orientation and training.

b. The Committee keeps the Plan current by reviewing it at least annually (i.e. one year from the date of the last review, plus or minus 30 days) and making necessary modifications based on the results of the evaluation and changes to policies, regulations, and standards.

c. In performing the annual review, the Committee shall use a variety of sources such as inspection and audit results, accident/incident reports, and other statistical information and tracking reports. The Committee may also use other forms of review and input from relevant sources such as leadership, management, staff, personnel, and volunteers.

d. The annual review includes the assessment of the Plan's scope, objectives, performance, and effectiveness.

VI. PERFORMANCE MEASURES: ~~2021~~ – 2022-2023

Performance Objective/Goal	**Performance Measure/Indicator**
Ensure staff performance through safety education and training.	95% of staff has documentation asserting their annual completion of safety and incident reporting training.
Manage safety risks by promptly reporting and resolving incidents.	100% of incident reports are submitted within two business days of the incident's occurrence.
Ensure cleanliness is practiced and maintained by housekeeping services for prevention of adverse employee and patient safety.	95% of reported cleanliness issues in all areas of the clinic or office setting are corrected or addressed within a twenty-four (24) hour period.

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ENVIRONMENT OF CARE
Security Management Plan: 2022-2023

I. PURPOSE

The Security Management Plan (the "Plan") has been established to ensure that Coastal Health & Wellness ("CHW") is providing the safest possible environments for all patients, staff, and other individuals that at any point enter a CHW facility. The Plan describes the framework for security management, which aims to: i) mitigate the occurrences of incidents that may pose dangers or threats by others; and ii) mitigate physical, structural, and infrastructural damages in the event of a security breach. The Plan applies to all facilities, employees, patients, contractors, volunteers, students, and visitors and conforms with the standards set forth by The Joint Commission in EC.02.01.01.

II. OBJECTIVES

a. Ensuring staff is knowledgeable of security risks and procedures through effective education and training;
b. Ensuring staff always has their CHW identification badge affixed to their person in a manner noticeable to patients and visitors; and
c. When necessary, updating the Plan in accordance with changes or relevant implementations set forth in the Coastal Health & Wellness approved Emergency Operations Plan, or by applicable regulatory authorities.

III. RESPONSIBILITIES

The Infection Control and Environment of Care Committee (the "Committee") is responsible for developing and implementing this Plan. The Healthcare Compliance Specialist is responsible for monitoring and enforcing this Plan.

a. The Joint Commission Committee shall:

1. Review sentinel events and make recommendations regarding security related incidents;
2. Develop procedures and guidelines consistent with the Coastal Health & Wellness Governing Board's approved Emergency Operations Plan;
3. Implement and monitor approved policies, procedures, guidelines, and recommendations in accordance with the Security Management Plan;
4. Select and implement procedures and controls to achieve plan objectives;

5. Respond appropriately when potential security issues may pose a foreseeable threat to life, human health and/or Coastal Health & Wellness property; and
6. Review the Security Management Plan as deemed necessary, but no less than at least once annually (see *Section V. Annual Evaluation*).

b. The Healthcare Compliance Specialist shall:

1. Conduct proactive risk assessments on a monthly basis via the Environmental ~~Risk~~, Safety and Compliance Assessment ("E~~R~~SCA") to monitor compliance with the Security Management Plan;
2. Identify unsafe practices or potential threats within CHW facilities which may pose adverse security circumstances, and present these findings to the Committee;
3. Educate staff on best practices for responding to security threats;
4. Immediately intervene and notify proper authorities when conditions that immediately threaten life or health, or damage to property are realized;
5. With the ~~Chief~~ Compliance Officer, serve as a primary liaison between staff and law enforcement when security issues are reported to law enforcement agencies; and
6. On a quarterly basis, work with the ~~Chief~~ Compliance Officer to prepare reports which document significant findings, discrepancies, observations, noted opportunities for improvement, and recommendations for review and consideration by the Governing Board's Quality Assurance Committee.

c. The Information Technology ("IT") Manager shall:

1. Remain knowledgeable about current IT trends and industry practices;
2. When applicable and at least annually, update and implement procedures and protocols delineated in the GCHD Security Manual; and
3. In the occurrence of a breach, take any and all actions to mitigate its effects and immediately report losses to the ~~Chief~~ Compliance and Risk Management Officer and Chief Operations Officer.

d. Ancillary Security Measures

1. The Texas City clinic has a contracted a full-time security guard to remain on location during all times at which the clinic is open.
2. Staff should dial 911 to report suspect or known illegal activity that occurs in or around the Coastal Health and Wellness clinic.
3. Each clinic has a security camera at its main entrance, which remains active at all times, and an alarm system on all exterior doors which, when activated, immediately sends notification to the police department with jurisdictional

authority over the respective clinic's location via the security system.

4. Numerous ingress doors at both locations remain locked at all times, and can be opened solely through badge access, which is restricted to CHW personnel deemed to have a professional need to enter these restricted areas. Additionally, several ingress doors which serve as barriers to vital items (i.e. specific medications) can only be accessed through use of a physical key, or code assigned only to personnel with reason to enter the rooms.

e. Security Sensitive Areas

1. Areas that contain sharps, medications or dangerous chemicals, vulnerable IT equipment, and highly sensitive information will be locked when not attended by a staff member.
2. Keys and badges at no time will be shared among staff. Additionally, these items must be returned to Human Resources when the employee's relationship with Coastal Health & Wellness is severed.
3. Lost badges are immediately deactivated upon notification from the employee when the badge is reported lost, and badges surrendered upon separation of employment are promptly shredded.
4. Locks opened with security codes supplant several badge restricted ingress doors. Employees with a need to access these areas are issued individual codes which they are prohibited from sharing, and codes are immediately deactivated when an employee with knowledge of such codes separates from CHW.
5. All spaces, rooms or areas that may be considered hazardous must be clearly marked with the appropriate signage.
6. Warning signs denoting types of hazards must be placed in clear view of those attempting to enter a hazardous area.

f. Identification

1. All Coastal Health & Wellness staff are required to wear a CHW issued badge while present at work.
2. Badges contain the employee's picture and name and must be located on their person in a means easily visible to others.

g. Security Incidents

In the event of a security or potential security incident, staff members present at the site of the incident are required to:

1. Identify the nearest area deemed safe;
2. With patients and visitors, move to the safe area;
3. If possible, notify others in imminent danger of the threat; and
4. Call 9-1-1.

h. Patient Expulsion

Patients who threaten staff, other patients, visitors or property, or who commit illegal activity on or around CHW property will be reported to the Coastal Health & Wellness Medical Director or Dental Director, who with guidance from the Chief Operations Officer will determine whether the patient is prohibited from receiving medical or dental services at CHW facilities in the future.

IV. PERFORMANCE MONITORING

The following processes may be used to identify, monitor, evaluate, report, and reduce security risks identified by individuals or the organization. This includes, but is not limited to:

a. Investigating, identifying, and reporting incidents and trends related to security to management, security personnel, and/or the Coastal Health & Wellness Governing Board.

b. Reviewing and monitoring incident reports to create performance improvement activities; and

c. Performing monthly inspections of the clinic faculties and grounds to determine if any security risks are present.

V. ANNUAL EVALUATION

a. The annual review is used as an opportunity to develop or modify programs, plans, and policies; identify and implement additional or more effective controls; and enhance employee orientation and training.

b. The Committee keeps the Security Management Plan current by reviewing the plan at least annually (i.e. one year from the date of the last review, plus or minus 30 days) and making necessary modifications based upon the results of the evaluation and changes to policies, regulations, and standards.

c. In performing the annual review, the Committee uses a variety of sources such as inspections and audit results, incident reports, employee survey responses, and other statistical information and tracking reports. The Committee may also use other

forms for review and input from relevant sources such as leadership, management, staff, personnel, volunteers and patients.

d. The annual review includes assessment of the Plan's scope, objectives, performance, and effectiveness.

VI. PERFORMANCE IMPROVEMENTS: ~~2021 –~~ 2022-2023

Performance Objective/Goal	**Performance Measure/Indicator**
Ensuring staff is knowledgeable of security procedures for displaying identification badges.	<3% staff observed not properly displaying their identification badges during badge audits.
Ensuring staff is aware of how to react during potentially adverse circumstances.	Facilitate at least six non-required emergency drills addressed in the Emergency Operations Policy (e.g. shelter-in-place training).
Ensure staff is knowledgeable about when and how to respond to suspected human trafficking situations.	100% of Coastal employees who interact with patients as part of their professional responsibilities receive training pertaining to the detection and suggested follow-up actions for dealing with suspected human trafficking victims.
Ensure providers know the appropriate processes and when it's required that they report suspected cases of abuse or neglect.	100% of Coastal providers be trained on how to detect and report abuse and neglect.

Coastal Health & Wellness
Serving, Healing, Caring

Effective: 10/28/2021
Last Approved: 08/2020
Expires: 09/2022

ENVIRONMENT OF CARE
Utilities Management Plan: 2022-2023

I. PURPOSE

The Utilities Management Plan (the "Plan") sets forth a means of warranting that Coastal Health & Wellness ("CHW") offers a safe, functional, and effective healthcare environment to all patients, staff, and visitors for the assurance of optimal patient care outcomes. This plan applies to all CHW facilities, employees, patients, contractors, volunteers, students and visitors, and conforms to all requirements set forth by The Joint Commission standard EC.02.05.01.

II. OBJECTIVES

a. To ensure optimal patient care and overall safety through stringent utility inspection; and
b. To foster the most efficient measures of communication between applicable CHW staff and facility landlords and/or maintenance associates.

III. RESPONSIBILITIES

a. The Joint Commission Committee (the "Committee") shall:

1. Review sentinel events related to any aspect outlined in the Utilities Management Plan and, as necessary, propose and implement new practices for utility improvements;
2. When applicable, develop new procedures and guidelines for utility systems necessary to remain consistent with the Coastal Health & Wellness approved Emergency Operations Plan, along with relevant regulatory updates established by applicable authoritative agencies;
3. Select and implement procedures and controls to achieve plan objectives; and
4. Review the Utilities Management Plan as deemed necessary, and no less than once annually (see *Section V. Annual Evaluation*).

b. The Healthcare Compliance Specialist shall:

1. When necessary, educate staff regarding aspects of the Utility Management Plan applicable to the staff member's scope of work;
2. Work in conjunction with the building's landlords or maintenance associates to ensure access to a utility system inventory which identifies equipment, location, ownership, emergency power shut-off valves, and a log related to utility failure history is retained in an up-to-date fashion;

3. On a monthly basis, inspect facilities for deficiencies, hazards, unsafe practices, and/or potentially adverse impacts caused by utility mishaps;
4. Investigate, track and report utility related incidents;
5. Ensure generator load tests, performed in accordance with Joint Commission standards, are facilitated and documented monthly; and
6. Present monthly reports concerning significant findings, discrepancies, observations, noted opportunities for improvement, and recommendations regarding utility systems to the Committee.

c. The Fleet and Facilities Coordinator shall:

1. When possible, update or restore utility maintenance systems to proper order;
2. Contact the applicable landlord, maintenance associate (or designee), or third-party service agent when a problem with a utility system at a CHW occupied facility is realized; and
3. Track reported utility systems problems noting, date reported, to whom, and date system restored, Monthly report should be sent to Compliance team.
4.
5. Monitor approved policies, procedures, guidelines and recommendations in accordance with the Utilities Management Plan and when applicable, notify the ~~Chief~~ Compliance Officer and / or Chief Operating Officer of recommended procedural revisions.

d. All staff, personnel, and volunteers shall:

1. Follow the policies, procedures, and guidelines approved by the Committee; and
2. Follow safety procedures in accordance with this Plan, the Safety Management Plan, and anything directly or incidentally related to such matters as delineated in the Emergency Operations Plan.

e. Landlord/Maintenance Associates/Contractors

1. Coastal Health & Wellness does not own either of the facilities in which it has a practice; rather, these buildings are both leased. The Texas City site is located at the Mid-County Annex, is owned and operated by the County of Galveston. The Galveston site is located at the Island Community Center, which is owned and operated by the Galveston Housing Authority.

2. Landlords and maintenance associates for these respective properties are responsible for inspecting, testing and retaining a list of utility systems, which include but may not be limited to: electrical power; heating, ventilation and air conditioning; plumbing; and gas. Landlords shall provide any requested documentation of any inspections, maintenance, or tests to the Healthcare Compliance Specialist and/or the Fleet and Facilities Coordinator.

f. Battery-Powered Lights

1. Each month, the Healthcare Compliance Specialist will test battery-powered lights required for egress at the Galveston location. The test will be performed for a minimum of thirty (30) seconds. Results will be documented and reported to the Committee.
2. Annually, the Healthcare Compliance Specialist will test battery-powered lights required for egress for a duration of one-and-a-half (1 ½) hours at the Galveston location. Results shall be documented and reported to the Committee and the CHW Governing Board's Quality Assurance group.
3. All tests performed at the Texas City site will be facilitated by the County of Galveston's Maintenance department. The Healthcare Compliance Specialist and/or the Fleet and Facilities Coordinator will work with Galveston County Maintenance personnel to ensure required tests are conducted and subsequent documentation is received.

IV. PERFORMANCE MONITORING

The following processes may be used to identify, monitor, evaluate, report, and reduce utility related safety risks identified by individuals or the organization. This includes, but is not limited to:

a. Investigating, identifying, and reporting incidents and trends related to utility system failures; and

b. Evaluating the outcomes of the Environment, ~~Risk,~~ Safety and Compliance Assessments ("E~~R~~SAs") at both CHW facilities, which are conducted monthly by the Healthcare Compliance Specialist.

V. ANNUAL EVALUATION

a. The annual review is used as an opportunity to develop or modify programs, plans, and policies; identify and implement additional or more effective controls; and to enhance employee education.

b. The Committee keeps the Utility Management Plan current by reviewing the plan at least annually (i.e. one year from the date of the last review, plus or minus 30 days) and making necessary modifications based upon the results of the evaluation and changes to policies, regulations, and standards.

c. In performing the annual review, the Committee shall utilize a variety of sources to improve inspection and audit results, accident/incident reports, and other forms of tracking reports. The Committee may also review and seek input from alternative sources of relevance including leadership, management, staff, personnel, volunteers and third parties.

d. The annual review will include assessment of the Plan's scope, objectives, performance, and effectiveness.

VI. PERFORMANCE MEASURES: 2021 - 2022

Performance Objective/Goal	**Performance Measure/Indicator**
Ensuring optimal patient care through stringent utility maintenance	Zero preventable maintenance related injuries incurred by patients, visitors or staff
Effective communication between CHW staff and landlords	100% of problems requiring landlord attention reported by CHW staff to landlord within twenty-four (24) hours of recognition.

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Governing Board
October 2022
Item#8
Consider for Approval the Coastal Health & Wellness Risk Management Report for the Quarter Ending September 30, 2022

Quarterly Risk Management Report
Coastal Health & Wellness Quality Assurance Subcommittee
October - December 2022

Objective	Goal	2020 - 2021 Results	2021 - 2022 Goal	Q3 (07/22-09/22)	Q4 (10/21-12/21)	Q1 (01/22-03/22)	Q2 (04/22-06/22)	Cumulative Total or Average	Comments	Quarterly Goal Met
Customer Service and Patient Satisfaction										
Promote positive patient service experience with all staff, with a particular emphasis on treating patients in a courteous manner.	Reduce grievances by 30% from the previous year.	40	<34	6 Medical: 5 Patient Serv: 1	3 Medical: 2 Dental: 1		1 Medical: 1 Dental: 0	9 Medical: 7 Dental: 1 Patient Serv: 1	All complaints received during the quarter were minor, compliants were addressed by the COO, Medical Director and Nurse Director	✓
Offer optimal care for all patients throughout the entirety of their visit.	Increase weighted results of patient satisfaction survey to 4.8.	4.77	4.80	See note	4.70		Current process of data collection does not yield quantitative data; but submits the measure in a continuous measure by use of a line chart. Will need another data collection process.	4.6	No data for July, August, September. New survey went live October.	✗
Promote patient appointment confirmations.	Reduce the cumulative patient no-show rate to 20%.	20.36%	18%	26.00%	18%		defered	19.00%	July cumalative 26% August cumalative 26% September cumalative27%	✗
Ensure staff always wear their Coastal Health & Wellness issued identification cards in a readily visible manner.	Biennial audits should yield 100% of identification cards being worn appropriately.	100%	100%	N/A	100%	N/A	100%	N/A	Badge audits occur biennial Q2 and Q4	✓
Minimize preventable injuries to all staff, patients and visitors.	Incur zero preventable injuries at all CHW locations.	0	0	1	1	2	0	1	A cleaned dental instrument, scratched an employees wrist as being packaged for sterilization	✗
KEY										

COLOR KEY

Missing Measures; Needs Improvement	Trending in Proper Direction; Still Needs Improvement	Compliant with Goals

Quarterly Risk Management Report
Coastal Health & Wellness Quality Assurance Subcommittee
October - December 2022

Objective	Goal	2020 - 2021 Results	2021 - 2022 Goal	Q3 (07/22-09/22)	Q4 (10/21-12/21)	Q1 (01/22-03/22)	Q2 (04/22-06/22)	Cumulative Total or Average	Quarterly Comments	Quarterly Goal Met
Staff Trainings										
Train staff on appropriate responses for different emergency scenarios.	Facilitate at least nine non-required emergency preparedness drills during the year.	9	9	3 Trainings	3 trainings and 2 fire drills	3 trainings; 2 actual emergencies	2 trainings 1 hotwash	11 trainings; 2 drills; 4 real COOP activities.	Three trainings: July: Flooding and Continuity of Operations (COOP) August: Safety Captain September: Loss of Power	✓
All staff is trained on SDS material pertinent to his/her work area and responsibilities.	Ensure documented training rate of 100% within 30 days of hire.	100%	100%	100%	100%	100%	100%	100%	Coastal hired fourteen new employees during the quarter, all of whom completed their mandatory trainings within the 30-day window.	✓
All staff is trained on equipment critical to his/her job performance.	Ensure documented training rate of 100% within 30 days from hire.	100%	100%	100%	100%	100%	100%	100%		✓
All staff is trained on the Coastal Emergency Operations Plan.	Documentation exhibiting all staff received Emergency Operations training.	N/A	100%	100% for new hires	100% for new hires	100%	100%	100%	All employees hired by Coastal during the reporting quarter completed the new-hire Emergency Operations Training during the on-boarding process. Annual all-staff training was conducted in January 2022.	✓
Train staff regarding detection of and follow-up actions for suspected human trafficking victims.	Provide training to 100% of employees about how to report suspected human trafficking.	100%	100% for new hires	100% for new hires	100%	100%	100%	100%	All Coastal employees completed a one-hour training in November about properly identifying and treating suspected sex trafficking victims.	✓
Staff receives safety and incident reporting training.	Documentation exhibiting 100% of staff received Risk Management and Safety Training.	N/A	100% for new hires	100% for new hires	100%	100%	100%	100%	All employees hired by Coastal during the reporting quarter completed the new-hire safety and incident reporting training. Annual all-staff training was conducted in May 2022.	✓
Continue to promote staff knowledge of hand-hygiene practices and policies.	Maintain hand-hygiene score of at least 95%.	98%	98%	99%	97%	97%		97%	Data captured by Infection Control Nurse, who performs hand hygiene audits monthly.	✓
KEY										

COLOR KEY

Missing Measures; Needs Improvement	Trending in Proper Direction; Still Needs Improvement	Compliant with Goals

Quarterly Risk Management Report
Coastal Health & Wellness Quality Assurance Subcommittee
October - December 2022

Objective	Goal	2020 - 2021 Results	2021 - 2022 Goal	Q3 (07/22-09/22)	Q4 (10/21-12/21)	Q1 (01/22-03/22)	Q2 (04/22-06/22)	Cumulative Total or Average	Quarterly Comments	Quarterly Goal Met
Maintenance and Reporting										
Protect patients and staff by ensuring incidents and adverse events are promptly reported.	100% of incident reports should be made within two business days of the incident's occurrence.	100%	100%	100%	100%	100%	100%	100%	Data captured monthly by the Healthcare Compliance Specialist through various means but notably through the monthly (ESCA) Environmental, Safety and Compliance audits. September	✓
Protect staff and patients by promptly reporting issues requiring landlord attention.	Report 100% of building and/or maintenance related issues to applicable landlord within 24 business hours of discovery.	100%	100%	100%	100%	100%	100%	100%		✓
Maintain staff and patient safety by keeping equipment properly tested and maintained.	95% of equipment (100% of critical equipment) documented in Equipment Inventory Log should be inspected and calibrated in accordance with manufacturer's recommendations in a timely fashion.	100%	95%	100%	100%	100%	100%	100%	Calibration of critical equipment occurred in September	✓
Minimize obstruction to fire exit doors.	Achieve a cumulative score for non-obstructed doors of at least 100%.	100%	100%	100%	100%	100%	100%	100%	Data captured monthly by the Healthcare Compliance Specialist through various means but notably through the monthly (ESCA) Environmental, Safety and Compliance audits. September	✓
Maintain at least 18" between storage and top of sprinkler heads.	Achieve a cumulative score of at least 95% when auditing sprinkler head ceiling clearance.	100%	100%	100%	100%	100%	100%	100%		✓
Access to fire extinguishers shall remain clear and unobstructed.	Achieve a cumulative score for non-obstructed pathways to fire extinguishers of at least 95%.	100%	100%	100%	100%	100%	100%	100%		✓
Maintain SDS binders with all applicable material.	Biennial audits should yield at least a 95% level of accuracy.	100%	95%	SDS audits performed during Q2 and Q4	100%	SDS audits performed during Q2 and Q4	98%	98%		✓
KEY										

COLOR KEY

Missing Measures; Needs Improvement	**Trending in Proper Direction; Still Needs Improvement**	**Compliant with Goals**

Quarterly Risk Management Report
Coastal Health & Wellness Quality Assurance Subcommittee
October - December 2022

Objective	Goal	2020 - 2021 Results	2021 - 2022 Goal	Q3 (07/22-09/22)	Q4 (10/21-12/21)	Q1 (01/22-03/22)	Q2 (04/22-06/22)	Cumulative Total or Average	Quarterly Comments	Quarterly Goal Met
Suits, Claims and Potentially Compensable Incidents										
Take all necessary precautions to ensure an environment optimally conducive to patient safety	Incur no malpractice or risk management related suits or claims.	0	0	0	0	0	0	0		✓
Retain open communication and promote timely reporting of adverse events	Ensure potentially compensable incidents are reported and deliberated upon by executive management within 72 business hours following their occurrence.	0 incidents	0 incidents	0 incidents	0 incidents	0 incidents	0 incidents	0 incidents	No potentially compesanble incidents (PCIs) incurred during the quarter.	✓
Notes										

Very clean quarter. FTCA, AKB and Stark training to be offered to providers at December in-service. Coastal staff has been instrumental in fulfilling the organization and community's mission of providing COVID vaccines to any and all individuals seeking the immunization.

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Governing Board
October 2022
Item#9
Consider for Approval Coastal Health & Wellness After Hours Policy
Submitted by Ami Cotharn

-Approved: 06/30/2022
By: Governing Board
-Effective:10/1/2015

Coastal Health & Wellness After Hours Coverage Policy

Purpose

The provision of comprehensive and continuous care includes care during hours in which the center is closed. All centers are required to establish firm arrangements for after-hours coverage and whenever possible this coverage should include the center providers.

Policy

It is the policy of Coastal Health & Wellness to provide clinic patients with access to a clinic representative and/or healthcare professionals for management of urgent health matters during hours in which the clinic is not open.

Procedure

Coastal Health & Wellness patients seeking to speak with a healthcare professional for an urgent health problem after normal business hours will

- Dial the main line at (409) 938-2234
- Hear a recorded message notifying the caller that the clinic is closed and if this is an emergency to call 911.
- The after-hours message will offer the caller the option to connect directly to the Answering Service for an urgent health matter
- For urgent health matters the Answering Service will text the on-call provider first and follow up with a call if message is not read, during on-call provider hours and:
  - States the callers' name and reason for the call and
  - Connects the on-call provider with the caller
- For urgent matters, patients calling outside of on-call provider hours will be instructed to seek care at an after-hours emergency clinic.
- For non-urgent matters such as refills on medications, appointment requests, and other non-urgent health questions will be directed to call back the following business day.

Medical and Dental providers qualified to triage patient clinical situations are scheduled to rotate on call duties during designated times that the center is closed. The Answering Service is provided an up-to-date schedule of on-call providers and their contact numbers All calls received by the on-call providers will be documented in the CHW electronic medical or dental record of the patient:

Information documented in the electronic medical or dental record of the patient:

- Name of the patient or representative making the call
- Phone number of the caller
- Reason(s) for the call
- Assessment/triage findings
- Disposition of the call encounter

An administrative staff person will compare the Answering Service logs with the provider documentation from the electronic medical or dental record of the patient to assure that all calls were documented by the on-call provider within 24-hours.

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Governing Board
October 2022
Item#10
Consider for Approval Revisions to the Coastal Health & Wellness Credentialing and Privileging Policy Submitted by Ami Cotharn

-Approved: 10/20//2022
By: CP Committee
-Effective 5/18/2016

COASTAL HEALTH & WELLNESS CLINIC
CREDENTIALING AND PRIVILEGING POLICY

Background

The authority for credentialing and competency validation is the Public Health Service Act (PHSA) and the Federal Tort Claims Act (FTCA) that requires, for deemed status, that CHW provide credentialing and competency validation for all licensed and certified staff. In addition, The Joint Commission (TJC) standards also require that licensed independent practitioners be credentialed.

The credentialing process is a system for validating and evaluating the credentials and competencies of licensed and/or certified staff of, or applicants to, Coastal Health & Wellness (CHW") as a basis for employment, continued employment, or change in assignment. Such staff includes CHW employees, contract providers, or providers to whom referrals are made on a regular basis by CHW.

All staff, who are licensed or certified, are subject to credential verifications with privileges reviewed and granted by the Board's Credentialing and Privileging ("CP) Committee and/or CHW Executive Director or designee upon employment or appointment consistent with the FTCA guidance. Staff is re-credentialed every two years thereafter or when position or scope or services have changed. The CHW CP Committee is conducted as a function of the CHW Credentialing and Privileging program under the direction of the Executive Director or designee. In addition, the findings of the re-credentialing process are reported to the CHW CP Committee for recommendation to the Executive Director or designee who recommends privileges to be granted for each staff to the Board for final approval.

POLICY:

It is the policy of CHW, consistent with FTCA requirements, that all staff are subject to a credentialing and competency validation process appropriate to their position, assignment, and the role at CHW. In addition, to ensure patient safety and a competent professional work force, all CHW Clinic provider staff (employed, volunteers and contracted) will be credentialed and privileged according to the following standards.

The CHW CP Committee, will be comprised of a minimum of two Board members, one consumer and one community member, the CHW Medical Director, Dental Director, Nursing Director, Human Resource Director, Chief Operating Officer, HIM Manager, Revenue Cycle Manager and the CHW Credentialing Coordinator. The CHW CP Committee will meet in-person and monthly for the establishment of standards for credentialing licensed and certified staff and for competencies of all staff. Individual staff evaluations and assignments are the function of the supervisor in the area not the CP Committee however the CP Committee must work with the Credentialing Coordinator, Medical Director, and Dental Director to ensure credentialing professional peer review and other evaluations of competency are all on a regular basis.

The credentialing and competency validation process is performed under the CHW CP Committee, as a professional peer review committee, and is subject to immunity and confidentiality protections.

A Credentialing Coordinator is designated to oversee the credentialing and competency validation processes and serves as a program manager and liaison for the CHW Board, Executive Director, and CP Committee. The Credentialing Coordinator functions as an agent of the CP Committee, is trained about credentialing in competency validation processes and procedures, understands the rationale for the procedures and the laws and regulations concerning employment, contracts, confidentiality, and non-discrimination. The Credentialing Coordinator must have means of maintaining confidential files and information, be able to receive confidential faxes, be able to receive unopened mail directly, and must be able to have telephone conversations and interviews in a confidential manner.

The Executive Director or designee overseas the CHW Credentialing and Privileging Program and the credentialing/competency validation process, ensures the Credentialing Coordinator has resources to carry out the process consistent with laws, regulations, and standards, is authorized to review all documents and attend any meetings of the CHW

CP Committee, makes recommendations to the committee and makes decisions regarding employment and privileging of staff, and makes recommendations to the Board or designee concerning granting privileges for Licensed Independent Practitioners ("LIPs").

Practitioners are credentialed and privileged for a two-year term. Thereafter, Practitioners must be re-credentialed and have their privileges renewed for additional two-year terms to provide services at CHW.

CHW may contract with a credentials verification organization (CVO) to perform the credentialing activities set forth in the Credentialing and Privileging Table in this Policy.

CHW will report adverse peer review actions as necessary.

APPLICABILITY: Except as otherwise set forth herein, any Practitioner as defined below, regardless of employment status (e.g., full-time, part-time, contracted, volunteer) must be credentialed, privileged, and appointed in accordance with the procedures in this Policy before providing healthcare services to CHW patients. If CHW contracts with provider organizations or has formal, written referral arrangements for the provision of services that are within CHW's scope of project to CHW patients, CHW shall ensure, through provisions in the contract or CHW's review of the organization's credentialing and privileging processes, that such Practitioners shall be licensed, certified, or registered as verified through a credentialing process that meets all applicable laws, and are competent and fit to perform the contracted services as assessed through a privileging process.

DEFINITIONS:

Credentialing: Credentialing is the process of assessing and confirming the qualifications of a Practitioner.

Re-credentialing: Updates staff assignments or privileges at least every two years comma and may be performed when new competences are recognized or when there is an occurrence of an adverse event.

Competency validation: Establishes the capabilities of a person to perform designated services/tasks for center clients. The validation is part of the assessment to determine the scope of practice (privileges) or position description for an individual. Competency means the level of performance, including knowledge, skills, abilities, and behaviors required for certain services or rolls. Assessment means the validation or monitoring of the level of performance based on scope of practice/privileges or position description.

Primary source verification: Securing documentation from an original source to verify education and training.

Secondary source verification: Securing a copy of documentation from a source to verify continuing education and expertise.

Privileging: Privileging is the process of authorizing a Practitioner's scope of patient care services. Practitioners must request privileges that are consistent with the CHW Clinic's scope of services and are appropriate for his/her education and training.

Practitioner. An individual who is a LIP, OLCP or OCS, as applicable.

Licensed Independent Practitioner ("LIP"). An individual required to be licensed, registered, or certified by the State of Texas to provide medical or dental services to patients. These individuals include, but are not limited to, physicians, dentists, behavioral health counselors, physician assistants and nurse practitioners.

Other Licensed or Certified Practitioner ("OLCP"). An individual who is licensed, registered, or certified but is not permitted by Texas State law to provide patient care services without direction or supervision. These may include, but are not limited to, registered nurses, licensed vocational nurses, dental hygienists, X-ray technicians and dental assistants.

Other Clinical Staff ("OCS"). An individual who is involved in patient care but is not required to be licensed or certified by the State of Texas. These may include, but are not limited to, medical assistants.

APPROVAL AUTHORITY:

The CHW CP Committee and CHW Executive Director or designee on behalf of the Board, and on the recommendation of the Medical or Dental Director, must approve the credentials and privileges for Medical Doctors, and other Licensed Independent Practitioners such as Dentists, Behavioral Health Counselors, and midlevel providers including Physician Assistants and Nurse Practitioners (collectively, "LIPs"). Approval authority for OLCPs is vested in CHW's Medical or Dental Director or through the practitioner's supervisor for Other Clinical Staff ("OCS").

CREDENTIALING & PRIVILEGING GUIDELINES:

Initial Credentialing:

1. CHW performs the credentialing activities in accordance with the **Credentialing and Privileging Table** set forth below.

2. The Texas Standardized Credentialing Application is provided to the LIP provider along with clear information about the application, required documents and deadlines. Other requested documents include the privileges request form, copies of relevant credentials including license(s), certifications, DEA and DPS certificates, Board certification, CPR, and government-issued picture identification.

3. OLCPs and OCSs complete an employment application with verification activities performed in accordance with the **Credentialing and Privileging Table** below, which includes a request for professional references, attestation of fitness for duty and such other information set forth in the table.

4. Primary source verification is used by direct correspondence, telephone, fax, email, or paper reports received from original sources to verify current licensure, certification, relevant training, and experience. The credentials are verified, in accordance with the **Credentialing and Privileging Table** below. If primary source verification cannot feasibly be obtained, Joint Commission-approved equivalent sources include, but are not limited to, the following: the American Medical Association Physician Masterfile, American Board of Medical Specialties, Educational Commission for Foreign Medical Graduates, American Osteopathic Association Physician Database, and Federation of State Medical Boards and the American Academy of Physician Assistants.

5. For LIP applicants, three professional references, as designated on the Texas Standardized Credentialing Application, will be required from the same field and/or specialty who are not partners in a group practice and are not relatives, as available. Professional references may be obtained from an educational program when the applicant is a recent graduate. If the applicant has had privileges at a hospital or clinic, a letter requesting verification of privileges is also used for primary source verification. References will be asked to complete a standard reference form about the applicant's clinical performance, ethical performance, history of satisfactory practice, specific knowledge about the applicant's clinical judgment and technical skills.

6. LIPs give a written statement and/or list of their requested privileges and attest to their fitness for duty and ability to perform their requested privileges which are reviewed by the Medical or Dental Director.

7. A Verification of Health Fitness will be required to determine the Practitioner's (LIP, OLCP and OCS) health fitness or the ability to perform the requested privileges.

8. Background checks will be completed on all Practitioners.

CREDENTIALING	**PRACTITIONER**	
ACTIVITY*Required for both initial and recurring Credentialing, as applicable	LIP	OLCP and, as applicable, OCS
Examples of Staff	Physician, Dentist, Physician Assistant, Nurse Practitioner	RN, Medical Assistant, LVN, Dental Assistant, X-ray Technician, Dental Hygienist
1. Verification of identity	Completed using government issued picture ID	Completed using government issued picture ID
2. Verification of current licensure, registration, or certification*	Primary source	Primary source N/A for OCS
3. Verification of education and training	Primary source. Verification of graduation from medical, dental, or other clinical professional school and, if applicable, residency, including receipt of sealed transcripts	Secondary source
4. National Practitioner Data Bank Query*	Required Copy of completed report from NPDB query or documentation of a change in provider's file (if CHW signs LIPs up with NPDB and receives a real-time report of any changes in a provider's file)	Required as applicable for OLCPs; Not required for OCSs Copy of completed report from NPDB query or documentation of a change in OLCP's file (if CHW signs providers up with NPDB and receives a real-time report of any changes in a provider's file)
5. Drug Enforcement Administration ("DEA") registration, *	If applicable, a copy of the physician/provider's current DEA registration certificate, which indicates the issue and expiration dates.	N/A
6. Basic life support training (if applicable) *	Required Secondary source (Documentation of completion of basic life support training, e.g., a copy of a certificate of completion of training or documentation of comparable/advanced training based on provider's licensure or certification standards)	Required Documentation of completion of basic life support training (e.g., a copy of certificate of completion of training, course completion dates, etc.)
Criminal Background Check	Primary source	Primary Source

**A query of the National Practitioner Data Bank (NPDB), as applicable to the Practitioner, the Health and Human Services Office of Inspector General List of Excluded Individuals database, and all individual state exclusionary databases will be conducted for information on sanctions or adverse actions against a Practitioner's license, as applicable.*

Initial Privileging

1. LIPs request specific privileges in writing based on their training, competence and within the scope of services of the Coastal Health & Wellness Clinic. The Medical or Dental Director recommends the LIP's privileges to the Board, which has the final approval authority. The Executive Director or designee notifies the LIP in writing of the granting of specific privileges. Privileging for OLCPs and OCSs occurs through supervisory evaluation per job description. Approval authority for OLCPs is vested in CHW's Medical or Dental Director or through the practitioner's supervisor for Other Clinical Staff ("OCS").

Recredentialing: The recredentialing process is accomplished at least every two years in accordance with the Credentialing and Privileging Table set forth below.

Re-privileging: Re-privileging of LIPs, OLCPs and OCSs is accomplished at least every two years in conjunction with recredentialing. Determinations on renewal of privileges shall be based on peer review, supervisory performance evaluations or comparable methods for LIPs and supervisory evaluations per job description for OLCPs and OCSs. Other data that can be utilized include clinical data gathered over the two years, including patient satisfaction, performance improvement activities and risk management activities and training completed. A Practitioner may request privileges revisions at any time. The final approval for re-privileging for LIPs is that of the Board. Approval authority for OLCPs is vested in CHW's Medical or Dental Director or through the practitioner's supervisor for Other Clinical Staff ("OCS").

Credentialing and Privileging Table. CHW performs the following credentialing and privileging activities, as applicable to the Practitioner:

PRIVILEGING ACTIVITY	**PRACTITIONER**	
*Required for initial and re-privileging	LIP	OLCP or OCS, as applicable
1. Verification of fitness for duty to assess the ability to perform the duties of the job	Completed self-attestation of fitness for duty Practitioner that is confirmed by either the director of a training program, chief of staff/department at a hospital where privileges exist, or a licensed physician	Completed statement or attestation of fitness for duty from the Practitioner that is confirmed by a licensed physician designated by GCHD, or a licensed physician
2. Verification of immunization and communicable disease* <u>Immunizations/Communicable disease screenings that are verified</u> according to GCHD Employee and Prehire Immunization Policy	Copy of immunization records/status i provider's file or provider attestation, including, if applicable, any declinations (provided by GCHD Immunization Program Manager).	Copy of immunization records/status in provider's file or provider attestation, including, if applicable, any declinations (Provided by GCHD Immunization Program Manager).
3. Verification of current clinical competence*	For initial privileges, verification through review of training, education, and as available, reference reviews. For renewal of privileges, Verification through peer review,	Supervisory evaluation per job description.

	supervisory performance reviews or other comparable methods.	

TEMPORARY PRIVILEGES:

Medical and Dental Directors: recommend temporary approval of privileges only in circumstances outlined below.

CHW Executive Director or Designee: Approves temporary privileges for physicians, midlevel providers including nurse practitioners and physician assistants, other LIPs, and dentists in specific circumstances as outlined below, upon recommendation of the Medical or Dental Director.

Temporary privileges for physicians, midlevel providers including nurse practitioners and physician assistants, other LIPs, and dentists shall be granted under the following circumstance:

1. Responding to a declared public health emergency.

i. In this circumstance, expedited review and verification of the professional credentials, references, claims history, fitness, professional review organization findings, and license status of providers; as well as, the results of the National Practitioner Data Bank query have been obtained and evaluated; any involuntary termination of medical staff membership at another organization has been evaluated; any voluntary or involuntary limitation, reduction, or loss of clinical privileges have been evaluated and current competence (as evidenced by at least two peer recommendations). In this case, temporary privileges will be approved for no more than ninety (90) days and will state the relevant patient care need. For individuals to be covered, they must follow the same guidelines as always. In summary, for employees the work needs to be within their scope of employment under the center's scope of project, and the same applies to contractors or volunteers.

Temporary privileges are not to be routinely used for other administrative purposes such as:

a. The failure of the provider to provide all information necessary to the processing of his/her reappointment in a timely manner; or

ii. Failure of the staff to verify performance data and information in a timely manner.

ADVERSE ACTIONS/APPEALS:

If, during the credentialing process, substantive adverse information on the applicant is received, the Medical Director or Dental Director, in conjunction with the Director of Human Resources and the CHW Executive Director or designee, may recommend to the CHW CP Committee that the applicant not be hired or contracted. LIP applicants may appeal a decision made regarding denial or limitation of privileges to the Board. Such appeals must be made in writing by certified mail to the Board and must be received within thirty (30) days of the decision. The Board, at their sole discretion, may reconsider the decision made to deny or limit privileges. The LIP applicant will be informed of the Board's action.

Adverse Actions on Privileges/Process for Medical or Dental Providers/Appeals Process

Coastal Health & Wellness' process is developed in accordance with its status as a governmental entity and employer and in accordance with policy and bylaws established by HRSA, the Texas Medical Board, the Texas Dental Board, the Texas Board of Nursing, and in accordance with approved Coastal Health & Wellness policies.

If CHW finds that a Practitioner fails to meet appropriate standards for clinical competence and/or fitness for duty, CHW (through its Medical or Dental Director, Executive Director, or the Board), as applicable, may take adverse action against a Practitioner's privileges including but not limited to suspension, limitation, or termination of privileges. OLCPs and OCSs

shall be notified of the determination and any corrective action or follow up required to address the action on privileges. OLCPs and OCSs shall not be entitled to review of such determination.

For LIPS, if the matter involves a compliance or quality of care issue, a comprehensive investigation will be performed to gather factual data and statements from all involved parties. The investigation will be reviewed by the CHW Executive Director or designee and Medical or Dental Director to determine if patient harm or non-compliance were substantiated by the investigation. If harm or non-compliance is questionable, the investigation will be forwarded for review by a confidential peer review committee of clinical counterparts for recommendations. The recommendations will be recorded and forwarded by the Medical or Dental Director to the involved provider for review and comment. All documentation will be kept in the providers' file. If the matter involves a substantiated violation of laws, organizations policies, or applicable licensure board regulations, the CHW Executive Director or designee and Medical or Dental Director, in consultation with the Human Resources Designee, will determine a fair and consistent corrective action in accordance with the *Health District Corrective Action Policy*.

Procedure

The center follows reporting requirements as set forth below.

I. Reporting Under the Federal Health Care Quality Improvement Act of 1986 (HCQIA).

Effective September 1, 1990, the HCQIA requires that certain actions be reported to the National Practitioner Data Bank (NPDB). Entities such as the community health centers, which provide health care services and are engaged in formal peer review for the purpose of furthering quality health care, must report certain adverse disciplinary actions taken against physicians and dentists. Insurers, including the Federal Tort Claims Act (FTCA) liability coverage program, that make any payment on behalf of any licensed health care practitioner must report that payment.

The report must be made on a report form provided by the NPDB. Each reporting entity must identify a single individual to submit and receive reports of the NPDB, as an agent of the center's Board of Directors.

Information required to be reported under 45 CFR Part 60, §60.7, 60.8 and 60.9 of the HCQIA must be submitted to the NPDB within thirty (30) days following the action to be reported, beginning with actions occurring on or after September 1, 1990, as follows:

1. Malpractice Payments. Persons or entities must submit information to the NPDB within thirty (30) days from the date that a payment [as described in §60.7] is made. If required under §60.7, this information must be submitted simultaneously to the appropriate state licensing board.

2. Licensure Actions. The Board must submit information within thirty (30) days from the date the licensure action was taken.

3. Adverse Actions. A health care entity must report an adverse action to the Board within fifteen (15) days from the date the adverse action was taken. The Board must submit the information received from a health care entity within fifteen (15) days from the date on which it received this information. If required under §60.9, this information must be submitted by the Board simultaneously to the appropriate State licensing board in the State in which the health care entity is located, if the Board is not such licensing Board.

Health care entities, including community health centers, which have entered or may be entering into employment or affiliation relationships with a physician, dentist, or other licensed health care practitioner (or from which the physician, dentist, or other health care practitioner has requested authority to practice) may request information on

the practitioner from the NPDB. Only licensed hospitals are required to request information from the NPDB when granting or renewing staff membership or privileges for these health care practitioners.

Although not required to do so, the center is encouraged to query the NPDB when entering an agreement (and every two (2) years thereafter) with a physician, dentist, or other Licensed Independent Practitioner (LIP) or allowing access to a health care practitioner to practice at the center. Contact may be made to:

1. Secure the center identification number and copies of the NPDB report and request forms.

2. Report adverse actions (reported by the center) or liability payments (to be reported by insurer or uninsured professional)

3. General Correspondence:

National Practitioner Data Bank

Healthcare Integrity and Protection Data Bank

P.O. Box 10832

Chantilly, VA 20153-0832

Overnight Mail: National Practitioner Data Bank
Healthcare Integrity and Protection Data Bank
4094 Majestic Lane, PMB-332
Fairfax, VA 22033

II. Texas Medical Board

1. Reporting Adverse Actions on clinical privileges. Under federal (HCQIA) and state law , the center is required to report to the NPDB and to the Texas Medical Board (TMB) any professional review action that adversely affects the clinical privileges of the physician for a period of longer than thirty (30) days. It must also report in case of acceptance of the surrender of clinical privileges or any restriction of such privileges by a physician: (i) while the physician is under investigation by the center for causes relating to possible incompetence or improper professional conduct; or (ii) in return for not conducting such an investigation or proceeding; or (iii) in the case of a health care entity which is a professional society, when it takes a professional review action concerning a physician. This duty to report cannot be by nullified through contract.

2. Report by Certain Practitioners. Under state law, medical peer review committees, licensed physicians, physicians-in-training (including medical students), physician assistants, or acupuncturists, physician assistant students, or acupuncturist students are also required to report to the TMB any relevant information relating to the acts of a physician in this state if, in the opinion of the person or committee, that physician poses a continuing threat to the public welfare through the practice of medicine, or practice as a physician assistant or as an acupuncturist.

3. Reporting Malpractice Payments. Each entity, including an insurance company, which makes a payment under an insurance policy, self-insurance, or otherwise, for the benefit of a physician, dentist or other health care practitioner in settlement of or in satisfaction in whole or in part of a claim or a judgment against such physician, dentist, or other health care practitioner for medical malpractice, must report information to the NPDB and the appropriate state licensing boards(s) in the state in which the act or omission upon which

the medical malpractice claim was based occurred. For purposes of this section, the waiver of an outstanding debt is not construed as a payment and is not required to be reported.

For additional information or to submit reports contact:

Texas Medical Board
P. O. Box 2018
Austin, TX 78768-2018

Or

333 Guadalupe, Tower 3, Suite 610
Austin, TX 78701
(512) 305-7010

III. State Board of Dental Examiners

1. Reporting adverse actions on clinical privileges. Under the HCQIA and the state Dental Practice Act (DPA) the center is required to report to the NPDB and to State Board of Dental Examiners any professional review action that adversely affects the clinical privileges of the dentist for a period of longer than thirty (30) days. It must also report in case of acceptance of the surrender of clinical privileges or any restriction of such privileges by a dentist: (i) while the dentist is under investigation by the center for causes relating to possible incompetence or improper professional conduct; or (ii) in return for not conducting such an investigation or proceeding; or (iii) in the case of a health care entity which is a professional society, when it takes a professional review action concerning a dentist. The center is required to report to the State Board of Dental Examiners any relevant information relating to the acts of such dentist if, in the opinion of the peer review committee, the dentist poses a continuing threat to the public welfare through the practice of dentistry.

2. Reporting Medical Malpractice Payments. Insurers, including self-insurers, are required to report medical malpractice payments to the State Board of Dental Examiners. For details concerning what information needs to be reported, see the HCQIA Regulations.

For additional information or to submit reports contact:

State Board of Dental Examiners
333 Guadalupe Street, Suite 3-800
Austin, Texas 78701
Phone: (512) 463-6400; Fax: (512) 463-7452
Complaints: (800) 821-3205

IV. Board of Nurse Examiners for the State of Texas

1. Reporting professional liability payments. Under the federal HCQIA, insurers, including self-insurers, must report professional liability payments made for the benefit of nurses in settlement of or in satisfaction in whole or in part of a claim or judgment against such practitioner to the NPDB and to the Board of Nurse Examiners for the State of Texas (BNE).

2. Reporting adverse actions on clinical privileges. Under the HCQIA. There is no mandatory reporting requirement under the federal HCQIA to query or to report to the NPDB health care practitioners other than physicians or dentists for adverse actions taken on clinical privileges. However, health care entities may voluntarily report: (1) Professional Review Actions related to professional competence or professional conduct that adversely affect clinical privileges of a health care practitioner (nurse) for more than thirty (30) days; (2) a health care practitioner's (nurse's) voluntary surrender or restriction of clinical privileges while under investigation for professional competence or professional conduct or in return for not conducting an investigation; and (3) revisions to such actions.

3. Reporting requirements by employers of nurses under state licensing Laws; grounds for reporting.

Under state nursing licensing laws, health care entities (including centers) must report in writing the action and pertinent information to the BNE if they employ, hire, or contract for the services of Nurses and terminate or, suspend for more than seven (7) days, or takes other substantive disciplinary action, as defined by the BNE, against a Nurse, or a substantially equivalent action against a Nurse who is a Staff agency Nurse based on the following grounds:

a. Likely exposure by the Nurse of a patient or other person to an unnecessary risk of harm.

b. Unprofessional conduct by the Nurse.

c. Failure by the Nurse to adequately care for a patient.

d. Failure by the Nurse to conform to the minimum standards of acceptable nursing practice.

e. Impairment or likely impairment of the Nurse's practice by chemical dependency.

The term nurse means either a registered nurse (RN) or a licensed vocational nurse (LVN).

4. Duty of Nursing Peer Review Committee to Report.

a. Minor incidents. A nurse involved in a minor incident need not be reported to the BNE or a Nursing Peer Review Committee if several factors exist. A minor incident is defined as "conduct that does not indicate that the continuing practice of nursing by an affected nurse poses a risk of harm to a patient or other person."

b. Safe Harbor Peer Review for Nurses. Entities that regularly employ, hire or contract for the services of ten (10) or more Nurses must have written policies and procedures for identifying and reporting nurses who may or do engage in reportable conduct and for complying with the requirements for "Incident-Based Nursing Peer Review" and "Safe Harbor Peer Review For Nurses". The policies and procedures must provide for review of any reportable conduct by a "Nursing Peer Review Committee."

Any determinations by the entity's Nursing Peer Review Committee, the entity's administration, and the BNE are exclusive and independent of one another.

5. Duty of Nurse to Report.

a. An individual nurse has a duty to report to the BNE if the nurse has reasonable cause to suspect that another nurse or nursing student is subject to a ground for reporting.

b. The report by a nurse to the BNE must:

i. Be in writing and signed.

ii. Include the identity of the nurse or nursing student being reported and include any additional information required by the BNE.

c. A nurse may make a report to the student nurse's nursing educational program in which the student is enrolled instead of reporting to the BNE.

d. If a nurse has reasonable cause to believe that another Nurse exposes a patient to substantial risk of harm as a result of a failure to provide patient care that conforms to minimum standards of acceptable and prevailing professional practice or to statutory, regulatory, or accreditation standards, the first nurse may report this to the nurse's employer or another entity at which the said nurse is authorized to practice. For purposes of this paragraph, the employer or entity includes an employee or agent of the employer or entity.

e. In a written, signed report to the appropriate licensing board or accrediting body, a nurse may report a licensed health care practitioner, agency, or facility that the nurse has reasonable cause to believe has exposed a patient to substantial risk of harm as a result of failing to provide patient care that conforms to the:

i. Minimum standards of acceptable and prevailing professional practice, for a report made regarding a practitioner.

ii. Statutory, regulatory, or accreditation standards, for a report made regarding an agency or facility.

If a nurse required to be reported is impaired or suspected of being impaired by dependency on chemicals or by mental illness, the Nurse may be reported to a state approved peer assistance program rather than to the BNE or a professional nursing peer review committee. For questions or

For additional information and to mail reports:

Board of Nurse Examiners for the State of Texas
P. O. Box 140466
Austin, Texas, 78714

Or

333 Guadalupe, #3-460
Austin, Texas, 78701
(512) 305-7400

Back to Agenda

Governing Board
October 2022
Item#11
Coastal Health & Wellness Updates

a. Update on COVID-19 Submitted by Executive Director
b. Operational Updates/Coastal Wave Submitted by Chief Operating Officer
c. Dental Updates Submitted by Dental Director

Coastal Wave

Coastal Health & Wellness

Serving. Healing. Caring. Providing high quality medical, dental and counseling services to everyone.

Mark your calendars: Marketplace Insurance open enrollment starts Nov. 1

Open Enrollment for 2023 Health Insurance Marketplace coverage kicks off Nov. 1. If you don't have health insurance through your job, Medicare, Medicaid, the Children's Health Insurance Program (CHIP) or another source that provides qualifying health coverage, Health Insurance Marketplace can help you get coverage.

All offered plans cover essential health benefits, pre-existing conditions and preventive services including maternity care, mammograms and other preventive care services. You cannot be denied health coverage for having pre-existing conditions such as diabetes, hypertension and cancer.

The certified application counselors at Coastal Health & Wellness stand ready to assist Galveston County residents apply for coverage in the 2023 Marketplace. Give us a call at 409.949.3439 for assistance.

Learn more about open enrollment for 2023 Marketplace Insurance.

County sees surge in reported flu cases

Now is time to get flu vaccine

Nearly 900 Galveston County residents have been diagnosed with the flu in just the first two weeks of October, up significantly compared to previous years.

“Getting your flu vaccine is incredibly important this year,” said Dr. Philip Keiser, Coastal Health & Wellness executive director and Galveston County local health authority. “Flu is already here. That is clear. Do not wait to get vaccinated.”

People 6 months and older should be vaccinated against the flu. Children who need two doses of vaccine to protect against the flu should start the vaccination process sooner as the two doses must be given at least four weeks apart. Vaccination is especially important for certain high-risk groups including those age 65 and older, pregnant women, young children and those with chronic health conditions who are at higher risk for complications or even death if they get the flu.

Vaccination is also important for health care workers and others who live with or care for high-risk people to keep from spreading the flu to them. It takes about two weeks after vaccination for antibodies that protect against the flu to develop in the body.

It is especially important this year to protect those at higher risk for flu and COVID-19 complications.

“It is likely we’re going to see flu viruses and the virus that causes COVID-19 spreading this fall and winter,” Keiser said. “There are thousands of Galveston County residents who are eligible to receive the updated bivalent COVID-19 booster dose who haven’t done so yet. We’re concerned we’re going to see an increase in COVID-19 cases while also facing what we expect to be an active season.”

Call us today at 409.938.2234 to schedule your flu vaccine appointment. Learn more about this flu season.

National Physician Assistant Week, Oct. 6-12

Coastal Health & Wellness celebrated National Physician Assistant Week, Oct. 6-12.

Did you know, there are more than 140,000 PAs practicing in the U.S., and we have the best four right here at CHW!

We’re proud to celebrate our fantastic PA team - Jason Borillo, Jacklyn Morgan, Julio Garza and Yaa Cherematenge - and their dedication to keep you and our community healthy.

Medical Assistants Recognition Week, Oct. 17-21

Coastal Health & Wellness celebrated its wonderful medical assistants during Medical Assistants Recognition Week, Oct. 17-21.

Our MA's play a vital role in helping perform administrative and clinical duties to make sure our patients have a comfortable visit.

A big THANK YOU goes out to Joana Gama, LaTonya Jones, Wendy Lazo, Ashley Gardner, Tabetha Breaux, Karen Trevino, Brenda Gonzalez, Sara Garcia, Cecilia Rodriguez, Ny'kedra Lartigue. (Not pictured are Jonathan Ramirez and Lilia Saenz.)

Happy National Dental Hygiene Month!

October marks National Dental Hygiene Month and we can't say enough about our fantastic dental hygienist team, Steffin John and Jamie Trinh!

Thank you for all you do to keep our patient's teeth squeaky clean.

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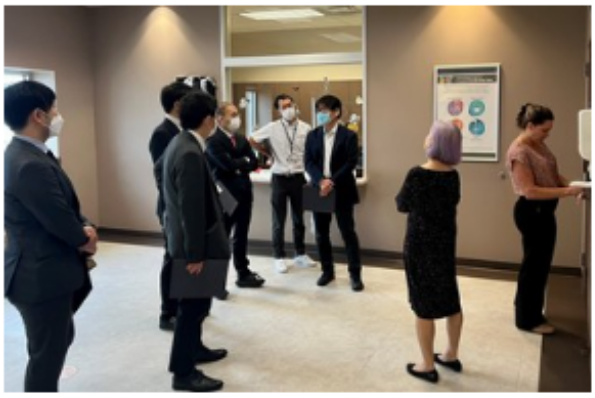
CHW, GCHD hosts Japanese Ministry of Health



Coastal Health & Wellness and Galveston County Health District earlier this month hosted four infectious disease doctors with the Japanese Ministry of Health, along with two doctors from The University of Texas Health Science Center at Houston.

They visited to understand the strategic approach against the monkeypox virus in the United States and the health district. The group was led by Dr. Norio Omagari, director of the Department of Infectious Diseases at the National Center for Global Health and Medicine in Tokyo, and Dr. Nigo Masayuki, an infectious diseases faculty member at The University of Texas Health Science Center at Houston. The group saw frontline work including community outreach and education, mobile vaccine clinics and clinical care for those infected.

Stay away from sticky candy this Halloween

If your planned Halloween festivities involve candy, you may want to check out these five ways to enjoy the spooky holiday, and keep your teeth healthy.

Stay away from candy and treats that stick. Unless it's sugar free, candies that stay in the mouth for a long time lead to an increased risk for tooth decay. Avoid beverages with added sugar and think twice before picking hard candies. The length of time sugary food is in your mouth plays a role in developing cavities.

Healthy lifestyle changes can lower chances of prediabetes

More than 37 million people in the U.S. have diabetes and another 96 million have prediabetes, a serious health condition where your blood sugar levels are higher than normal, but not high enough yet to be diagnosed as type 2 diabetes. Many with prediabetes don't even know it.

There is good news. Early detection and treatment of diabetes can decrease the risk of developing complications from the disease. Manage your diabetes by working with your health care team. Making small lifestyle changes can have a big impact - adopt a healthy diet, be physically active and work to lose weight.

Take control and learn more during National Diabetes Awareness Month.

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Governing Board
October 2022
Item#12
Consider for Approval Preliminary September 2022
Financial Report Submitted by Trish Bailey

COASTAL HEALTH & WELLNESS

Governing Board

FINANCIAL SUMMARY

For the Period Ending

September 30, 2022

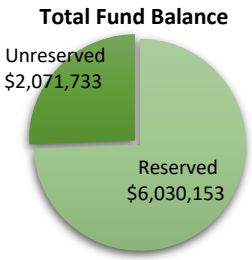
October 27, 2022

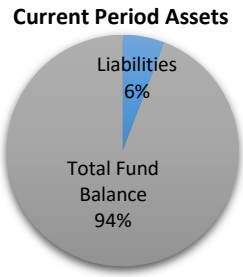
GCHD Board Room | 9850-A Emmett F. Lowry Expy. | Texas City, TX 77591

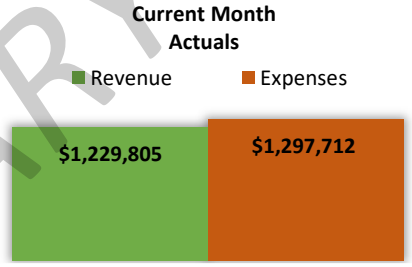
CHW - BALANCE SHEET

as of September 30, 2022

	Current Month Sep-22	Prior Month Aug-22	Increase (Decrease)
ASSETS			
Cash & Cash Equivalents	$7,787,149	$7,447,253	$339,896
Accounts Receivable	2,880,644	2,760,138	120,505
Allowance For Bad Debt	(1,426,676)	(1,384,842)	(41,834)
Pre-Paid Expenses	314,187	201,983	112,205
Due To / From	(289,259)	263,789	(553,048)
Total Assets	**$9,266,046**	**$9,288,321**	**($22,275)**
LIABILITIES			
Accounts Payable	$53,940	$104,337	($50,397)
Accrued Salaries	464,324	368,295	96,029
Deferred Revenues	24,642	24,642	0
Total Liabilities	**$542,906**	**$497,274**	**$45,632**
FUND BALANCE			
Fund Balance	$8,131,580	$8,131,580	0
Current Change	591,560	659,466	(67,907)
Total Fund Balance	**$8,723,140**	**$8,791,047**	**($67,907)**
TOTAL LIABILITIES & FUND BALANCE	**$9,266,046**	**$9,288,321**	**($22,275)**







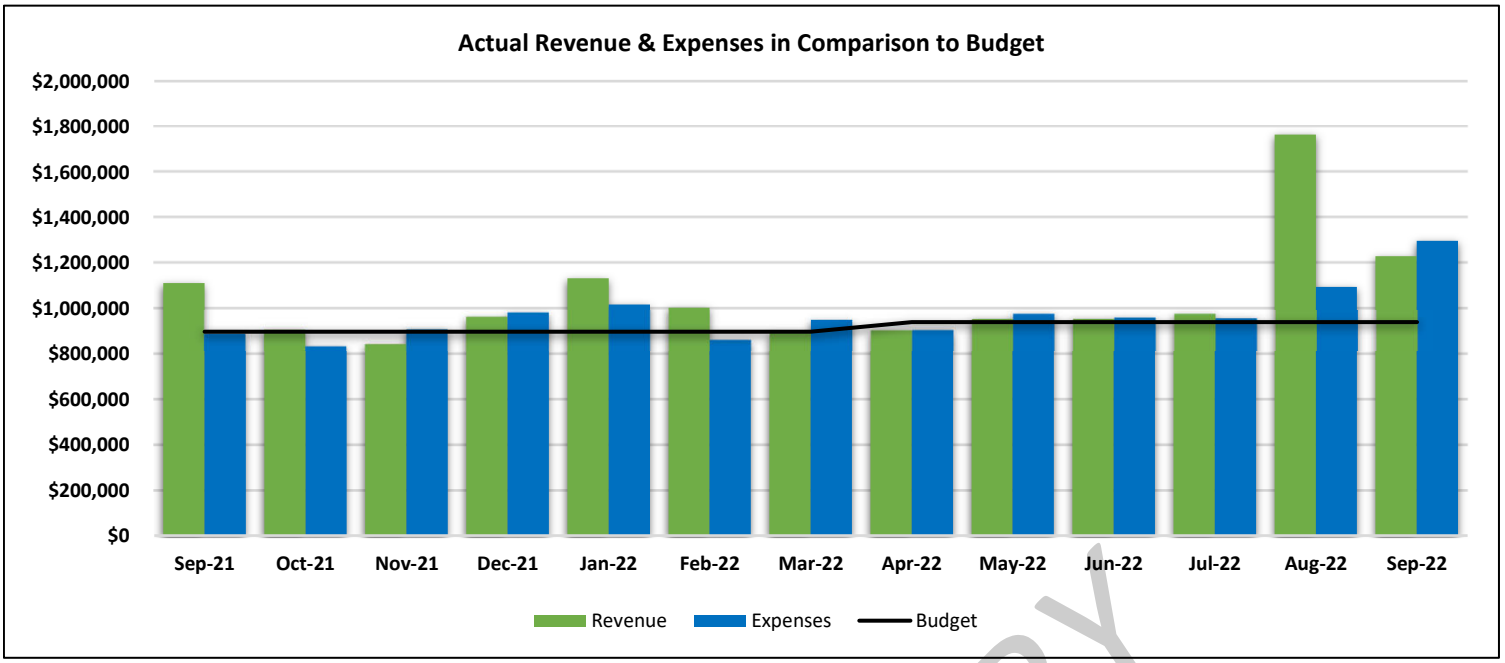
CHW - REVENUE & EXPENSES

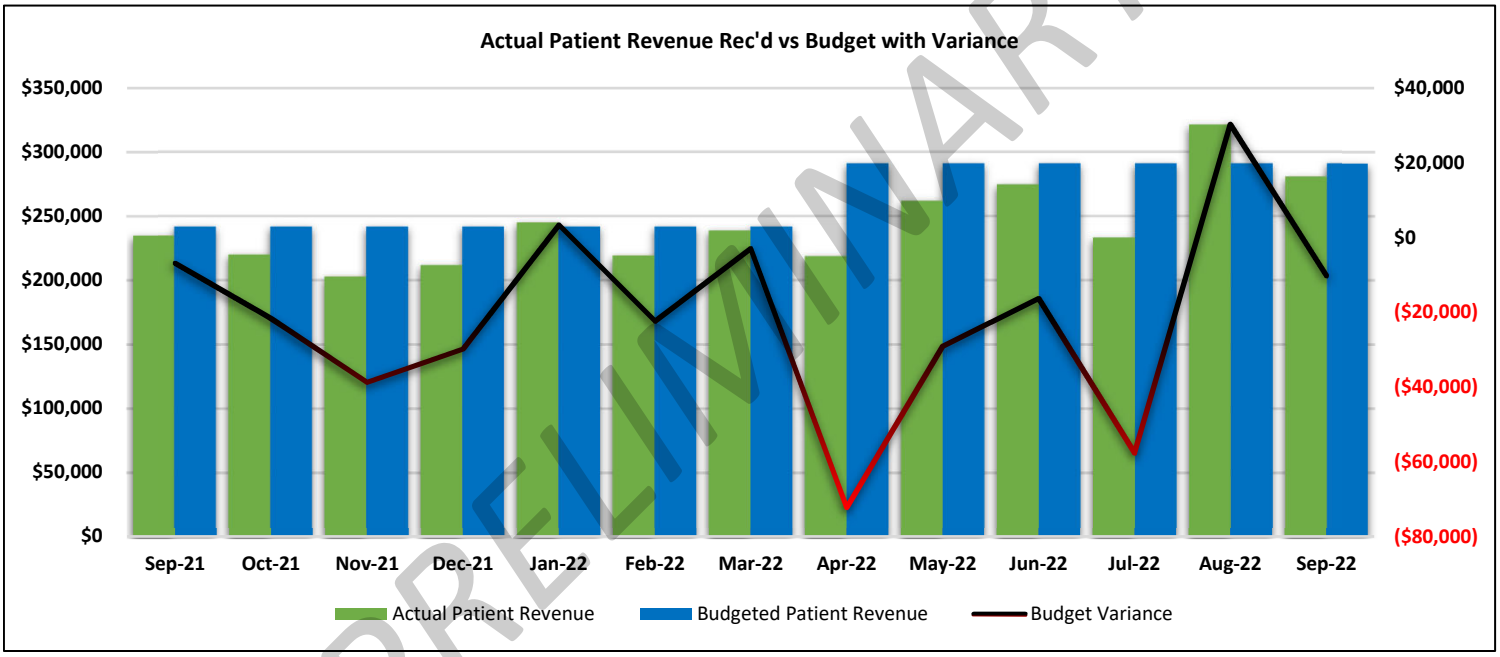
as of September 30, 2022

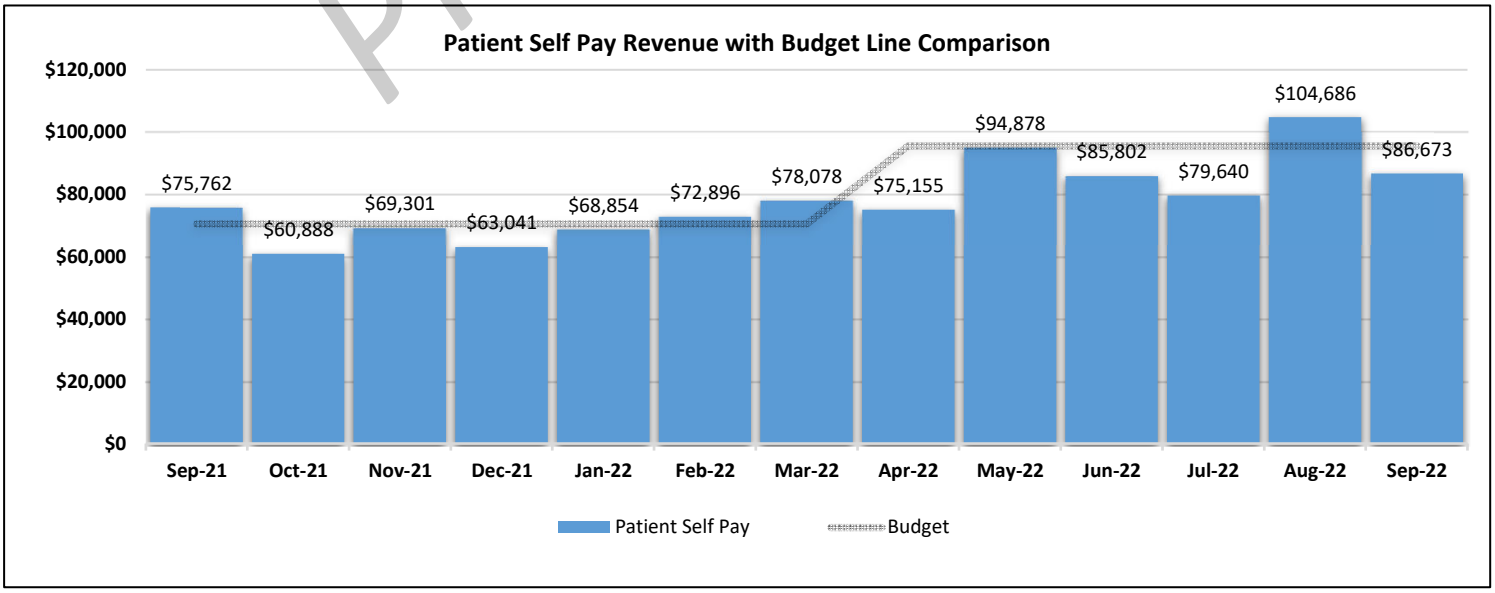
	MTD Actual Sep-22	MTD Budgeted Sep-22	MTD Budget Variance	YTD Actual thru Aug 2022	YTD Budget thru Aug 2022	YTD Budget Variance
REVENUE						
County Revenue	$311,222	$311,222	$0	1,867,333.50	$1,867,334	-
DSRIP Revenue	0	62,500	(62,500)	712,500	375,000	337,500
HHS Grant Revenue	633,604	269,783	363,821	2,540,828	1,618,700	922,128
Patient Revenue	280,771	290,952	(10,181)	1,590,508	1,745,712	(155,203)
Other Revenue	4,208	4,976	(768)	59,103	29,854	29,249
Total Revenue	**$1,229,805**	**$939,433**	**$290,372**	**6,770,272**	**$5,636,599**	**1,133,673**
EXPENSES						
Personnel	$701,400	$618,574	($82,826)	3,919,665.58	$3,711,442	($208,224)
Contractual	102,223	77,767	(24,456)	526,625	466,601	(60,024)
IGT Reimbursement	235,125	20,569	(214,556)	235,125	123,413	(111,713)
Supplies	90,127	84,323	(5,804)	510,391	505,940	(4,451)
Travel	8,468	3,278	(5,190)	16,924	19,668	2,744
Bad Debt Expense	41,834	33,454	(8,380)	255,493	200,723	(54,770)
Other	118,536	101,469	(17,068)	714,489	608,814	(105,675)
Total Expenses	**$1,297,712**	**$939,433**	**($358,279)**	**6,178,712**	**$5,636,599**	**($542,113)**
CHANGE IN NET ASSETS	**($67,907)**	**$0**	**($67,907)**	**591,560**	**$0**	**591,560**

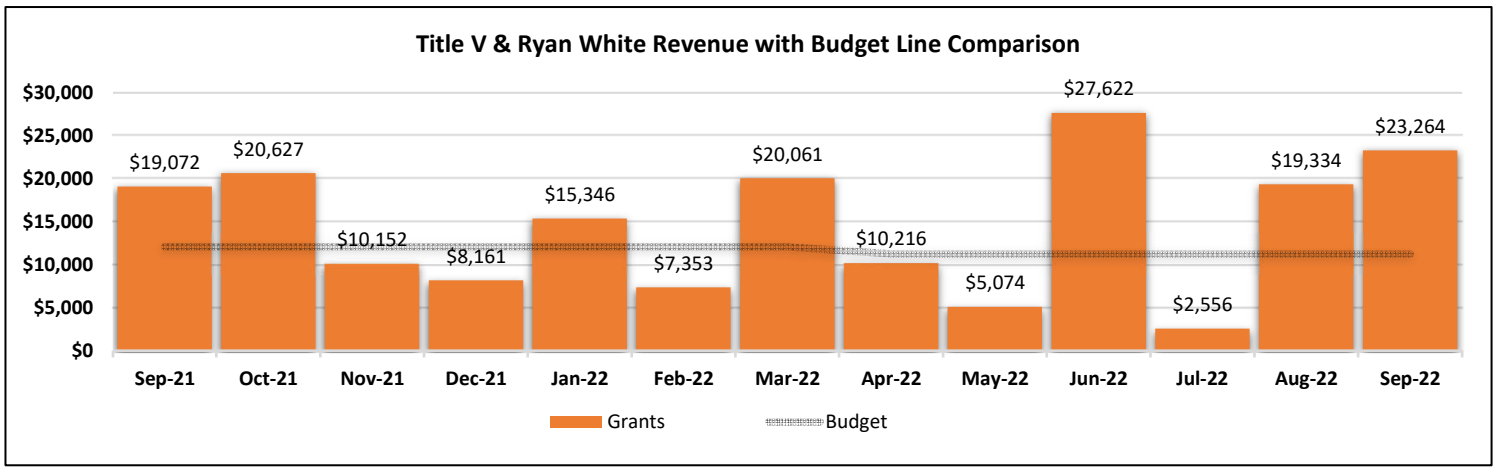
HIGHLIGHTS

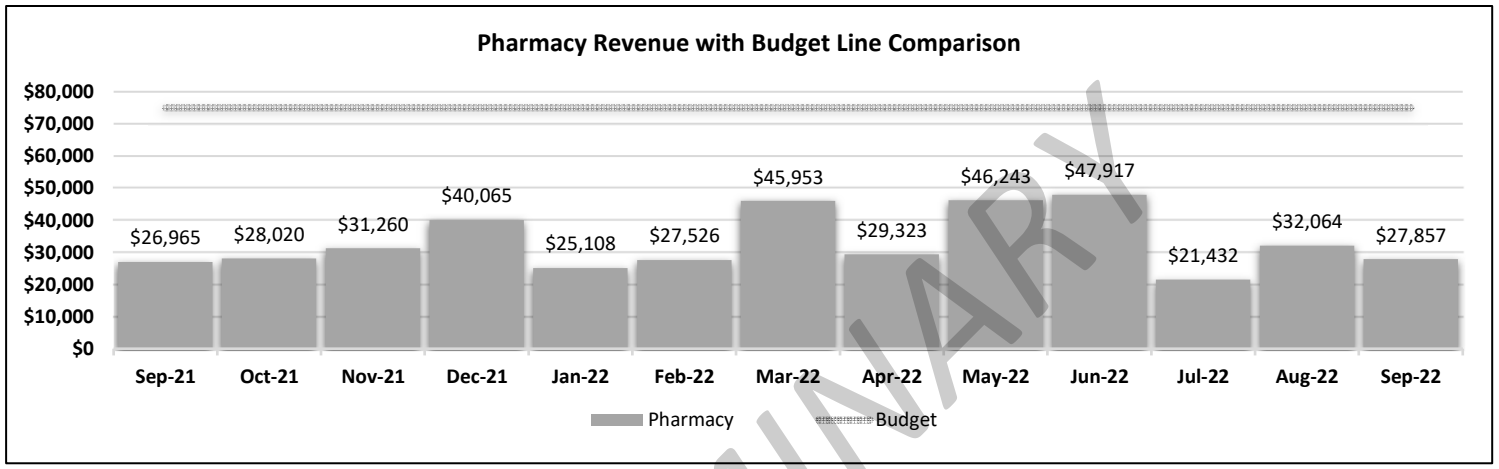
- ***Fund Balance:*** For the month of September the total fund balance was $8,723,140, a decrease of $67,907 from August. Decrease due to IGT Reimbursement paid in September for DSRIP revenue received prior month.
- ***Revenue:*** MTD revenue was $1,229,805 which is over budget by $290,372. YTD revenue was $6,770,272 and is over budget by $1,133.673. The large difference between actual and budget for MTD and YTD is due to the extra funding from HHS and the DSRIP revenue coming in all at once.
- ***Expense:*** MTD expenses were $1,297,712 which is $358,279 over budget. YTD expenses were $6,178,712 which are $542,113 over budget. This difference between actual and budget is due to the increase in personal and other personal changes as well as the IGT payment. The overage in personnel is offset by revenue from the HRSA ARP grant.

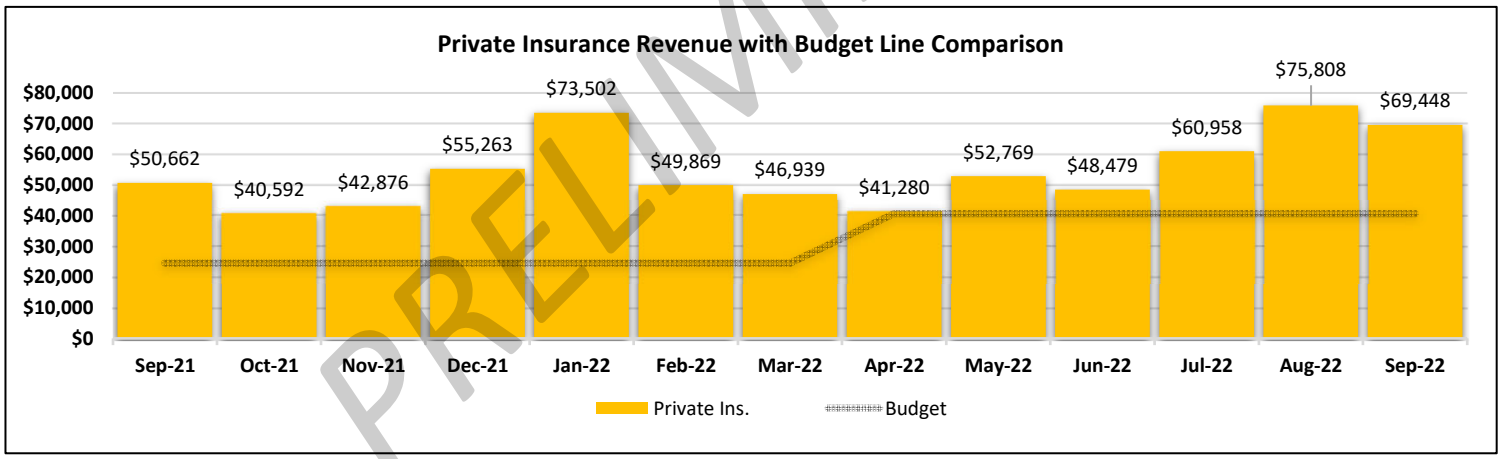


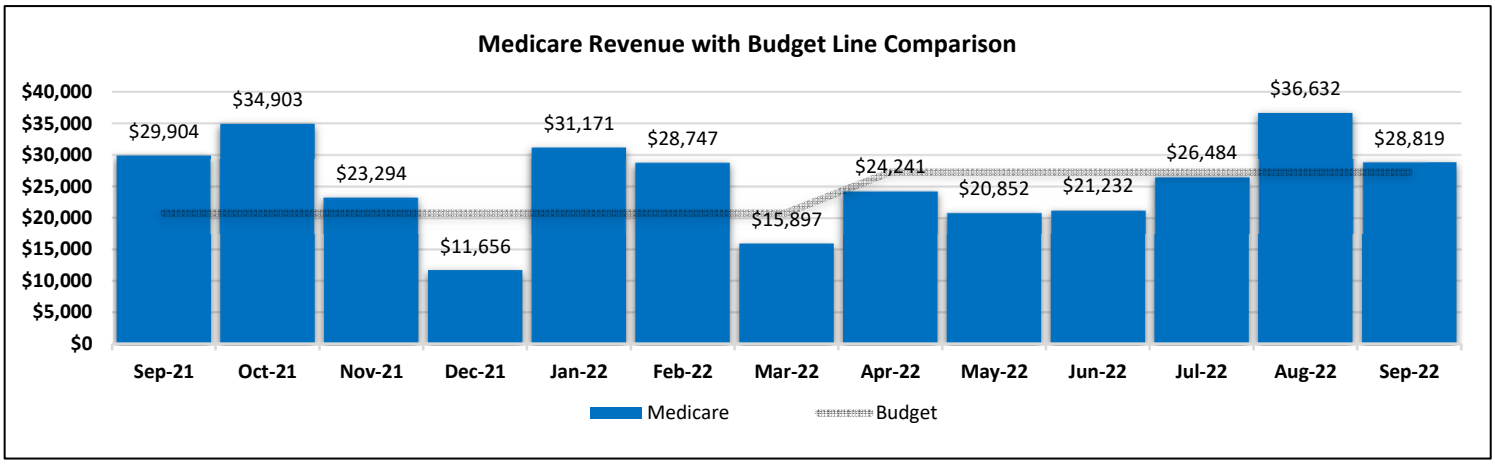


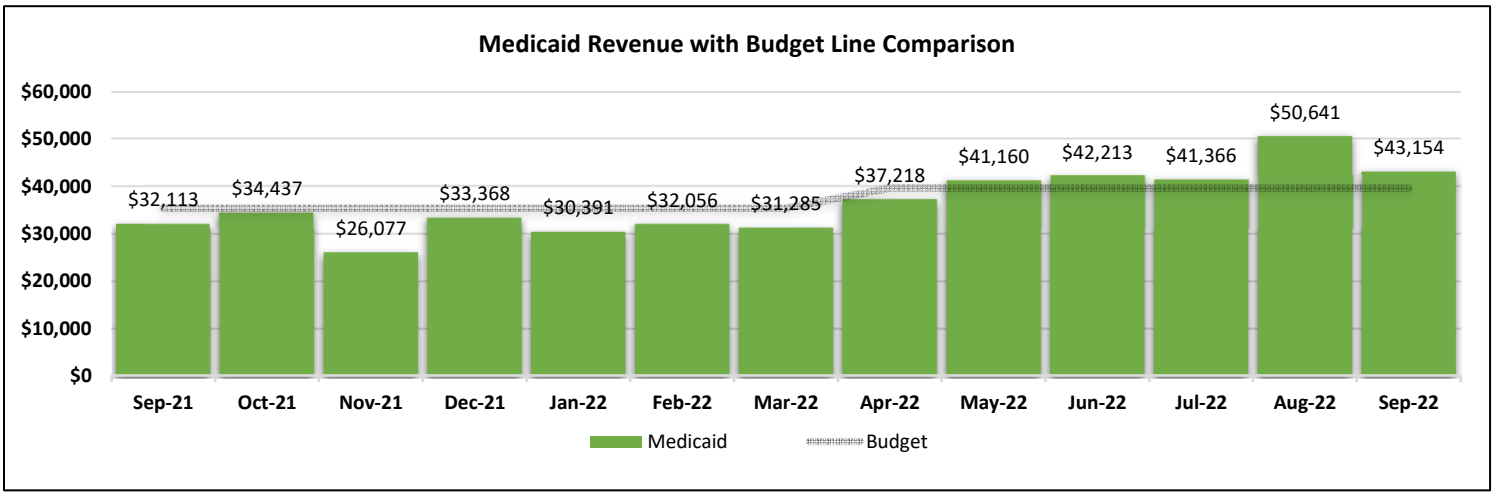


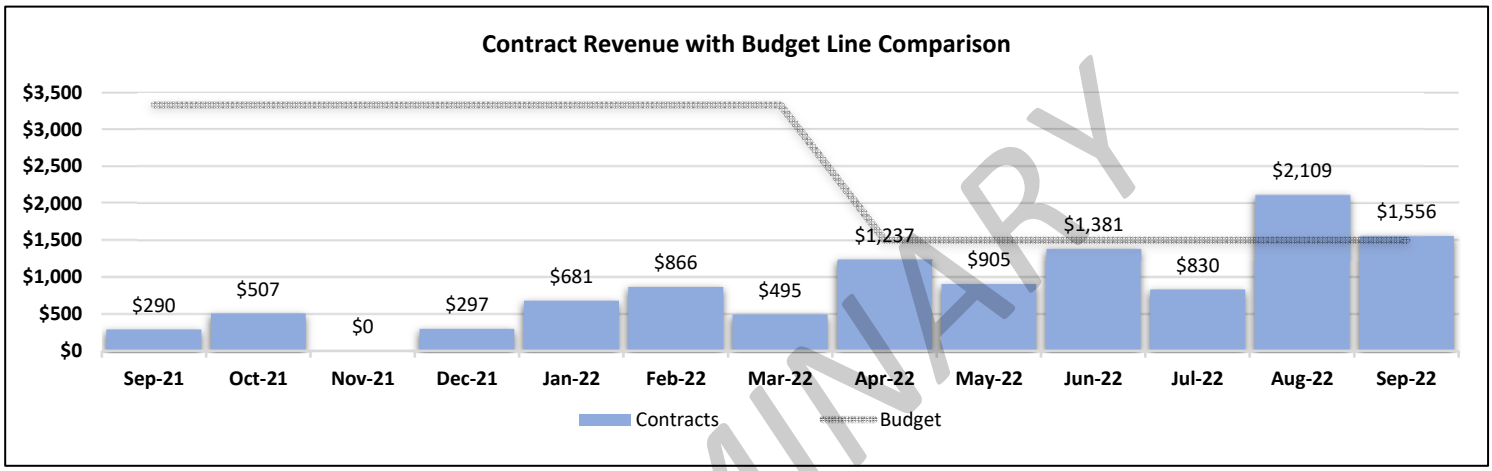


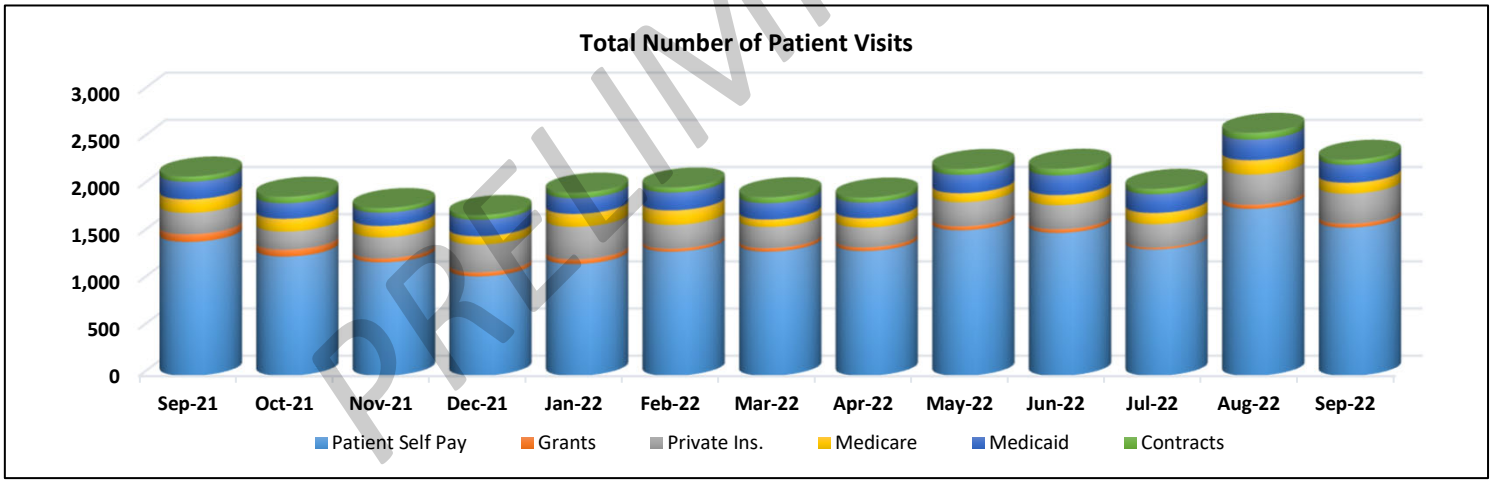












Coastal Health & Wellness
Statement of Revenue and Expenses for the Period ending September 30, 2022

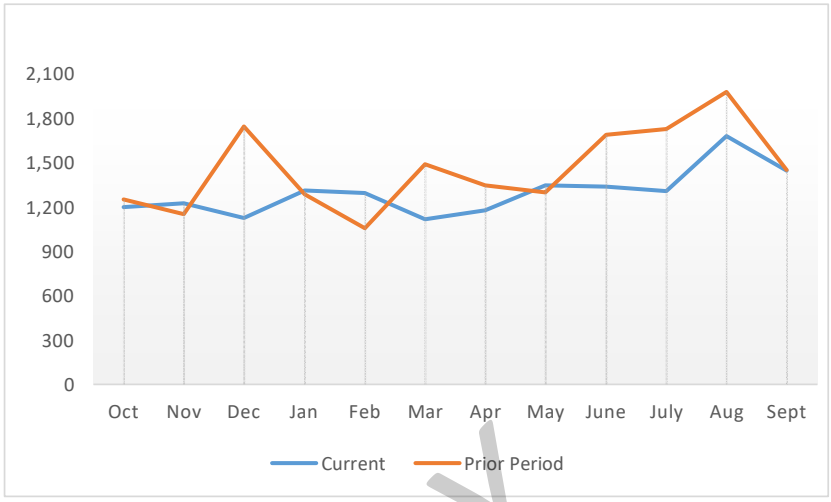
Cost Category	Account Description	Annual Budget	Period Ending 09/30/22	MTD Budget	MTD Budget Variance	YTD Actual	YTD Budget	YTD Budget Variance
Grouping	***Revenue***							
HHS	HHS Grant Revenue - HRSA	3,237,400	633,604	269,783	363,821.09	2,540,828	1,618,700	922,128
	Base Funding	*3,237,400*	*259,575*	*269,783*	*(10,208)*	*1,533,400*	*1,618,700*	*(85,300)*
	COVID ECT	-	*545*	-	*545*	*6,488*	-	*6,488*
	Hypertension (HTN)	-	-	-	-	*2,939*	-	*2,939*
	COVID ARP	-	*373,484*	-	*373,484*	*998,000*	-	*998,000*
HHS	HHS Grant Revenue - Other	-	-	-	-	-	-	-
Patient	Grant Revenue *(Title V, Ryan White*	135,140	23,264	11,262	12,003	88,066	67,570	20,496
Patient	Patient Fees	1,146,988	86,673	95,582	(8,910)	526,834	573,494	(46,660)
Patient	Private Insurance	487,920	69,448	40,660	28,788	348,741	243,960	104,781
Patient	Pharmacy Revenue - 340b	900,000	27,857	75,000	(47,143)	204,836	450,000	(245,164)
Patient	Medicare	327,375	28,819	27,281	1,538	158,261	163,688	(5,427)
Patient	Medicaid	476,000	43,154	39,667	3,487	255,751	238,000	17,751
Other	Local Grants & Foundations	16,208	-	1,351	(1,351)	-	8,104	(8,104)
Other	Medical Record Revenue	14,000	126	1,167	(1,041)	3,852	7,000	(3,149)
Other	Medicaid Incentive Payments	-	-	-	-	36,600	-	36,600
County	County Revenue	3,734,667	311,222	311,222	-	1,867,334	1,867,334	-
DSRIP	DSRIP Revenue	750,000	-	62,500	(62,500)	712,500	375,000	337,500
Other	Miscellaneous Revenue	-	191	-	191	877	-	877
Other	Gain on Fixed Asset Disposals	-	-	-	-	-	-	-
Other	Interest Income	24,500	3,581	2,042	1,539	16,383	12,250	4,133
Patient	CHW Contract Revenue	18,000	1,556	1,500	56	8,018	9,000	(982)
Other	Local Funds / Other Revenue	5,000	310	417	(106)	1,391	2,500	(1,109)
	Total Revenue	**$ 11,273,198**	**$ 1,229,805**	**$ 939,433**	**$ 290,372**	**$ 6,770,272**	**$ 5,636,599**	**$ 1,133,673**
	Expenses							
Personnel	Hourly Pay	5,919,231	571,807	493,269	(78,538)	3,148,743	2,959,616	(189,128)
Personnel	Supplemental/Merit Compensati	-	536	-	(536)	536	-	(536)
Personnel	Provider Incentives	5,000	750	417	(333)	6,000	2,500	(3,500)
Personnel	Overtime	24,000	3,162	2,000	(1,162)	18,213	12,000	(6,213)
Personnel	Part-Time Hourly Pay	217,127	25,781	18,094	(7,687)	161,113	108,564	(52,550)
Personnel	Comp Pay Premium	-	-	-	-	209	-	(209)
Personnel	FICA Expense	471,649	43,951	39,304	(4,647)	245,314	235,825	(9,490)
Personnel	Texas Unemployment Tax (SUTA)	11,808	51	984	933	(1,305)	5,904	7,209
Personnel	Life Insurance Expense	16,166	1,521	1,347	(173)	8,438	8,083	(355)
Personnel	Long Term Diability Coverage	15,038	1,166	1,253	87	6,590	7,519	929
Personnel	Employer Paid Health Insurance	418,938	29,114	34,912	5,798	169,838	209,469	39,631
Personnel	Worker's Comp Insurance	18,501	(4,974)	1,542	6,516	2,204	9,251	7,046
Personnel	Cobra Expense	-	100	-	(100)	226	-	(226)
Personnel	Health Reimbursement Account	-	(2)	-	2	(0)	-	0
Personnel	Employer Sponsered Healthcare	72,991	5,677	6,083	405	27,961	36,496	8,535
Personnel	Pension/Retirement	232,434	22,759	19,370	(3,390)	125,584	116,217	(9,367)
Contractual	Outside Lab Contract	205,632	18,054	17,136	(918)	106,755	102,816	(3,939)
Contractual	Outside X-Ray Contract	18,720	1,584	1,560	(24)	10,224	9,360	(864)
Contractual	Misc Contract Services	390,792	55,623	32,566	(23,057)	253,947	195,396	(58,551)
Personnel	Temporary Staffing	-	-	-	-	-	-	-
Contractual	CHW Billing Contract Services	90,000	7,831	7,500	(331)	41,590	45,000	3,410
IGT	IGT Reimbursement	246,825	235,125	20,569	(214,556)	235,125	123,413	(111,713)
Contractual	Janitorial Contract	196,438	16,395	16,370	(25)	98,372	98,219	(153)
Contractual	Pest Control	960	435	80	(355)	836	480	(356)
Contractual	Security	30,660	2,301	2,555	254	14,902	15,330	428
Supplies	Office Supplies	90,600	8,898	7,550	(1,348)	52,596	45,300	(7,296)
Supplies	Operating Supplies	258,000	30,021	21,500	(8,521)	194,781	129,000	(65,781)
Supplies	Outside Dental Supplies	52,000	6,329	4,333	(1,996)	37,919	26,000	(11,919)
Supplies	Pharmaceutical Supplies	600,000	44,041	50,000	5,959	199,890	300,000	100,110
Supplies	Janitorial Supplies	1,200	-	100	100	-	600	600
Supplies	Printing Supplies	5,280	617	440	424	731	2,640	1,909

Coastal Health & Wellness
Statement of Revenue and Expenses for the Period ending September 30, 2022

Cost Category	Account Description	Annual Budget	Period Ending 09/30/22	MTD Budget	MTD Budget Variance	YTD Actual	YTD Budget	YTD Budget Variance
Supplies	Uniform Supplies	-	-	-	-	51	-	(51)
Supplies	Controlled Assets *(i.e. computers)*	4,800	821	400	(421)	24,423	2,400	(22,023)
Other	Postage	9,000	465	750	285	3,132	4,500	1,368
Other	Telecommunications	67,812	4,002	5,651	1,649	32,752	33,906	1,154
Other	Water	372	-	31	31	153	186	34
Other	Electricity	18,000	(125)	1,500	1,625	5,787	9,000	3,213
Travel	Travel, Local	3,200	137	267	129	737	1,600	863
Travel	Travel, Out Of Town	-	1,203	-	(1,203)	6,554	-	(6,554)
Travel	Training, Local	30,135	5,578	2,511	(3,067)	7,638	15,068	7,429
Travel	Training, Out Of Town	6,000	1,549	500	(1,049)	1,995	3,000	1,005
Other	Rentals	58,440	3,550	4,870	1,320	30,422	29,220	(1,202)
Other	Leases	519,924	43,327	43,327	0	259,961	259,962	1
Other	Maint/Repair, Equip.	90,799	7,906	7,567	(339)	46,036	45,400	(636)
Other	Maint/Repair, Bldg.	3,017	-	251	251	-	1,509	1,509
Other	Maint/Repair, IT Equipment	-	-	-	-	518	-	(518)
Other	Insurance, Auto/Truck	108	8	9	1	46	54	8
Other	Insurance, General Liability	10,908	866	909	44	5,193	5,454	261
Other	Insurance, Bldg. Contents	14,736	1,217	1,228	11	7,302	7,368	66
Other	Operating Equipment	-	-	-	-	(8,575)	-	8,575
Other	Newspaper Ads/Advertising	23,900	765	1,992	1,227	6,076	11,950	5,874
Other	Subscriptions, Books, Etc.	18,000	1,435	1,500	65	8,329	9,000	671
Other	Association Dues	34,975	1,000	2,915	1,915	36,260	17,488	(18,773)
Other	IT Software / Licenses	299,566	44,299	24,964	(19,335)	237,297	149,783	(87,514)
Other	Prof Fees/Licenses/Inspections	4,670	637	389	(248)	2,236	2,335	99
Other	Professional Services	22,800	6,625	1,900	(4,725)	28,229	11,400	(16,829)
Other	Med/Hazard Waste Disposal	5,400	-	450	450	3,374	2,700	(674)
Other	Transportation	6,000	81	500	419	1,458	3,000	1,542
Other	Employee Betterment	-	1,393	-	(1,393)	1,393	-	(1,393)
Other	Board Meeting Operations	600	99	50	(49)	1,926	300	(1,626)
Other	Service Charge - Credit Cards	8,600	989	717	(272)	5,097	4,300	(797)
Other	Cashier Over/Short	-	-	-	-	86	-	(86)
Bad Debt	Bad Debt Expense	401,446	41,834	33,454	(8,380)	255,493	200,723	(54,770)
Other	Miscellaneous Expense	-	-	-	-	-	-	-
	Total Expenses	**$ 11,273,198**	**$ 1,297,712**	**$ 939,433**	**$ (358,279)**	**$ 6,178,712**	**$ 5,636,599**	**$ (542,113)**
	Net Change in Fund Balance	***$ -***	***$ (67,907)***	***$ -***	***$ (67,907)***	***$ 591,560***	***$ -***	***$ 591,560***

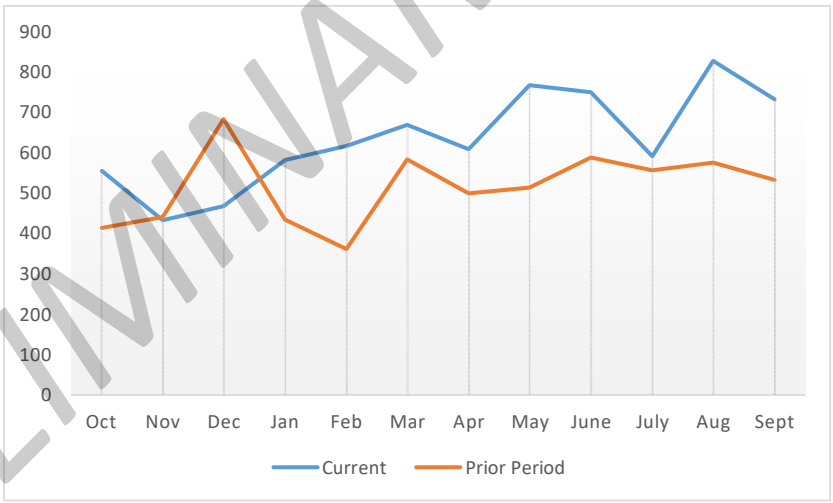
Medical Visits

	Current	Prior Period
Oct	1,198	1,251
Nov	1,227	1,150
Dec	1,124	1,745
Jan	1,311	1,288
Feb	1,294	1,058
Mar	1,119	1,488
Apr	1,178	1,345
May	1,345	1,299
June	1,337	1,689
July	1,309	1,727
Aug	1,684	1,980
Sept	1,445	1,450
	15,571	17,470



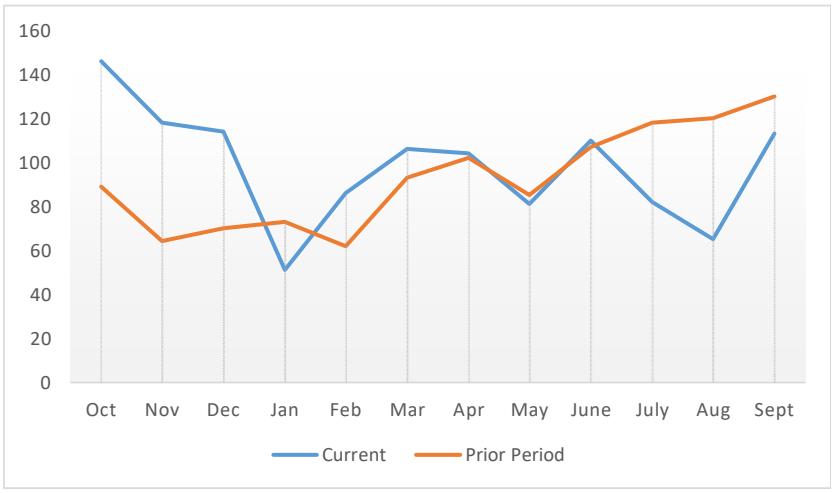
Dental Visits

	Current	Prior Period
Oct	554	412
Nov	433	440
Dec	466	682
Jan	580	433
Feb	616	361
Mar	668	582
Apr	607	499
May	766	512
June	748	587
July	591	555
Aug	827	574
Sept	732	532
	7,588	6,169



Counseling Visits

	Current	Prior Period
Oct	146	89
Nov	118	64
Dec	114	70
Jan	51	73
Feb	86	62
Mar	106	93
Apr	104	102
May	81	85
June	110	107
July	82	118
Aug	65	120
Sept	113	130
	1,176	1,113



Vists by Financial Class - Actual vs. Budget
As of September 30, 2022 (Grant YTD 04/01/22 - 09/30/22)

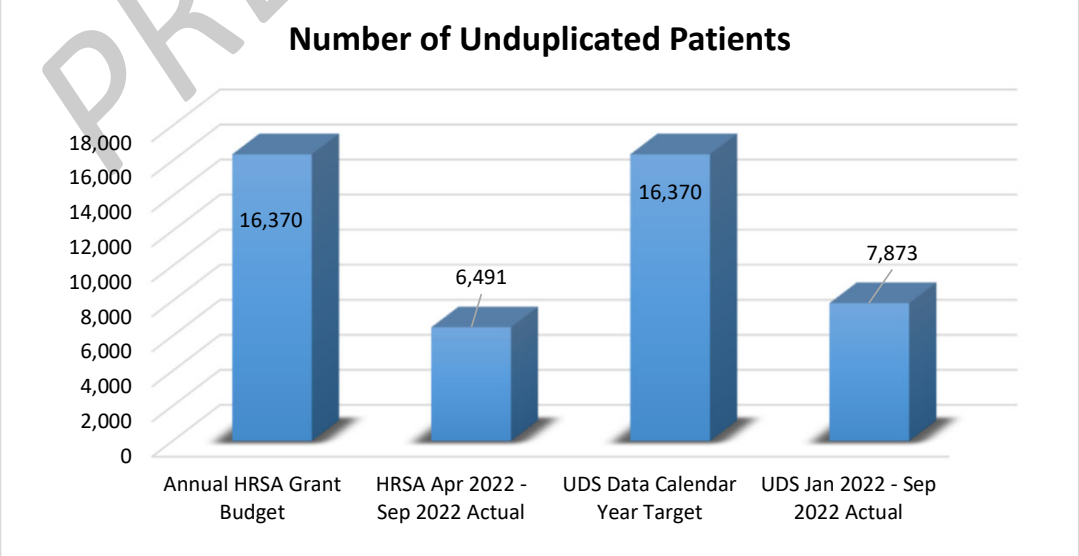
	Annual HRSA Grant Budget	MTD Actual	MTD Budget	Over/(Under) MTD Budget	YTD Actual	YTD Budget	Over/(Under) YTD Budget	% Over/(Under) YTD Budget
Medicaid	3,400	190	283	(93)	1,338	1,700	(362)	-21%
Medicare	2,425	117	202	(85)	715	1,213	(498)	-41%
Other Public *(Title V, Contract, Ryan White)*	993	94	83	11	597	497	101	20%
Private Insurance	4,435	318	370	(52)	1,641	2,218	(577)	-26%
Self Pay	24,404	1,571	2,034	(463)	8,942	12,202	(3,260)	-27%
	35,657	**2,290**	**2,971**	**(681)**	**13,233**	**17,829**	**(4,596)**	**-26%**

Unduplicated Patients - Current vs. Prior Year
UDS Data Calendar Year
January through December

	Current Year Annual Target	Jan 2021 - Sep 2021 Actual	Jan 2022 - Sep 2022 Actual	Increase/ (Decrease) Prior Year	% of Annual Target
Unduplicated Patients	16,370	7,209	7,873	664	48%

Unduplicated Patients - Current vs. Prior Year
HRSA Grant Year
April through May

	Annual HRSA Grant Budget	Apr 2021 - Sep 2021 Actual	Apr 2022 - Sep 2022 Actual	Increase/ (Decrease) Prior Year	% of Annual Target
Unduplicated Patients	16,370	6,156	6,491	335	40%



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Governing Board
October 2022
Item#13
Consider for Approval Quarterly Visits and Analysis Report Including Breakdown of New Patients by Payor Source for Recent New Patients
Submitted by Ami Cotharn

Coastal Health & Wellness - Quarterly Visit & Analysis Report
for the period ending September 30, 2022
**based on UDS Reporting period (January 1 to December 31) Qualified Encounters*

Total Visits by Financial Class	September 2022	September 2021	% Change	* YTD Average 2022	* YTD Average 2021	% Change		* YTD Payor Mix 2022	* YTD Payor Mix 2021	% Change
Self Pay	1,571	1,419	11%	1,426	1,440	-1%		66.7%	68.6%	-2.0%
Medicare	117	144	-19%	119	146	-18%		5.6%	7.0%	-1.4%
Medicaid	190	187	2%	215	204	5%		10.0%	9.7%	0.3%
Contract	53	54	-2%	62	26	143%		2.9%	1.2%	1.7%
Private Insurance	318	226	41%	277	225	23%		13.0%	10.7%	2.2%
Title V	41	82	-50%	38	57	-32%		1.8%	2.7%	-0.9%
Total	**2,290**	**2,112**	**8%**	**2,138**	**2,098**	**2%**		**100%**	**100%**	

Department	* YTD Total Visits 2022	* YTD Total Visits 2021	% Change
Medical	16,618	13,326	25%
Dental	6,747	4,635	46%
Counseling	946	890	6%
Total	**24,311**	**18,851**	**29%**

Qualifying Visits	* YTD Total Users 2022	* YTD Total Users 2021	% Change
Medical	4,833	5,648	-14%
Dental	1,968	1,393	41%
Counseling	182	173	5%
Total	**6,983**	**7,214**	**-3%**

NextGen / Crystal Reports - Summary Aging by Financial Class
for the period ending September 30, 2022 (based on encounter date)

	0-30	31-60	61-90	91-120	121-150	151-180	181-up	Total	%	Days in A/R Current Period	Days in A/R Last Qtr
Self Pay	$51,512.07	$64,185.39	45,891	51,625	51,343	42,647	156,773	$463,976	32%	261	385
Medicare	$17,321.39	$12,100.17	7,544	5,841	3,507	3,601	275,010	$324,924	22%	844	67
Medicaid	18,877	12,972	7,868	9,626	12,673	7,044	108,296	$177,356	12%	213	56
Contract	$2,122.04	$12,035.53	4,823	-$1,414.55	-$1,466.50	-$1,586.35	4,971	$19,485	1%	42	75
Private Insurance	$43,610.98	$20,840.00	20,904	11,938	10,818	7,417	368,080	$483,608	33%	537	91
Title V	$5,538.06	$6,080.97	2,480	5,734	5,812	5,663	69,554	$100,862	7%	835	290
Unapplied	-$117,536.96	$0.00	-	-	-	-	-	($117,537)	-8%	---------	---------
Totals	**$18,877**	**$12,972**	**$89,510**	**$84,763**	**$84,153**	**$66,372**	**$982,684**	**$1,452,673**	**100%**	**455**	**161**
Previous Quarter Balances	**$39,967**	**$98,175**	**$72,290**	**$67,364**	**$43,839**	**$32,948**	**$653,388**	**$1,007,971**			
% Change	-53%	-87%	24%	26%	92%	101%	50%	44%			

Charges & Collections	September 2022	September 2021	% Change	* YTD 2022	YTD 2021	% Change
Billed	$816,431	$697,751	17%	$6,563,355	$3,414,828	92%
Adjusted	(572,802)	(476,503)	20%	(4,705,778)	(2,444,804)	92%
Net Billed	$243,629	$221,248	10%	$1,857,577	$970,024	91%
Collected	226,728	$207,560	9%	2,002,549	$1,401,136	43%
% Net Charges collected	93%	94%	-1%	108%	144%	-25%

Payor	YTD Current Period Visits	Payor Mix	Net Revenue per Visit	(Net Billed) Net Revenue	YTD Prior Year Visits	Payor Mix	Net Revenue per Visit	(Net Billed) Net Revenue
Self Pay	12,830	66.7%	$37.47	$480,739	17,731	66.4%	$21.07	$373,599
Medicare	1,075	5.6%	$96.70	103,958	2,150	8.0%	$65.66	141,165
Medicaid	1,933	10.0%	$116.35	224,897	2,383	8.9%	$83.33	198,586
Contract	559	2.9%	$222.96	124,637	1,189	4.5%	$53.90	64,081
Private Insurance	2,496	13.0%	$97.37	243,032	2,637	9.9%	$59.91	157,994
Title V	345	1.8%	$94.59	32,632	626	2.3%	$55.27	34,599
Total	19,238	100%	$62.89	$1,209,894	26,716	100%	$36.31	$970,024

Item	2022	2021
Self Pay - Gross Charges	$3,932,140	$3,429,069
Self Pay - Collections	252,914	$576,977
% Gross Self Pay Charges Collected	**6.4%**	**16.8%**
% Net Self Pay Charges Collected	**52.6%**	**154.4%**

Coastal Health & Wellness New Patients by Financial Class from 1/1/2022 to 9/30/2022

Payer	Current Period		Prior Period	
Summary	New Patients	Current %	New Patients	%
Self Pay	1617	30.99%	1006	21.53%
Medicaid	195	22.86%	169	21.56%
Medicare	67	13.76%	48	9.02%
Private Insurance / Commercial	290	26.98%	222	23.64%
Title V	23	19.49%	61	30.05%
Contracts	17	13.82%	8	11.11%

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Governing Board
October 2022
Item#14
Consider for Approval the Quarterly Compliance Report for the Period Ending September 30, 2022 Submitted by Wendy Jones

Coastal Health & Wellness Governing Board
Quarter 3 (July, August, September), FY2022 Compliance Report

Internal Audits		
AUDITOR- DATE CONDUCTED	***TYPE OF AUDIT & FINDINGS***	***ACTION TAKEN***
Nursing Director July 1, 2022 – September 30, 2022	**340B Medication Audit:** • The Nursing Director performed a 340B medication audit to determine fullness of charting 340B ordered meds, which requires documentation reflecting consistency in medication logs, NextGen and billing activities. • Of the 20 charts analyzed (ten at each of the two sites), no discrepancies were discovered, yielding a clean audit.	• Continue operating under current protocol.
Nursing Director July 1, 2022 – September 30, 2022	**Abnormal Pap Audit:** • The Nursing Director performed an audit of 269 charts to determine compliance of record documentation of Pap results in (July-Sept 2022) • Results 100% Compliant with follow up from Providers	• Continue operating under current protocol.
External Audits		
AUDITOR – DATE OCCURRED	***TYPE OF AUDIT & FINDINGS***	***ACTION TAKEN***
TV Well Child Audit - Screening	• Previous audits have met the criteria of 90% compliance therefore audits will be conducted biannual. If the compliance rate drops below 90% then audits will occur quarterly.	
AUDITOR – DATE OCCURRED	***TYPE OF AUDIT & FINDINGS***	***ACTION TAKEN***
Health Access - Texas Ryan White QCR Dental Services September 28, 2022	• Quality Compliance Review • No deficiencies noted - 100% compliant – The official results have not been received to date but there were no findings.	• Continue operating under current protocol.

HIPAA Breach Reports		
DEPARTMENT – DATE OCCURRED	***SUMMARY***	***FOLLOW-UP***
	None to report	

Warning and Termination Letters	
REASON	***TYPE OF LETTER***
Verbally abusive and inappropriate language	Termination

NOTE: Various issues were discussed in peer review.

Incidents involving quality of care issues, In accordance with Section 161 et seq., Health and Safety Code, are reviewed such that proceedings and records of the quality program and committee reviews are privileged and confidential.

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Governing Board
October 2022
Item#15
Consider for Approval Coastal Health & Wellness Quality Assurance Performance Improvement Plan 2022-2023 "QAPI" Submitted by Jason Borillo

COASTAL HEALTH & WELLNESS
Quality Assurance and Performance Improvement Plan 2022-2023

Introduction

The purpose of this Quality Assurance and Performance Improvement (QAPI) is to outline how Coastal Health & Wellness (CHW) will assure that a meaningful performance improvement program is implemented with continuous monitoring, clear organizational roles and responsibilities for carrying out the Plan, and how performance improvement data will be evaluated and reported to the Governing Board Quality Assurance/Performance Improvement/Risk Management (QA/PI/RM) Committee and the CHW Governing Board (GB).

Responsibilities

Coastal Health & Wellness Governing Board

The CHW Governing Board is the policy-making authority for CHW clinical operations. The Board approves CHW operational policies, ensures CHW's continuing alignment with its vision and mission, and tracks CHW's progress to achieve goals and objectives adopted by the organization and as set forth in accordance with the Healthy People 2020.

As outlined in the Governing Board's bylaws, execution and operational aspects of Board policies are delegated to the Executive Director or his/her designee. The Health Resources and Services Administration (HRSA) mandates that a Quality Assurance/Performance Improvement/Risk Management (QA/PI/RM) Committee comprised of Governing Board members, oversee the progression and effectiveness of Coastal Health & Wellness's overarching initiatives. In doing so, the Governing Board's QA/PI/RM Committee will convene on a quarterly basis to review performance improvement data and priority indicators which shall include CHW's compliance with standards stipulated by CHW accrediting organizations including but not limited to HRSA and The Joint Commission (TJC).

The Governing Board's QA/PI/RM Committee is responsible, when necessary, for requesting that the Executive Director bring pertinent information from these meetings to the Governing Board in its entirety. The Governing Board is subsequently expected to offer feedback to CHW administration regarding these matters.

Coastal Health & Wellness Quality Assurance Performance Improvement (QAPI) Committee

The Coastal Health & Wellness Quality Assurance/Performance Improvement Committee includes the Director of Innovation and Clinical Quality, Chief Operating Officer, Chief Compliance Officer, Chief Financial Officer, Medical Director, Nursing Director, Dental Director and all other clinic managers. The Quality Assurance/Performance Improvement Committee meets monthly to evaluate and improve upon current clinical processes as they pertain to patient care, customer service, administrative functions, and adherence to other goals and objectives subject to Governing Board oversight. Minutes from the Quality Assurance/Performance Improvement Committee are distributed to all members within five (5) business days after the meeting and reviewed with all members of the Quality Assurance Performance Improvement Committee at the start of the subsequent meeting.

Members of the Quality Assurance/Performance Improvement Committee use data presented at these meetings to establish monthly, quarterly, and annual performance matrices. The Director of Innovation and Clinical Quality and other designated staff coordinate with the Governing Board's QA/PI/RM Committee to establish organizational responsibilities required to accomplish identified goals and objectives.

Coastal Health & Wellness Supervisors

All Coastal Health & Wellness managers and supervisors are responsible for capturing and tracking data essential to monitoring and evaluating the progress and quality initiatives as they relate to each supervisor's departmental purview, and ensure members of their respective staff are adequately educated about their individual roles and responsibilities, and how these roles and responsibilities fit into CHW's overall objectives. When instructed by the Chief Operation Officer, supervisors will coordinate the collection of data and its subsequent aggregation and analysis, including frequency, statistical tools, historical trends, etc.

Approach to Quality Assurance/Performance Improvement

The framework for the Coastal Health & Wellness Performance Improvement Plan is developed in collaboration with a broad and inclusive group of community stakeholders and takes into consideration local morbidity and mortality data. Strategic planning fosters integrated priorities across the entire organization. For 2022-2023, data will be collected on:

a. Medical and dental productivity
b. Access to care
c. Patient satisfaction survey results
d. Patient complaint data for unresolved complaints
e. Patients with hypertension
f. Patients with Type 2 diabetes
g. Breast and colon cancer screening initiatives
h. Insurance credentialing
i. Chart audits for quality-of-care measures
j. Other measures identified by HRSA (clinical measures), Healthcare Effectiveness Data and Information Set (HEDIS) TJC, the Department of State Health Services and/or the QA/PI/RM Committee

The 2022-2023 Performance Improvement Plan will also mandate that CHW administration continue working to collaborate with Texas Association of Community Health Centers (TACHC) to meet the requirements of the Patient Centered Medical Home credential. Clinic staff will also continue to develop measures over the next year to comply with regulatory changes set forth by any regulatory body.

Measurements for 2022 - 2023

Coastal Health & Wellness is committed to achieving certain goals set forth by HRSA in its Healthy People 202030 initiative. Accordingly, CHW will strive to exceed the following specific measures, which will be reviewed quarterly by the Governing Board's Quality Assurance Committee.

Objectives

1. Improve by at least 5% the proportion of patients with Type 2 Diabetes who have a hemoglobin A1C less than 9%
2. Increase by 10% the proportion of children, adolescents and adults who have weight screenings and counseling for overweight or obesity
3. Improve blood pressure control of our population to 80%
4. Improve depression remission at 12 months to 20%

5. Focus on the Care of Older Adults by facilitating advanced care planning, defining their functional status, and reconciling medication to reduce potentially harmful medication and polypharmacy.
6. Improve antibiotic stewardship by reducing the inappropriate use of antibiotics for upper respiratory infections in children and bronchitis in adults.
7. Prevent diabetes and cardiovascular disease in patients who have been prescribed an antipsychotic medication
8. Promptly engage patients after hospitalization and provide follow-up and medication reconciliation within 30 days of discharge
9. Continue the established peer review process for all dental providers
10. Place dental sealants on at least 70% of eligible patients ages 6-9 years old

Measures from the Bureau of Primary Health Care Review

Clinical measures in the Bureau of Primary Health Care grant and mandatory reporting system will be integrated into routine QA monitoring and improvement activities to assure baseline numbers are accurate for the Uniform Data System (UDS) reporting tool.

Dental Peer Review

Dental Peer Review will continue to serve as a vehicle to evaluate and improve the quality of dental health services at Coastal Health & Wellness. Monthly measures for dental are reviewed by audit of individual records or data gathered through electronic reports generated from the system. Currently, Dental Peer Review measures are reviewed monthly by the Coastal Health & Wellness Quality Assurance/Performance Improvement Committee, and feedback from these meetings is presented to all providers by the CHW Dental Director at their department's monthly in-service meeting.

Medical Peer Review

The CHW Medical Team has modified its peer review process and is implementing the clinical education initiative for a more comprehensive approach to quality assurance.
Monthly medical chart reviews are conducted by audit of randomly selected 10% of medical records gathered through electronic reports generated from the system. Medical chart review summaries are reviewed monthly during the Coastal Health & Wellness providers monthly in-service meeting.

Environment of Care and Infection Control Program

The program has predetermined measures for the effectiveness of efforts in safety, life safety, security, hazardous materials, utilities, medical equipment, emergency preparedness and infection control. Improvements are driven by identification of opportunities for enhancement through conformance with the measures and data analysis. These are reviewed and approved annually by the QA/PI/RM Committee and follow guidelines set forth by The Joint Commission, OSHA, AAMI and CDC.

Staff Competencies

Licensed independent providers are credentialed and privileged in accordance with the *CHW Credentialing and Privileging Policy for Professional Provider Staff* (attached), which is reviewed and approved annually by the Coastal Health & Wellness Governing Board. Other licensed staff is periodically credentialed and works under the applicable supervision. An assessment of all staff competency is made annually as a part of the Coastal Health and Wellness performance evaluation process.

Sentinel Events

A sentinel event is a serious occurrence in CHW that results in the death or serious injury of a patient, staff or visitor. It also includes an event that causes risk of death or injury, in that if it were repeated, injury or death might occur. Injury may be physical or psychological. It is not related to the course of a patient's illness or condition. Sentinel events are preventable occurrences. Some examples are death or serious injury from a medication error, from transmission of a nosocomial infection, and from breach of a safety measure or avoidable delay in treatment.

Sentinel events shall be reported as incidents and reviewed by the Coastal Health & Wellness Quality Assurance/Performance Improvement Committee. In the rare instance that a sentinel event should occur, a root cause analysis focusing on improving systems and processes will be undertaken by an appropriate multi-disciplinary group assigned by the Quality Assurance/Performance Improvement Committee. Should the event mandate reporting to an external agency, such reports will be prepared by the Chief Compliance Officer, unless directed otherwise by the COO.

Incidents that do not rise to the level of a sentinel event are also thoroughly investigated, and corrective actions, when appropriate, are employed. Such incidents are important learning and improvement opportunities and are analyzed by the Quality Assurance & Performance Improvement (QAPI) Committee. Process improvements are made based upon Committee recommendations and established procedures for best practices.

Attachments:

a. Patient Safety and Quality of Care Statement

b. Clinical Peer/Midlevel Review

c. QAPI Performance Index/Work Plan Index

d. Galveston County Health District Coastal Health & Wellness Clinic Quality Management Program for DSHS and HHS Funded Programs

e. Coastal Health & Wellness Credentialing and Privileging Policies for Professional Provider Staff

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Samantha Robinson, Chair Date
Coastal Health & Wellness Governing Board

Patient Safety and Quality of Care
Coastal Health & Wellness Statement

Patient Safety and excellent quality of care is of the utmost importance to Coastal Health & Wellness staff at all levels. Patients can be assured that Coastal Health & Wellness (CHW) has all the standard systems in place for patient safety, quality assurance, and quality of care improvements.

CHW's goal is to continuously improve health care for the public by evaluating its health care processes and outcomes, and by inspiring a collective sentiment striving for excellence, safety and the highest quality of care possible among all staff. CHW strives for each of its patients to experience the safest, highest quality, best-value health care available anywhere.

Safety & Quality of Care is addressed in many ways. A few highlights include:

- **Joint Commission Accreditation** (www.jointcommission.org) – The Joint Commission is an independent, not-for-profit organization. The Joint Commission accredits and certifies more than 18,000 health care organizations and programs in the United States. Joint Commission accreditation and certification is recognized nationwide as a symbol of quality that reflects an organization's commitment to meeting certain performance standards.
- **Risk, Safety, Infection Control and Medication Management** guidelines are annually reviewed and staff practices are routinely improved and monitored.
- **Investigations** of possible adverse occurrence with root cause analysis are conducted and improvements are implemented when deemed appropriate.
- **Medical Peer Reviews** of patient records are performed and are targeted at discovering ways of improving the quality of care offered.
- **Midlevel Reviews** are conducted by the Associate Medical Director, randomly selected 10% of midlevel clinical records. Midlevel providers are typically physician assistants and nurse practitioners employed at Coastal Health & Wellness.
- **Peer Reviews** of patient's dental records are performed as part of the established dental peer review process with the dentists and dental hygienists. These peer reviews are targeted at identifying opportunities for improving the quality of care offered.

Coastal Health & Wellness follows national safety guidelines and standards. Staff routinely manages CHW facilities to optimize security, fire safety, medical equipment safety, reliable power and utility systems, and maintains a functional clinic environment. Staff also addresses medication and infection control risks, keeps accurate records, continuously ascertains the competency of staff, and provides care in accordance with recognized standards.

As a Coastal Health & Wellness patient, you should speak up if you have questions or if you wish to discuss an issue of safety or the quality of your care. You may contact Clinic Administration at (409) 949-3406. If your concerns are not addressed, you may contact The Joint Commission at (800) 994-6610.
Your health and safety are of the utmost importance to our organization.

COASTAL HEALTH & WELLNESS CLINICAL
PEER/MIDLEVEL REVIEW

A Medical and Dental Quality of Care Improvement Program

These guidelines are an attachment to the approved Coastal Health & Wellness Governing Board's Performance Improvement Plan.

LEGAL FRAMEWORK OF PROGRAM

Pursuant to the *Federal Tort Claims Act*, which provides liability coverage for the Coastal Health & Wellness clinics and its employees, all official Coastal Health & Wellness professional staff are subject to review to evaluate quality of services, provide feedback and be given the opportunity for improvement or corrective action as may be indicated. The *Texas Medicaid Managed Care Program* also requires that providers be subject to review, and that quality improvement and corrective actions be taken and monitored, as appropriate.

To qualify for the confidentiality and immunity protections afforded, all Peer/Midlevel Review activities must be carried out pursuant to these guidelines and must be performed at the direction of or on behalf of the Coastal Health & Wellness Quality Assurance Committee comprised of the Executive Director, Chief Nursing Officer, Chief Compliance Officer, Medical Director, Dental Director, Nursing Director, along with other business and clinical staff, as deemed necessary, based upon the issue being addressed.

The evaluation of qualifications, credentials, and privileges of licensed and certified staff are performed in accordance with *Credentialing and Privileging Policy for Professional Provider Staff.*

PEER TO PEER CLINICAL EDUCATIONAL INITIATIVE

Context

Primary health care clinicians are responsible for partnering with our patients to work toward the goals of achieving and maintaining excellent health. This partnership for the purpose of successfully achieving measurable goals is known as value-based care.

The evidence for successful prevention and management of health conditions continues to accumulate and the care we provide needs to evolve as new evidence is obtained. This necessitates a commitment to lifelong learning for all providers and requires ongoing, continuous review and mastery of accepted medical and dental practice.

Peer to Peer Clinical Education Initiative

CHW's Medical Director strictly monitors the peer review process to ensure that every provider:

- Has access to up-to-date evidence for the most common and impactful health conditions managed in CHW clinics.
- Is aware in a timely fashion of changes in the evidence and the application of best practice as it relates to patient care

- Actively engages with other providers and the health care team to provide exemplary evidence-based care for our patients.

Content

Quality measures and provider clinical performance review

Taken alone, UDS measures do not indicate whether CHW is upholding appropriate care. However, the data does offer markers for conditions known to impact the health of communities so when followed over time they can help determine if we are on course to effectively manage the care of our patients.
(goal is providers meet and improve individual UDS measure goals, certain HEDIS goals and being educated for best practice and monitor outcome.)
Our goal is for providers to meet and improve individual UDS goals and to meet and improve on selected HEDIS measures.

The following table lists the health conditions and primary preventive services that will form the basis of our current peer to peer clinical education initiative. All measures are represented, and many are contained within more than one subject area.

Screening and Preventative Care	• Cervical Cancer Screening • Breast Cancer Screening • Body Mass Index (BMI) Screening and Follow-up Plan • Tobacco Use: Screening and Cessation Intervention • Colorectal Cancer Screening • HIV Screening • Screening for Depression and Follow-up Plan • Transitions of Care: Patient Engagement and Medication Reconciliation Post-Inpatient Discharge • Diabetes and Cardiovascular Screening for Patients Using Antipsychotic Medications
Maternal Care and Children's Health	• Early Entry into Prenatal Care • Childhood Immunization Status • Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents
Care for Older Adults	• Reporting the Rates of Advanced Care Planning, Medication Review, Functional Status Assessment, and Pain Assessment
Disease Management	• Statin therapy for Statin Therapy for the prevention and Treatment of Cardiovascular Disease • Ischemic Vascular Disease (IVD): Use of Aspirin or another Antiplatelet • HIV Linkage to Care • Depression Remission at Twelve Months • Antibiotic Avoidance in Children/Adolescents with Upper Respiratory Illness and Adults with Acute Bronchitis

GUIDELINES FOR TYPES OF REVIEWS

Patient Complaints, Adverse Occurrences and Sentinel Events

1. Quality of care concerns and patient complaints that are reported to CHW employees will be thoroughly investigated by the appropriate manager.
2. The appropriate manager will gather and review documentation regarding the incident/complaint including but not limited to, medical records, logs, electronic records, witness written statements, etc.
3. The appropriate manager will draft a chronological report of key findings based on documentation and present the findings to the Executive Director for review.
4. The Executive Director will review for completeness and appropriateness of the findings and formulate recommendations, including, but not limited to, staff and practice expectations, employee corrective actions, training needs, and procedures/guideline development.
5. Depending upon the nature of the infraction, the Chief Compliance Officer may report the incident to The Joint Commission, National Practitioner Databank, Texas Medical Board, Texas Board of Nursing and/or other appropriate professional licensing boards, as well as to law enforcement if necessary.
6. CHW administration will advise appropriate staff of the incident, and any related policies or procedures implemented as a result.

MIDLEVEL SUPERVISORY REVIEWS

1. On a monthly basis, at least 10% of patient visits with mid-levels are electronically selected.
2. The Medical Director or Associate Medical Director reviews these records for appropriate documentation of history, physical exam, diagnosis(es), and plan according to established clinical practice guidelines and evidence-based clinical standards of care.
3. When the Medical Director or designee finds a quality-of-care concern, he or she will document the concern and communicate with recommendations and educate the providers
4. For most frequent findings, the Medical Director or designee provides education on the topic during the monthly in-service. An alternative would be to arrange for a topic expert to present on the subject matter.
5. The Dental Director reviews 10% of the dental hygienist's records at least monthly according to an approved review form and gives feedback to the hygienist(s) at least monthly regarding expected improvements in care or documentation.

DENTAL PEER REVIEW PROCEDURE

Dental reviews are conducted by the Dental Director according to measures discussed and approved by the QA/PI Committee according to a review calendar approved by the QA/PI Committee. Dental Peer Review will continue to serve as a vehicle to evaluate and improve the quality of dental health services at CHW. Monthly measures for dental are reviewed by audit of individual records or data gathered through electronic reports generated from the system. Currently, Dental Peer Review measures are reviewed monthly by the CHW Quality Assurance/Performance Improvement Committee, and feedback from these meetings is presented to all providers by the CHW Dental Director at their department's monthly in-service meeting. Dental Peer review includes the evaluation of each type of procedure offered at CHW.

CHW's Dental Director strictly monitors the peer review process to ensure that every provider:

- Has access to up-to-date evidence for the most common and impactful dental conditions managed in CHW clinics;
- Is aware in a timely fashion of changes in evidence, technology and dental materials and the application of these advances as it relates to patient care; and
- Actively engages with other providers and the dental team as a whole to provide exemplary evidence-based care for our patients.

ABOUT CLINICAL PRACTICE GUIDELINES

The QAPI Committee recommends new and updated Clinical Practice Guidelines that provide an accepted, evidence based, cost-effective standard-of-care for clinical practice at the Coastal Health & Wellness, prioritizing common conditions or prevention. Variations from the standards are acceptable for documented medical reasons. Recommendations are to be submitted in writing, by the Medical Director or Dental Director to the Coastal Health & Wellness Quality Assurance & Performance Improvement Committee for review and possible action.

Recommended Clinical Practice Guidelines should reflect the most frequently addressed health and medical problems at Coastal Health & Wellness, as well as those for which care is delegated to midlevel practitioners (APN/PA) with prescriptive authority.

GALVESTON COUNTY HEALTH DISTRICT COASTAL HEALTH & WELLNESS QUALITY MANAGEMENT PROGRAM FOR DSHS AND HHS FUNDED PROGRAMS

Purpose
This guideline is designed to ensure clinic compliance with contract requirements of Department of State Health Services (DSHS), and Texas Health and Human Services (HHS) funded programs and to promote quality healthcare services for clinic patients.

Laws, Regulations and Policies:
All GCHD/CHW programs abide by the *Civil Rights Act*, including Title VI regarding limited English proficiency, *the Americans with Disabilities Act*, including Section 504 – the *Rehabilitation Act*. Policies pertinent to these laws and their applicability at Coastal Health & Wellness are posted on the employee extranet site. Employees are educated about these policies upon initial hire and annually thereafter.

Abortions: No federal or DSHS funds are used for abortion or for abortion-related activities. No abortion-related activities are conducted in the Coastal Health &Wellness Clinics. No members of the Coastal Health & Wellness Governing Board or administrative staff may sit on a board of an organization that performs or endorses abortions.

Child Abuse Screening, Documenting and Reporting Guidelines: Coastal Health & Wellness staff abides by the DSHS Child Abuse Screening, Documenting and Reporting Policy requirements and posts internal procedures on the employee extranet.

Human Trafficking: Coastal Health & Wellness employees are provided with annual training along with a written policy about human trafficking and resources. The resources are also made available to employees via the extranet.

Domestic and Intimate Partner Violence: Coastal Health & Wellness employees are able to review and obtain written policy/guidelines on Domestic and Intimate Partner Violence on the employee extranet site. The employee extranet also offers staff with patient resources that are transcribed in both English and Spanish.

Cultural and Linguistic Competency: Coastal Health & Wellness receives annual training about requirements for overcoming barriers presented by cultural and linguistic differences, and about best practices when handling such situations.

Clinic Operations
Consent: A general consent for treatment is obtained through the Patient Services area before services are rendered. Patients sign a new general consent each time financial screening is completed. Informed consents are completed by clinical staff before an invasive procedure is performed.

Client Grievance: This procedure is covered in the Coastal Health and Wellness *Operational Policy*, approved annually by the Governing Board. Issues and complaints are addressed and resolved at the lowest possible level, in the most immediate and effective manner. Complaints that are unresolved by staff are addressed by clinic administrative staff, who report the complaint to the department supervisor/manager. The supervisor/manager will then investigate and resolve the complaint in a timely fashion. Those that are not resolved to the patient's satisfaction at the department/manager level are investigated and resolved by the Executive Director or his/her designee. The *Customer Service Policy* also discusses grievance procedures and is available on the employee extranet for review.

Release of Information: The procedures and forms that guide release of patient health information ("PHI") from Coastal Health &Wellness Clinic is posted on the employee extranet site. Fees for documented records are approved by the Governing Board annually and coincide with the fee schedule stipulated by the Texas Medical Association.

Privacy and Confidentiality: Policies that address privacy include the *Work Environment Policy*, *HIPAA Policy*, *Computer and Electronics Usage Policy* and *Employee Ethics and Standards of Conduct Policy*. These policies can be found on the employee extranet.

Format Order Within the Record: Electronic records have specific formats within the medical and dental electronic programs, including templates and summary documents, which are adhered to by default EHR settings.

Record Retention: CHW has a Record Management Program in compliance with Title 6, Subtitle C, Local Government Code (Local Government Records Act), which includes adoption of appropriate records control schedules issued by the Texas State Library and Archives Commission, as well as DSHS and HHS medical record retention schedules. Paper records are retained both on and off-site and are destroyed according to schedule, and only after receiving approval by the Records Management Coordinator and Chief Compliance Officer. Destruction, when appropriate, is accomplished by the outside contractor per contract guidelines.

Infectious Disease Control: Coastal Health & Wellness has an *Infection Control Policy* for all staff that outlines responsibilities for using standard precautions, employee health practices, reporting contagious diseases and how employees are required to handle blood borne pathogen exposures. An *Immunization Policy* also exists for employees and volunteers. The Infection Control Nurse, with assistance from department supervisors, is responsible for the development of procedures for specific components of the infection control program. Coastal Health and Wellness outlines infection control program goals annually, identifies high risk procedures and describes monitoring activities in the *Infection Control Policy*.

Personnel Policies Address:

Job descriptions containing required qualifications and licensure for all personnel including contracted positions: *Hiring Process, Performance Evaluation, Credentialing and Privileging Policy for Professional Staff.*

A written orientation plan for new staff: Orientation Plan for New Staff; Orientation Training PowerPoint presentations on the employee extranet site.

Staff development based on employee needs: Staff development activities are determined by department supervisors or by executive leadership (Executive Director, Medical and Dental Directors) through the process of developing staff in-service agendas on a monthly basis. Activities are determined by standards set forth by regulatory authorities (Joint Commission, Bureau of Primary Care, DSHS, HHS etc.), by results of quality assurance monitoring (chart audits, etc.), by clinical needs (training on new equipment, new processes), compliance with regulatory activities (HIPAA, fraud, etc.) and by organizational needs.

Annual job evaluations of personnel, to include observation of staff/client interactions during clinical, counseling and educational settings: *Performance Evaluation Policy.*

Staff who have contact with clients are appropriately identified (name badge): *Dress Code Policy*

The agency has current Protocols for Physician Assistants (PAs) and Advanced Practice Nurses (APNS), which have been reviewed, agreed upon and signed annually by the physician, PAs and APNs: Well Child Protocols
The agency has current SDOs which have been reviewed, agreed upon and signed annually by the physician that delineates who is authorized to perform specific functions: Medical Director's SDOs for MAs that administer medications

Quality Assurance / Performance Improvement
The agency has a written and implemented internal Performance Improvement Plan used to evaluate services, processes, and operations within the agency. All Coastal Health and Wellness administrative policies and procedures pertinent to federal, state or regulatory stipulations will be reviewed and approved by the Coastal Health & Wellness Quality Assurance/Performance Improvement Committee.

Evaluation of administrative policies and procedures and review of facilities: Approval of administrative policies is the responsibility of the Coastal Health and Wellness Governing Board when applicable and is otherwise tasked to the Galveston County Health District United Board of Health. Policies are reviewed and approved annually by the Board.

Facility Maintenance and Environmental Safety
Review of facilities is accomplished in accordance with the *Safety Manual and Risk Management Policy*, along with Joint Commission Environment of Care policies, *GCHD/CHW Safety Manual* and *Infection Control Plan*. Reports are provided monthly to the Coastal Health & Wellness Infection Control and Joint Commission Committee, and quarterly to the GB Quality Assurance Committee.

Evaluation of eligibility and billing functions: For Title V and other potential DSHS/HHS funded programs, eligibility and billing audits (at least 10 records) are completed at least twice yearly by staff, and results are reviewed by the CHW Quality Assurance/Performance Improvement Committee. When findings fall below 90% compliance per the review tool, quarterly eligibility and billing audits are implemented. On review and recommendation of the Quality Assurance/Performance Improvement Committee, more or less frequent audits may be resumed. It is the responsibility of the CHW Quality Assurance/Performance Improvement Committee to suggest improvement activities when compliance falls below 90%, or whenever such activities are deemed appropriate.

Clinical Record Reviews: For Title V and other potential DSHS/HHS funded programs, data is pulled from the EHR/EDR by the Medical Assistant IV/designated Dental provider and compiled by the Nursing Director and Dental Director. Results are then reviewed and discussed by the CHW Quality Assurance/Performance Improvement Committee. When audit findings demonstrate 90% or more compliance, audits are performed twice yearly with at least five Title V and five Texas Health Steps' medical visits sampled from each clinic site, along with five Title V Dental records sampled from each clinic site. The Title V and Texas Health Step audit tools are utilized for these reviews. When findings demonstrate less than 90% compliance, reviews are conducted quarterly on at least a total of ten Title V and ten Texas Health Steps records that can be from either clinic site. Records chosen for audit are from various providers and selected at random. It is the responsibility of the CHW Quality Assurance/Performance Improvement Committee to suggest improvement activities when compliance falls below 90% or whenever such activities are deemed appropriate. Corrective action may be taken as deemed appropriate.

Adverse Outcomes: Adverse outcomes are broadly defined in the Coastal Health and Wellness *Performance*

Improvement Plan. Adverse outcomes include medication errors, delay in addressing lab results or other delay in diagnosis or treatment, or other adverse outcomes due to services provided.

Adverse outcomes are completely investigated by applicable supervisors as designated by the Executive Director or designee. Root causes are determined when possible, and improvement activities and follow up is completed. Outcomes may be discussed with relevant personnel in the appropriate venue. A discussion of adverse outcomes, to include improvement activities and follow-up, will be addressed in the CHW Quality Assurance/Performance Improvement Committee meetings. If there are no adverse outcomes to report, the minutes will contain documentation of no adverse outcomes.

Client Satisfaction Surveys:–A Governing Board approved survey is given to patients to complete. Survey tallies are reported to the Coastal Health &Wellness Quality Assurance/Performance Improvement Committee on a monthly basis, and to the Governing Board on a quarterly basis.

Prepared for compliance with DSHS/HHS policies and approved by the Quality Assurance Committee on August 10, 2010. Revised per DSHS technical assistance September 3, 2010. Reviewed and approved September 21, 2011; June 14, 2012; July 23, 2013; August 20, 2014; October 21, 2015; December 07, 2017, May 22, 2018; May 18, 2019, July 29, 2020.

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Ami Cotharn MSN, RN Date

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Maryann Choi, MD, MPH, MPH, MS, CMD Date
Coastal Health &Wellness Medical Director

Back to Agenda

Governing Board
October 2022
Item#16
Consider for Approval Coastal Health & Wellness Title V Child Health & Dental Eligibility Policy Submitted by Jennifer Koch

-Approved:
By: CHW Governing Board
-Effective: 09/26/2016

Coastal Health & Wellness Title V Child Health & Dental Eligibility Policy

Purpose
Coastal Health & Wellness (CHW) provides Title V Child Health and Dental services. As a Title V Contractor, CHW is required to perform Title V eligibility screening assessments on pediatric clients who present for services at the clinic.

This policy outlines the Title V Child Health & Dental eligibility requirements.

Definitions
Below are some general definitions of terms or phrases that are used throughout this policy.

- **Case Management** – An individualized approach for each person that involves the integration of personal, social and vocational support services. Case management aims to assist clients to navigate social service systems and attain the highest quality of care.
- **Children Health Insurance Program (CHIP) –** A child health insurance program for non-Medicaid eligible children with family incomes up to 200% Federal Poverty Level (FPL).
- **Children and Adolescents –** A person from his/her 1st birthday through the 21st year of age.
- **Client –** An individual who has been screened, determined to be eligible for services, and has successfully completed the eligibility process.
- **Contractor** – Any entity HHSC has contracted with to provide services. The contractor is the responsible entity even if there is a subcontractor involved who implements the services.
- **Department of State Health Services (DSHS) –** The agency responsible for administering physical and mental health-related prevention, treatment, and regulatory programs for the State of Texas.
- **Eligibility Date –** Date the individual submits a completed application to the provider and is deemed eligible. The eligibility expiration date will be twelve months from the eligibility date.
- **Family Composition** – A person living alone or a group of two or more persons related by birth, marriage (including common law) or adoption, who reside together and who are legally responsible for the support of the other person. **Unborn children are also included in family size.**
- **Federal Poverty Level (FPL)** – The set minimum amount of income that a family needs for food, clothing, transportation, shelter, and other necessities. In the United States, this level is determined by the Department of Health and Human Services. FPL varies according to family size. The number is adjusted for inflation and reported annually in the form of poverty guidelines. Public assistance programs define eligibility income limits as some percentage of FPL.

- **Health and Human Services Commission (HHSC)** – The state agency that has oversight responsibilities for designated health and human services agencies, including DSHS, and administers certain health and human services programs.

- **Medicaid** – Title XIX of the Social Security Act; reimburses for health care services delivered to low-income clients who meet eligibility guidelines.

- **Minor** – A person who has not reached his/her 18th birthday and who has not had the classification of minor removed in court, or who is not or never has been married or recognized as an adult by the state of Texas.

- **Payer Source** – Programs, benefits or insurance that pays for the service provided.

- **Provider** – An individual clinician or group of clinicians who provide services.

- **Re-certification** – The process of re-screening and determining eligibility for the next year.

- **Texas Resident** – An individual who resides within the geographic boundaries of the state.

Policy

It is the Policy of Coastal Health & Wellness to perform Title V eligibility screening assessments on individuals from birth up to their 22nd birthday who present for services and meet the Title V eligibility criteria of (1) Texas residency (2) Gross family income at or below 185% Federal Poverty Level (FPL); and (3) Not eligible for other programs/benefits providing the same services (for example Medicaid/CHIP or other payor sources).

Title V Child Health and Dental Services performed at CHW

A. Child Health Preventive and Primary Health Services

Child Health Infant/child/adolescent preventive and primary health services are provided for ages birth to their 22nd birthday. These services include well child checkups with labs, immunizations and minimal sick care and case management.

B. Child Dental Services

Child Dental Infant/child/adolescent dental services are provided for ages birth to their 22nd birthday. These services include comprehensive and periodic oral evaluations, radiographs; preventative services including cleanings, fluoride treatment, placement of dental sealants to any tooth at risk of dental decay; and therapeutic services including restorative treatment.

Contractor Responsibilities

A. Ensure the eligibility process is complete and include documentation of the following:
   1. Applicant/household member's name, current address, date of birth and whether the applicant/household members are currently eligible for Medicaid or other benefits.
   2. Health insurance policies, if applicable, providing coverage for the applicant, spouse, and dependent(s).
   3. Gross monthly household income of applicant and spouse.
   4. Other benefits available to the household or applicant; and
   5. Any specified or other supporting documentation necessary for the contractor to determine eligibility.

B. Ensure the applicant's household income is at or below 185% of the FPL, documented in the client's record.

C. Assist the applicant with accurately completing the application for screening and eligibility determination.

D. Ensure the documentation the applicant provides is sufficient to make an eligibility decision.

E. Accept reasonable documentation provided by the applicant.

F. Determine eligibility for Title V services based on the required Title V eligibility criteria.

G. Provide the eligible applicant information regarding the Title V services his/her household is entitled to receive and his/her household's rights and responsibilities.

Applicant/Client Responsibilities

A. Complete **Form 3029 Office of Primary and Specialty Health Application for Program Benefits** with the assistance of Patient Services.

B. Provide documents requested by the contractor. Failure to provide all required information will result in dental of eligibility.

C. Report Changes (within 30-days) to CHW in the following areas: income, family composition, residence, address, employment, types of medical insurance coverage, and receipt of Medicaid and/or other third-party coverage benefits.

Texas Health and Human Services Title V Eligibility Screening Forms:

A. **Form 3029, Office of Primary and Specialty Health Application for Program Benefits**

B. **Form 3051, Statement of Self-Employment Income** (with Instructions Form) (English and Spanish)

C. **Form 3049**, **Employment Verification** (English and Spanish)

D. **Form 3056**, **Request for Information** may be used to assist applicants with requested verification requirements for all programs. (English and Spanish)

E. **Form 3046**, **Statement of Applicant's Rights and Responsibilities** (English and Spanish)

F. **Form 3048**, **Notice of Eligibility** (English and Spanish)

Title V- Child Health & Dental Eligibility Process:

Coastal Health & Wellness will perform an eligibility screening assessment on all clients who present for services at a clinic supported by Title V services. If the client has a Medicaid card, this documents their Medicaid eligibility.

A. The eligibility process has two steps in determining and maintaining services:

1. Screening and Eligibility Determination:
   a. Completion of the required screening forms.
   b. Applicant/Client submission of required verification.
   c. Determination of eligibility.
   d. Completion of Statement of Applicant's Rights and Responsibilities.
   e. Completion of Notice of Eligibility.
   f. Applicant/Client will be given copies of (1) Statement of Applicant's Rights and Responsibilities and (2) Notice of Eligibility.

2. Annual Re-Certification: Individual client eligibility will be determined on an annual basis, prompted by the anniversary the client was deem eligible. Coastal Health & Wellness will track the clients' status and renewal eligibility through the clients' Electronic Health Record.

Family Composition

A. Documentation of Client's Family Composition– If family relationship appears questionable, one of the following items shall be provided:

1. Birth Certificate
2. Baptismal certificate
3. School records
4. Other documents or proof of family relationship determined valid by the contractor to establish the dependency of the family member upon the client or head of household.

B. Determine Family Composition/Household size as follows:

1. If married (including common-law marriage), include applicant, spouse, and any mutual or non-mutual children (including unborn).
2. If not married, include applicant and children (including unborn).
3. If not married and living with a partner with whom applicant has mutual children, include applicant, partner, and children (including unborn).
4. A Child who is 18 years of age or older and resides with his/her parent(s)/guardian(s), but is not currently attending high school, GED classes, or vocational or technical training is considered a family of one.

5. The contractor has discretion to document special circumstances in the calculation of family composition. For example, a child may be considered part of a family when living with relatives other than natural parents if documentation can be provided that verifies the relationship.

C. Documentation of Client's Date of Birth shall include one of the following:

1. Birth Certificate
2. Baptismal certificate
3. School records
4. Other documents or proof of date of birth valid by the contractor

Residency

A. Texas Residency Requirement:

An individual must be physically present within the geographic boundaries of Texas and:

1. Has the intent to remain within the state, whether permanently or for an indefinite period.
2. Does not claim residency in any other state or country; and/or
3. Is less than 18 years of age and his/her parent, managing conservator, caretaker, or guardian is a resident of Texas.

B. There is no requirement regarding the amount of time an individual must live in Texas to establish residency for the purposes of Title V eligibility.

C. Although the following individuals may reside in Texas, they are not considered Texas residents for the purpose of receiving Title V services and are considered ineligible:

1. Persons who move into the state solely for the purpose of obtaining health care services.
2. Student primarily supported by their parents; whose home residence is in another State.

D. The following individuals are NOT considered Texas residents for the purpose of receiving services and are considered ineligible:

1. Inmates of correctional facilities.
2. Residents of state schools
3. Patients in state institutions or state psychiatric hospitals

E. Verification/Documentation of Residency will include one of the following:

1. Valid Texas Driver's License
2. Current voter registration
3. Rent or utility receipts for one month prior to the month of application
4. Motor vehicle registration
5. School records
6. Medical cards or other similar benefit cards
7. Property tax receipt
8. Mail addressed to the applicant, his/her spouse, or children if they live together
9. Statement from landlord, neighbor, other reliable sources
10. Other documents considered valid by the contractor

F. Temporary Absences from State – Individuals do not lose their Texas residency status.

Income

All household income received must be included. Household income is calculated before taxes (gross). Income is reviewed and determined either countable or exempt (based on the source of the income), as defined in Office of Primary and Specialty Health (OPSH) Definition of Income (available via the Provider Portal on the HHS website).

A. Documentation of income

The pay periods must accurately reflect the individual's usual and customary earnings. Proof may include, but is not limited to:

1. Copy(ies) of the most recent paycheck stub (at least 2 consecutive pay periods) or monthly earnings statement(s);
2. Employer's written verification of gross monthly income;
3. Award letters;
4. Domestic relation printout of child support payments;
5. Statement of Support;
6. Unemployment benefits statement or letter from the Texas Workforce Commission;
7. Award letters, court orders, or public decrees to verify support payments;
8. Notes for cash contributions; and
9. Other documents or proof of income determined valid by the contractor.

B. Types of income that are Countable:

1. Earned Income - income a person receives for a certain degree of activity or work— related to employment: counted in the month received
2. Unearned income - payments received without performing work-related activities: counted in the month received.

C. Income Countable toward gross family income:

1. Cash gifts and Contributions
2. Child Support payments
3. Disability insurance benefits
4. Dividends, Interest and Royalties
5. Loans (non-educational)
6. Lump-sum payments—count as income in the month received if the person receives it or expects to receive it more than once a year
7. Military Pay
8. Mineral rights
9. Pensions and annuities
10. Reimbursements
11. RSDI Payments
12. Self-Employment Income—must be annualized if intended for family support.
13. SSDI
14. Unemployment Compensation
15. Veteran's Administration (except Exempt VA special needs payments, such as annual clothing allowances or monthly payments for an attendant for disabled veterans).
16. Wages and Salaries, Commissions
17. Worker's Compensation

D. Types of income that are Exempt:

1. Adoption Payments
2. Child's Earned Income
3. Crime Victim's Compensation
4. Educational Assistance
5. Energy Assistance
6. Foster Care Payment
7. In-Kind Income
8. Job Training
9. Lump-Sum Payments –received once a year or less.
10. SSI Payments
11. TANF
12. VA Payments –special needs payments

Income Determination Procedure

A. Count income already received and any income the household expects to receive. If the household is not sure about the amount expected or when the income will be received, Coastal Health and Wellness will use the best estimate.

B. Coastal Health and Wellness will count terminated income in the month received and use actual income, not the conversion factors if terminated income is less than a full month's income.

C. Use at least two consecutive, current pay periods to calculate projected monthly income. If client is paid one time per month and receives the same gross pay each month, then one pay period will suffice.

D. If actual or projected income is not received monthly, convert it to a monthly amount using one of the following methods:
    1. Weekly income is multiplied by 4.33.
    2. Income received every two weeks is multiplied by 2.17.
    3. Income received twice monthly is multiplied by 2.

Income Deductions

A. Dependent childcare or adult with disabilities care expenses shall be deducted from total income in determining eligibility, if paying for the care is necessary for the employment of a member of the household.

B. Allowable deductions:
    1. Actual expenses up to $200.00 per child per month for children under age 2
    2. Actual expenses up to $175.00 per child per month for children age 2 or older, and
    3. Actual expenses up to $175.00 per adult with disabilities per month

C. Child support payments made by a member of the household group will also be deducted. Payments made weekly, every two weeks or twice a month must be converted to a monthly amount by using one of the conversion factors in the Income Calculation form.

Self-Employment Income

A. If an applicant earns self-employment income, it must be added to any income received from other sources.

B. Annualize (annual return on investment) self-employment income that is intended for an individual or family's annual support, regardless of how frequently the income is received.

C. **Determine the costs of producing self-employment income by allowing the following deductions:** Capital asset improvements; Capital asset purchases, such as real property, equipment, machinery and other durable goods (in the last 12 months); Fuel; Identifiable costs of seed and fertilizer; Insurance premiums; Interest from business loans on income producing property; Labor; Linen service; Payments on the principal of loans for income producing property; Property taxes; Raw materials; Rent; Repairs that maintain income-producing property; Sales tax; Stock; Supplies; Transportation costs (50 cents per mile), Utilities.

D. If the applicant conducts a self-employment business in his home, consider the cost of the home (rent, mortgage, utilities) as shelter costs, not business expenses, unless these costs can be identified as necessary for the business separately.

E. If the self-employment income is only intended to support the individual or family for part of the year, average the income over the number of months it is intended to cover.

F. If the individual has had self-employment income for the past year, use the income figures from the previous year's business records or tax forms.

G. If current income is substantially different from income the previous year, use more current information, such as updated business ledgers or daybooks. Remember to deduct predictable business expenses.

H. If the individual or family has not had self-employment income for the past year, average the income over the period of time the business has been in operation and project the income for one year.

~~I.~~ If the business is newly established and there is insufficient information to make a reasonable projection, calculate the income based on the best available estimate and follow-up at a later date~~.~~

J. A signed Self declaration of Income from individuals who are self-employed and have no documentation of their income will be accepted with manager approval. Title V coverage cannot be extended on subsequent applications without formal verification and documentation of self-employment income.

Seasonal Employment

Include the total income for the months worked in the overall calculation of income. The total gross income for the year can be verified by a letter from the individual's employer, if possible.

Statements of Support
The Statement of Support is used to document income when no supporting documentation is available or when income is irregular. If questionable, the Contractor may document proof of identification such as a Texas Driver's License, Social Security card, or a birth certificate of the supporter.

Reporting Changes
A. Coastal Health & Wellness will advise the client of his/her responsibility to report changes; and determine the effect reported changes have on the client's eligibility by re-screening and completing the eligibility determination process.
B. Coastal Health & Wellness will explain to the client that they must report changes in the following areas: income, family composition, residence, address, employment, types of medical insurance coverage, and receipt of Medicaid and/or third-party coverage benefits.
C. Coastal Health & Wellness will encourage client to report changes by mail, telephone, in-person, or through someone acting on the individual's behalf no later than 30 days after the client is aware of the change.

No Co-pays
Coastal Health & Wellness will not charge clients co-pays for Title V medical and dental services.

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Consider for Approval Consumer Board Member Cynthia Darby to serve on the Appointing Committee Submitted by Samantha Robinson

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Consider for Approval Nominee Courtni Tello, RDH, DDS to fill the Community Representative/Interim Vice Chair Position through June 2023

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