COASTAL HEALTH & WELLNESS

GOVERNING BOARD

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

AMENDED
AGENDA
Thursday, July 27, 2023 12:30 PM

As of September 1, 2021, a quorum must be physically present at the meeting in order to utilize videoconferencing. Pursuant to § 551.127 of the Act:

A member or employee of a governmental body may participate remotely and be counted as present if the video and audio feed of the member's or employee's participation is broadcast live at the meeting.

CONNECTING VIA INTERNET:
Access the URL: https://us06web.zoom.us/j/85643547787?pwd=ZW90dW42ZFhQK3c4U2NrYXM4c082dz09
Meeting Password: **360285**
An automated prompt should appear on your screen; when it does, click "Open Zoom Meetings."

1. If you would prefer to use your computer for audio connection, please do the following:
    a. When prompted, select "Join Audio"?
    b. Another popup box will appear, select the tab, "Computer Audio."
    c. Now click the box stating, "Join with Computer Audio." Your connection to the meeting will be automatically established upon doing so.
2. If you would prefer to utilize a phone for your audio connection, please do the following:
    a. Mute your computer's volume.
    b. When prompted, select "Join Audio"?
    c. Another popup box will appear, select the tab, "Phone Call."
    d. You will be presented with a Dial-In, Audio Code, and Participant ID. Call the Dial-In number from your phone and follow the subsequent voice prompts. Your connection to the meeting will be automatically established upon doing so.

CONNECTING VIA PHONE (AUDIO ONLY):

1. Dial 346-248-7799
2. You will be prompted to enter the Meeting ID, which is **856 4354 7787**# Meeting Password: **360285**
3. Finally, you will be instructed to enter your Participant ID. When this occurs, merely select the pound (hashtag) key without entering any numbers. Your connection to the meeting will be automatically established upon doing so.

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 #2ACTION**.....Agenda

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

*Item #4**ACTION**.....Consider for Approval Minutes from June 29, 2023 Governing Board Meeting

*Item #5**ACTION**.....Consider for Approval Minutes from July 13, 2023 QA Board Committee Meeting

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

*Item #7**ACTION** .....Consider for Approval Quarterly Visit and Collection Report Including a Breakdown by Payor Source for Recent New Patients

*Item #8**ACTION**.....Consider for Approval Quarterly Compliance Report for the Period Ending June 30, 2023

*Item #9**ACTION**.....Consider for Approval Coastal Health & Wellness Service Area Annual Review Policy

*Item#10**ACTION**.....Consider for Approval Coastal Health & Wellness Revised Infection Control Plan

*Item#11**ACTION**.....Consider for Approval Coastal Health & Wellness Revised Credentialing and Privileging Policy

*Item#12**ACTION**.....Consider for Approval Forvis Review Project

*Item #13**ACTION**.....Consider for Approval Benefit Package for UKG

Item #14**ACTION**.....Consider for Approval June 2023 Financial Report Submitted by Trish Bailey

Item #15.....Coastal Health & Wellness Updates

a) Current Public Health Concerns and Status; COVID/Flu/Monkey Pox Submitted by Executive Director
b) Operational Updates/Coastal Wave Submitted by Chief Operating Officer
c) Dental Updates Submitted by Dental Director
d) Medical Updates Submitted by Medical Director

Item #16.....Comments from Board Members

Adjournment

Next Regular Scheduled Meeting: August 31, 2023

Appearances before the Coastal Health & Wellness Governing Board

A speaker whose subject matter as submitted relates to an identifiable item of business on this agenda will be requested by the presiding officer to come to the podium where they will be limited to three minutes (3). A speaker whose subject matter as submitted does not relate to an identifiable item of business on this agenda will be limited to three minutes (3) and will be allowed to speak before the meeting is adjourned. Please arrive prior to the meeting and sign in with Galveston County Health District staff.

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
July 2023
Item#3
Excuse Absence(s)

Back to Agenda

Governing Board
July 2023
Item#4
Consider for Approval Minutes from June 29, 2023
Governing Board Meeting

Coastal Health & Wellness
Governing Board
June 29, 2023

Board Members:

Samantha Robinson
Dr. Tello
Elizabeth Williams
Sergio Cruz
Rev. Walter Jones
Clay Burton
Flecia Charles
Donnie VanAckeren
Victoria Dougharty
Kevin Avery
Cynthia Darby
Dr. Thompson

Staff:

Ami Cotharn, Chief Operations Officer
Hanna Lindskog, Dental Director
Kenna Pruitt
Jennifer Koch
Tiffany Carlson
Virginia Lyle
Judie Olivares
Pisa Ring
Wendy Jones
Ashton Martin
Debra Howey
Tikeshia Thompson-Rollins
Anthony Hernandez

Excused Absence: N/A
Unexcused Absence: Sharon Hall, Ivelissa Caban
Guest: Godwin Okoye

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

Items#2-6 Consent Agenda
A motion was made by Sergio Cruz to approve the consent agenda items two through six. Elizabeth Williams seconded the motion, and the Board unanimously approved the consent agenda.

Item#7 Consider for Approval FY2022 Independent Auditor's Report and Financial Statement and Single Audit Reports
Samantha Robinson, Board Chair, asked the Board to consider for approval the FY2022 independent audit report presented by Godwin Okoye with Bankole, Okoye & Associates, P.C. Godwin Okoye, remonnended the following.

1. Review and reconcile the Clinic's General Ledger Account No. 02-00-00-1110: Patient A/R.
2. Consider requesting NextGen software vendor to reset or reprogram the software to always generate financial reports based on Transaction Posting Dates instead of Patient Service Dates.

Samantha Robinson, recommended that the finance committee be informed of the recommended changes from Bankole, Okoye & Associates and receive a summary when completed. A motion to accept the financial report as presented was made by Rev. Jones. Sergio Cruz seconded the motion and the Board unanimously approved.

Item#8 Consider for Approval May 2023 Financial Report Submitted by Trish Bailey
Kenna Pruitt, CHW Financial Accountant, presented the May 2023 Financial Report. A motion to accept the financial report as presented was made by Donnie VanAckeren. Clay Burton seconded the motion and the Board unanimously approved.

Item#9 Consider for Approval Coastal Health & Wellness Patient Experience Policy and Procedure Submitted by Ami Cotharn
Ami Cotharn, Chief Operating Officer, asked the Board to consider for approval the Coastal Health & Wellness Patient Experience Policy and Procedure. A motion to accept the policy/procedure as presented was made by Donnie VanAckeren. Flecia Charles seconded the motion and the Board unanimously approved.

Item#10 Consider for Approval OSIS NextGen Services Submitted by Ami Cotharn

Ami Cotharn, Chief Operating Officer, asked the Board to consider for approval OSIS NextGen services. A motion to accept the nextgen service as presented was made by Sergio Cruz. Victoria Dougharty seconded the motion and the Board unanimously approved.

Item#11 Consider for Approval the Reappointment of the following Coastal Health & Wellness Governing Board Members for a 2 Year Term Expiring June 2023

Samantha Robinson, Board Chair, asked the Board to consider for approval the reappointment of the following Coastal Health & Wellness Governing Board members for a 2-year term expiring June 2023. A motion to accept the following Board members for reappointment as presented was made by Victoria Dougharty. Cynthia Darby seconded the motion and the Board unanimously approved.

- Courtni Tello, RDH, DDS (Community Member)
- Elizabeth Williams (Community Member)
- Ivelisse Caban (Consumer Member)
- Sharon Hall (Community Member)
- Cynthia Darby (Consumer Member)
- Rev. Walter Jones (Community Member)
- Flecia Charles (Consumer Member)

Item#13 Coastal Health & Wellness Updates

a) Current Public Health Concerns and Status; COVID/FLU/Monkey Pox Submitted by Executive Director
b) Operational Updates/Coastal Wave Submitted by Chief Operating Officer
c) Dental Updates Submitted by Dental Director
d) Medical Updates Submitted by Medical Director

Ami Cotharn, Chief Operating Officer, presented the June 2023 Coastal Wave.

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

- Samantha requested that Dr. Keiser speak on Malaria at the July Board meeting.
- Rev. Jones raised a question regarding Economy Plasma. Ami will look into and bring back her findings.

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

- Visit Numbers
    - May 2022: 781
    - May 2023: 788
    - 0.9% increase
    - Part time provider out 7 days in May
    - Expect to see a drop in June numbers due to one full-time provider being out 3 weeks and another full-time provider being out 1 week
    - We have increased the designated appointment slots for emergencies during this time period
    - We have also started to see walk in patients in pain as we are able to fit them into our schedule
- Current projects, plans, department overview for dental
    - Sterilization Renovation – We are finalizing the plans for redesigning a section of our sterilization area in Texas City. This will allow us to add two more sterilizers to be more efficient and help meet sterilization needs.
    - The new dental chairs for Galveston are on order.
    - We are still waiting for our old images to be transferred to the Cloud for the new x-ray program and expected it to be complete by 5/25/2023. However, they ran into some mapping issues which

were expected to be resolved by 6/19/2023. Dr. Lindskog has been frequently communicating with SOTA and we hope to have the issue resolved ASAP.
    - Dr. Lindskog continues to serve on the COM Hygiene School Advisory Board. As previously reported, their application for accreditation has been submitted to CODA and they are hoping to enroll their first class of students for Fall 2024.
    - The bill related to dental hygienists administering anesthesia was signed by the Governor. We will stay informed of any education opportunities to train our dental hygienists to administer local anesthesia.
- Provider Education Opportunities
    - All providers continue to select and participate in continuing education of their choice. They also share knowledge from these courses with the other providers during monthly meetings.
- Barriers or Needs (if applicable)
    - Provider Staffing: As previously reported, our new dental hygienist started on 5/25/2023. She has over 20 years of experience as a dental hygienist, and we are excited to have her on the team. She began seeing patients on her own with a modified schedule on 6/22/2023.
    - Assistant Staffing: We currently have one dental assistant opening. This position has been open since March 2023, but our Dental Assistant Supervisor has been out on FMLA since April. She returned on June 13th and we are in the process of interviewing applicants.

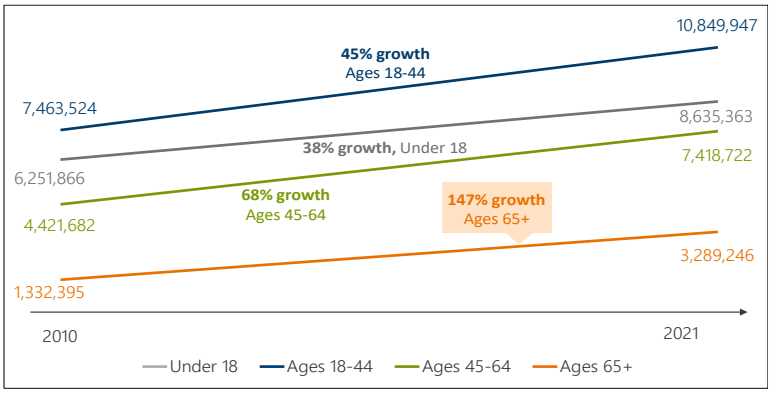
Maryann Choi, Medical Director, updated the Board on Medical services in the Coastal Health & Wellness Clinic.

The Community Health Center Chartbook 2023 key points

- Health Centers Serve all Patients Regardless of Insurance Status
    - Medicaid 48%
    - Medicare 11%
    - Private insurance 20%
    - Uninsured 20%
    - Other public insurance 1%

- Health Center Patients Suffer from Chronic Conditions at Higher Rates than the General Population

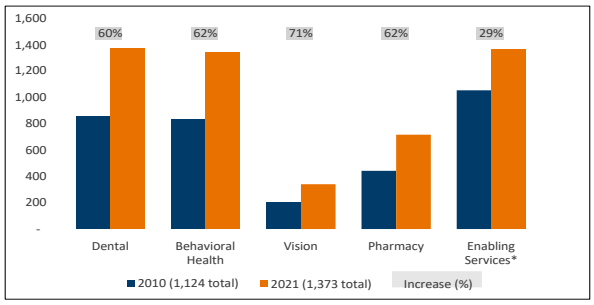
- Health Center Patients Ages 65 and Older are the Fastest Growing Age Group Over the Past Decade: 147% growth Ages 65plus



Health Centers Expanding Access to Care

Health Centers Have Expanded Onsite Services

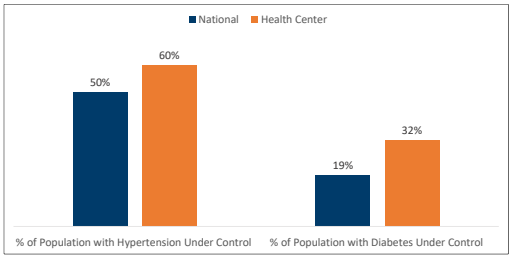
Number of Health Centers Employing Staff (Full-time Equivalent) for Selected Services



* The Health Resources and Services Administration (HRSA) defines enabling services as, "non-clinical services that do not include direct patient services that enable individuals to access health care and improve health outcomes." Examples of enabling services include case management, translation/interpretation, transportation, and health education.

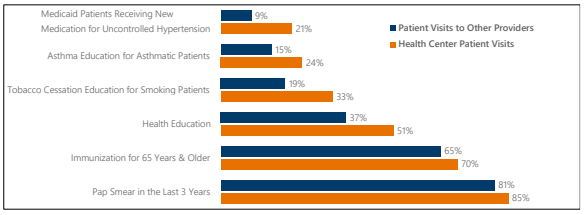
- **Health centers provide High-Quality Care and Reducing Health Disparities**

Health Centers Achieve Higher Rates of Hypertension and Diabetes Control than the National Average, Despite Serving More At-Risk Patients



Sources: (1) NACHC Analysis of 2021 Uniform Data System, Bureau of Primary Health Care, HRSA, DHHS. (2) CDC, Million Hearts. March 2021. Estimated Hypertension

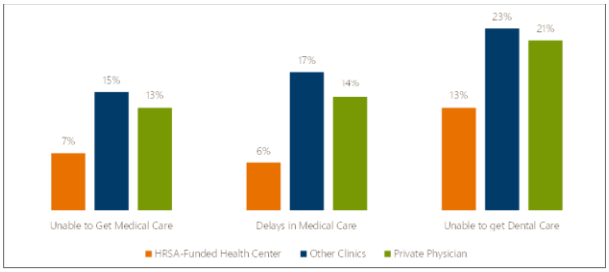
Health Centers Provide More Preventive Services than Other Primary Care Providers



Sources: (1) Shi L, Tsai J, Higgins PC, Lebrun La. (2009). Racial/Ethnic and Socioeconomic Disparities in Access to Care and Quality of Care for U.S. Health Center Patients Compared with Non-Health Center Patients. J Ambul Care Manage 32(4): 342 – 50. (2) Shi L, Lebrun L, Tsai J and Zhu J. (2010). Characteristics of Ambulatory Care Patients and Services: A Comparison of Community Health Centers and Physicians' Offices J Health Care for Poor and Underserved 21(4): 1169-83. (3) Hing E, Hooker RS, Ashman JJ. (2010). Primary Health Care in Community Health Centers and Comparison with Office-Based Practice. J Community Health. 2011 Jun; 36(3): 406 - 13. (4) Fontil et al. Management of

Health Centers Reduce Unmet Health Care Needs

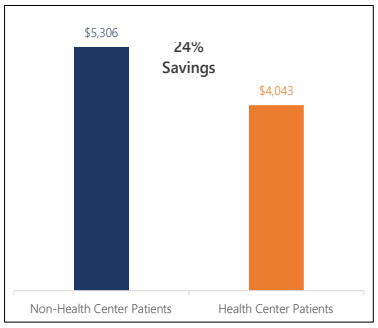
Percent of Patients Experiencing Unmet Care Needs or Delayed Care by Source of Care



- Health Centers provide Cost-Effective Care

Health Centers Save $1,263 Per Patient Per Year

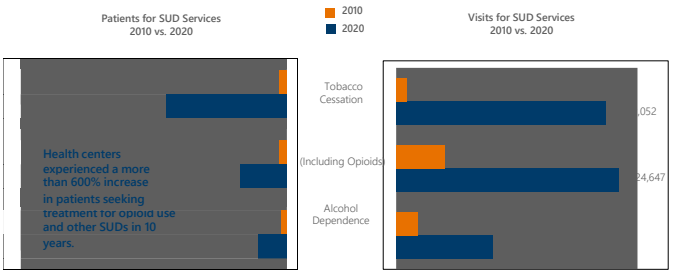
Total Health Expenditures Per Patient Per Year



- Health centers are seeing more patients with Substance Use Disorder

Figure 5-12

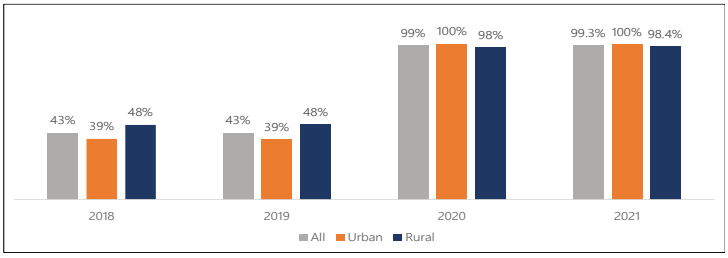
Health Centers are Seeing More Patients for Substance Use Disorder (SUD) Treatment and Therapy

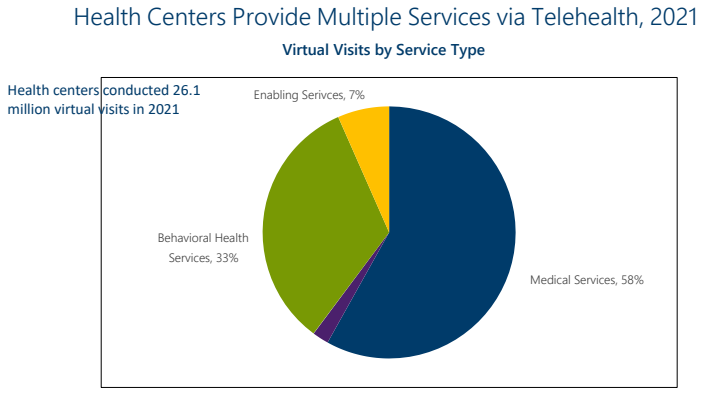


- Health Centers are Using Telehealth to Expand Access to Needed Services

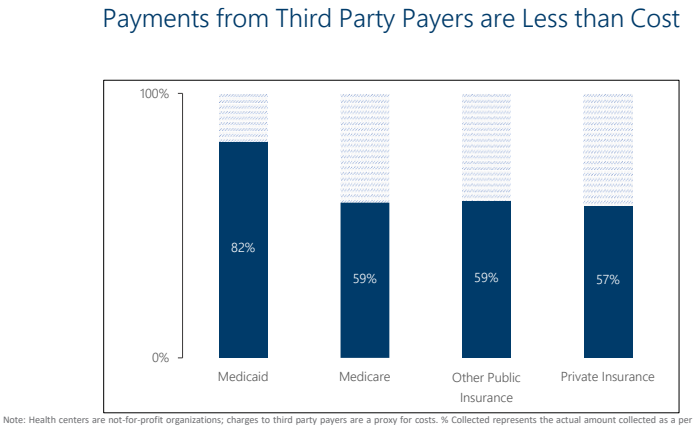
Health Centers' Telehealth Utilization Increased Dramatically from 2018 - 2021

% of Health Centers Offering Telehealth Services by Location

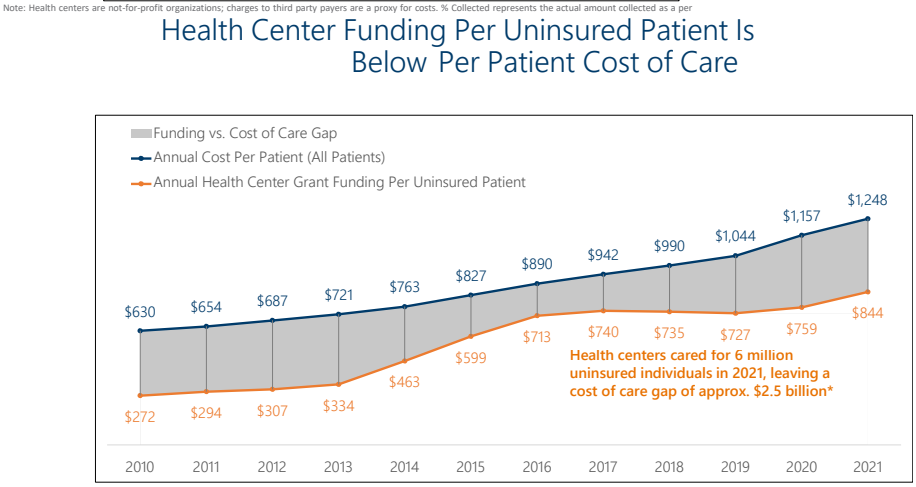




- Challenges in Meeting Demand for Care



Note: Health centers are not-for-profit organizations; charges to third party payers are a proxy for costs. % Collected represents the actual amount collected as a per



*Calculated by taking the difference between 2021 cost per patient (all patients) and 2021 health center funding per uninsured patient, then multiplying by the number of

Item #13 Comments from Board Members

No comments from the Board

The meeting was adjourned at 1:43p.m.

_____ _____

Chair Secretary/Treasurer

_____ _____

Date Date

Back to the Agenda

Governing Board
July 2023
Item#5
Consider for Approval Minutes from July 13, 2023
QA Board Committee Meeting

Coastal Health & Wellness Governing Board

Quality Assurance Committee Meeting
July 13, 2023

BOARD QA COMMITTEE MEMBERS:
Kevin Avery-Consumer Member
Sharon Hall-Community Member

EMPLOYEES PRESENT:
Ami Cotharn (Chief Operations Officer), Dr. Lindskog (Dental Director), Jason Borillo (Director of Innovation and Clinical Quality), Tiffany Carlson (Nursing Director), Jennifer Koch, (Enabling Services Manager), Pisa Ring (Patient Services Manager), Virginia Lyle (Lab/X-Ray Manager), Wendy Jones (Compliance & Risk Management Officer), Tyler Tipton (Public Health Emergency Preparedness Manager) Judie Olivares (Human Resources Manager), Debra Howey (Infection Control Nurse), 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 Submitted by Pisa Ring ➢ Quarterly Patient Satisfaction Report Submitted by Pisa Ring ➢ Call Quality Performance Submitted by Pisa Ring ➢ Quarterly Visit and Collection Report Including a Breakdown by Payor Source for Recent New Patients Submitted by Ami Cotharn	**Quarterly Access to Care Report** • Report reviewed; 2nd quarter (April, May, and June) no-show rate is at 26%. **Quarterly Patient Satisfaction Report** • Report reviewed; overall average for 1st quarter is 4.59. **Call Quality Performance** • Report reviewed; Report reviewed, Pisa will update the call back queue numbers and submit to Tikeshia and Anthony. **Quarterly Visit and Collection Report Including a Breakdown by Payor Source for** • Report reviewed; No Action
Clinical Measures ➢ Quarterly Report on UDS Medical Measures in Comparison to Goals Submitted by Jason Borillo	**Clinical Measures** • UDS measures were reviewed and will be brought back to the Committee October 2023
Quality Assurance/Risk/Management/ Emergency Management Reports ➢ Quarterly Risk Management Report Submitted by Wendy Jones ➢ Dental Quarterly Summary Submitted by Dr. Lindskog ➢ Quarterly Emergency Management Report Submitted by Tyler Tipton	**Quarterly Risk Management Report** • Wendy will make the recommended changes to hand hygiene, and summary of complaints document to reflect resolution. **Dental Quarterly Summary** • Report reviewed; No Action **Quarterly Emergency Management Report** • Tyler reviewed the Emergency Management Report and gave an update on training and plans that occurred during the quarter.
Plans and Policies ➢ Coastal Health & Wellness Service Area Annual Review Policy Submitted by Jennifer Koch	**QAPI Plan (revisions) 2022-2023** • Policy reviewed; No Action

Next Meeting: October 12, 2023

Back to Agenda

Governing Board
July 2023
Item#6
Consider for Approval Quarterly
Investment Report

Coastal Health & Wellness
Investment Report
For the period ending June 30, 2023

Coastal Health & Wellness	Money Market Account		
	Apr	May	June
Beginning Balance	6,810,068	5,770,328	2,839,002
Deposits	505,000	759,815	1,135,000
Withdrawals	(1,560,000)	(3,699,710)	(285,000)
Interest Earned	15,261	8,569	7,246
Ending Balance	$5,770,328	$2,839,002	$3,696,249
Current Annual Yield	3.04%	3.04%	3.04%
Previous Quarter Yield (1/2023 - 3/2023)	2.27%	2.27%	2.36%

Tex Pool Investments		
Apr	May	June
27,173	777,773	2,789,578
750,000	2,000,000	-
-	-	-
600.74	11,804.29	11,588.47
777,773	2,789,578	2,801,166
4.80%	4.98%	5.05%
4.24%	4.50%	4.61%

Summary	Interest Earned	Avg Balance	Yield
October 1, 2022 to December 31, 2022	30,966	6,862,379	0.67%
January 1, 2023 to March 31, 2023	33,912	6,007,686	0.83%
April 1, 2023 to June 30, 2023	55,070	6,145,442	0.87%
July 1, 2023 to September 30, 2023	-	-	
YTD Totals	$119,947	$6,338,503	2.37%

Back to Agenda

Governing Board
July 2023
Item#7
Consider for Approval Quarterly Visit and Collection Report Including a Breakdown by Payor Source for Recent New Patients

Coastal Health & Wellness - Quarterly Visit & Analysis Report
for the period ending June 30, 2023
**based on UDS Reporting period (January 1 to December 31) Qualified Encounters*

Total Visits by Financial Class	June 2023	June 2022	% Change	* YTD Average 2023	* YTD Average 2022	% Change		* YTD Payor Mix 2023	* YTD Payor Mix 2022	% Change
Self Pay	1,900	1,509	26%	1,802	1,360	32%		60.0%	66.3%	-6.4%
Medicare	254	108	135%	216	111	94%		7.2%	5.4%	1.8%
Medicaid	309	223	39%	324	215	50%		10.8%	10.5%	0.3%
Contract	89	67	33%	83	60	37%		2.8%	2.9%	-0.2%
Private Insurance	540	259	108%	480	264	82%		16.0%	12.9%	3.1%
Title V	120	39	208%	100	40	151%		3.3%	2.0%	1.4%
Total	**3,212**	**2,205**	46%	**3,004**	**2,050**	47%		**100%**	**100%**	

Department	* YTD Total Visits 2023	* YTD Total Visits 2022	% Change
Medical	12,845	7,829	64%
Dental	4,706	4,117	14%
Counseling	473	545	-13%
Total	**18,024**	**12,491**	**44%**

Unduplicated Visits	* YTD Total Users 2023	* YTD Total Users 2022	% Change
Medical	6,016	4,400	37%
Dental	1,828	1,523	20%
Counseling	122	153	-20%
Total	**7,966**	**6,076**	**31%**

NextGen / Crystal Reports - Summary Aging by Financial Class
for the period ending June 30, 2023 (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	$64,868.15	$60,092.73	$ 54,898.36	$ 54,110.37	$ 53,507.13	$ 44,995.19	($44,011.63)	$ 288,460.30	29%	92	124
Medicare	$65,388.37	$30,037.35	$ 15,251.81	$ 19,958.78	$ 19,064.59	$ 23,795.62	($4,236.33)	$ 169,260.19	17%	113	270
Medicaid	$63,992.37	$52,873.28	$ 53,115.27	$ 74,083.17	$ 38,820.87	$ 37,748.87	($3,630.48)	$ 317,003.35	32%	121	161
Contract	$16,007.83	($4,718.92)	$ 5,631.10	($4,272.50)	$ (984.39)	$ 1,075.73	($9,458.22)	$ 3,280.63	0%	5	64
Private Insurance	$78,979.78	$34,558.61	$ 32,338.67	$ 48,625.83	$ 39,464.88	$ 21,668.32	($18,778.18)	$ 236,857.91	24%	103	252
Title V	$22,112.64	$11,924.10	$ 13,034.62	$ 60.33	$ 409.12	$ 328.89	$ 3,208.77	$ 51,078.47	5%	112	321
Unapplied	($86,505.65)	$0.00	-	-	-	-	-	$ (86,505.65)	-9%	(8)	(10)
Totals	**$224,843.49**	**$184,767.15**	**$ 174,269.83**	**$ 192,565.98**	**$ 150,282.20**	**$ 129,612.62**	**($76,906.07)**	**$ 979,435.20**	**100%**	**77**	**169**

Previous Quarter Balances	$217,825	$229,825	$158,770	$145,155	$137,431	$131,044	$1,039,659	$2,059,709
% Change	3%	-20%	10%	33%	9%	-1%	-107%	-52%

Charges & Collections	June 2023	June 2022	% Change	* YTD 2023	YTD 2022	% Change
Billed	$1,053,110	$737,133	43%	$5,967,302	$4,131,621	44%
Adjusted	(658,118)	(535,340)	23%	($4,037,427.31)	$ (2,963,513.45)	36%
Net Billed	$394,992	$201,793	96%	$1,929,875	$1,168,107	65%
Collected	$557,001.00	$226,729	146%	$ 2,489,899.01	$1,236,363	101%
% Net Charges collected	141%	112%	26%	129%	106%	22%

Payor	YTD Current Period				YTD Prior Year			
	Visits	*Payor Mix*	*Net Revenue per Visit*	*(Net Billed) Net Revenue*	*Visits*	*Payor Mix*	*Net Revenue per Visit*	*(Net Billed) Net Revenue*
Self Pay	10,810	60.0%	$52.41	$566,574	8,159	66.3%	$58.07	$473,792
Medicare	1,296	7.2%	$207.48	$268,897.47	668	5.4%	$146.08	97,582
Medicaid	1,941	10.8%	$242.36	$470,427.43	1,290	10.5%	$180.62	233,003
Contract	497	2.8%	$253.30	$125,889.65	362	2.9%	$343.06	124,187
Private Insurance	2,878	16.0%	$144.46	$415,745.90	1,581	12.9%	$130.87	206,910
Title V	602	3.3%	$136.78	$82,340.00	240	2.0%	$135.97	32,632
Total	18,024	100%	$107.07	$1,929,875	12,300	100%	$94.97	$1,168,107

Item	2023	2022
Self Pay - Gross Charges	$3,292,791	$2,443,577
Self Pay - Collections	734,541	$475,663
% Gross Self Pay Charges Collected	**22.3%**	**19.5%**
% Net Self Pay Charges Collected	**129.6%**	**100.4%**

Q2 New Pts. By Financial Class	
Payor - Financial Class	**Q2 2023 # of New Pts.**
CIHCP	2
Commercial - Dental	11
Commercial - Medical	180
Medicare Advantage	7
Medicaid - Medical	50
Medicaid - Dental	1
Medicare	51
Self Pay	494
Title V Medical	26
Title V Dental	6
Total New Pts. Q2 2023	**837**
Total New Pts. Charges Q2 2023	**$266,053.54**

Back to Agenda

Governing Board
July 2023
Item#8
Consider for Approval Quarterly Compliance Report for the Period Ending June 30, 2023

Coastal Health & Wellness Governing Board
Quarter 2 (April - June), FY2023 Compliance Report

Internal Audits		
AUDITOR- DATE CONDUCTED	***TYPE OF AUDIT & FINDINGS***	***ACTION TAKEN***
Nursing Director April 1, 2022 – June 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. • 10 charts were audited from each clinic: • MCA 100% Compliant • ICC 90% Compliant (documentation)	• Continue operating under current protocol. • The audit was reviewed during the Quality Assurance & Performance Improvement meeting.
Nursing Director April 1, 2023 – June 30, 2023	**Abnormal Pap Audit:** • MCA: 19 charts were audited for compliancy with follow up care; (2) missed opportunities were found for an 89% compliancy with provider follow up. • ICC: 10 charts were audited for compliancy with follow up care: (3) missed opportunities were found for a 63% compliancy rate with provider follow up care.	• The Nursing Director communicated all findings with the Medical Director for review and discussion with providers during training.
TV Well Child Audit - Screening April 1, 2023 – June 30, 2023	**Record Review encompassed review of 10 charts for ea. age group** • Comprehensive Health and Development History • Laboratory Screening • Comprehensive Physical Examination **0-4 years** • 98% Compliant **5-11 years** • 95% Compliant **12-18 years** • 92% Complaint Grand Total: overall 95% Compliancy	• Continue operating under current protocol.
AUDITOR –	***TYPE OF AUDIT & FINDINGS***	***ACTION TAKEN***

Coastal Health & Wellness Governing Board
Quarter 2 (April - June), FY2023 Compliance Report

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

Warning and Termination Letters	
REASON	***TYPE OF LETTER***
Inappropriate communication with Medical Provider	Warning Letter

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.

Back to Agenda

Governing Board
July 2023
Item#9
Consider for Approval Coastal Health & Wellness
Service Area Annual Review Policy

Approved:
By:
Effective:

COASTAL HEALTH & WELLNESS
SERVICE AREA ANNUAL REVIEW POLICY

BACKGROUND

Each year, Coastal Health & Wellness's (CHW) Governing Board reviews the organization's strategic plan to assess services and progress. This assessment includes a review of the service area and patient population. CHW maps the existing service area and generates a patient origin analysis based on the previous year's Uniform Data Systems (UDS) metrics. The Center ensures that the service area represents at least 75% of the ZIP codes from which existing patients originate. CHW uses this data to generate an updated strategic plan that includes estimates for the number of patients and visits for the coming year and goals focused on addressing the service area's most common health concerns.

POLICY

It is the policy of Coastal Health & Wellness to conduct a service area review annually as required by Health Resources & Services Administration (HRSA).

DEFINITIONS

Health Resources & Services Administration (HRSA) - an agency of the U.S. Department of Health and Human Services who is the primary federal agency for improving health care to people who are geographically isolated, economically or medically vulnerable.

Public Health Service Act - federal law enacted in 1944 that provides legal authority for the Department of Health and Human Services (HHS) to respond to public health emergencies

Service Area – CHW's service area is composed of twenty Galveston County, Texas ZIP codes Service areas are along the Gulf Coast of Texas, approximately 80 miles southwest of the Louisiana state line. The Gulf of Mexico serves as the county's boundary to the southeast, and Harris County/City of Houston metropolis is the boundary to the north.

Uniform Data Systems (UDS) - standardized data set and annual program requirement that is defined in Section 330 of the Public Health Service Act.

GUIDELINES

Per HRSA guidelines, CHW is required to annually review service area zip codes by comparing zip codes in our scope of Form 5B: Service Sites with patient origin data reported by zip code in the UDS. The annual review of a health center's service area may be conducted in a number of ways (for example, as part of submission of a competitive application or as a "stand-alone" activity during the year, such as review of annual UDS patient origin data or other data on where patients reside).

PROCEDURE

1. Utilize the UDS Mapper website to identify target populations that remain unserved by Health Center Program (HCP) awardees and look-alikes reporting data to the UDS (but may be served by other providers).
2. This data will be used and compared with previous year's data to update our strategic plan and goals for the future.

Back to Agenda

Governing Board
July 2023
Item#10
Consider for Approval Coastal Health & Wellness
Revised Infection Control Plan

Coastal Health & Wellness (CHW)
2023 Infection Control Plan

Introduction Update

The CHW Infection Control Plan (ICP) has been developed as part of the CHW Infection Prevention and Control Program (IPCP). The primary goal of an infection prevention and control program (IPCP) is to prevent health care-associated infections (HAIs). Its purpose is to provide guidelines, procedures, and practices to reduce the risk of spreading infectious diseases, promote safer work practices in caring for patients and others, and to assist staff in conforming to standards, evidence-based rules, regulations, and practices.

This plan has been developed utilizing a hierarchical method to address the various IPC requirements relevant to the organization.

Including:

A. Local, state, and federal rules and regulations (such as those from the Occupational Safety and Health Administration [OSHA] and the Food and Drug Administration [FDA]).
B. Centers for Medicare & Medicaid Services (CMS) Conditions of Participation (CoPs) and Conditions for Coverage (CfCs) particularly for those healthcare organizations using Joint Commission accreditation for CMS deemed status purposes.
C. Manufacturer's instructions for use (IFU).
D. Consensus Documents.
E. Evidenced-based guidelines and national standards (such as Joint Commission standards) and guidance from the CDC and WHO.

Guidelines established by the Centers for Disease Control (CDC) and Prevention incorporates guidance and recommended practice for sterilization set forth by the Association for the Advancement of Medical Instrumentation (AAMI).

Leadership approves the annual Infection Control Plan (ICP) and supports its implementation strategies.
IC.01.05.01 The organization has an infection prevention and control plan.

Responsibilities

A. All CHW staff, including volunteers, students, and contractors, are responsible for:
   1. Adhering to the hand hygiene guidelines.
   2. Adhering to the plan for the prevention and control of infections.
   3. Notifying their supervisors or designee of infection related issues.
   4. Reporting exposure incidents in the workplace to CHW_Incidents@gchd.org.

B. Supervisors are responsible for:
   1. Understanding the general guidelines and principals and those that apply to their departments or programs.
   2. Orienting their new staff to the applicable guidelines.
   3. Periodically training staff on the guidelines.
   4. Monitoring the practices of their staff in the workplace.
   5. Assuring any exposure incidents in the workplace are reported to the CHW_Incidents@gchd.org and Human Resources.
   6. Counseling employees who need guidance or redirection in infection control practices.

C. Infection Control Nurse (ICN) is responsible for:
   1. Surveillance monitoring of outcome and processes to plan, implement, evaluate, and improve ICP strategies.
   2. Orientation of new CHW staff to the ICP and its components.
   3. Education and annual staff training related to infection prevention and control activities.
   4. Monitoring, evaluating, and reporting program effectiveness.
   5. Expanding activities as needed in response to unusual events or to control outbreaks of disease.
   6. Reviewing and recommending revisions of the ICP to the Compliance Committee quarterly or more frequently if indicated.
   7. Overseeing the seasonal influenza vaccination program for CHW staff.

D. The Compliance Committee will consist of CHW staff and leadership and responsibilities include the following:
   1. Meet monthly to review surveillance data collected by the ICN and managers; this will include reports on handwashing data, spot audits conducted in all clinical areas (dental, lab and medical), reports on sterilization monitoring, and any other issues that might arise, such as any infectious disease trends. Report results of surveillance, data analysis and trends to the Compliance Committee quarterly.
   2. Review any incidents that involve infection control activities.
   3. Review the annual Risk Assessment and develop next year's multidisciplinary Risk Assessment.
   4. Develop annual Goals and Responsibilities for the IPCP and report progress and outcomes to the GB QA and the GB annually.
   5. Review and update the IPCP annually and as needed if any special circumstances arise.

Risk Assessment

An infection control risk assessment will be conducted annually and presented to the Compliance Committee for review and recommendations. The risk assessment will include consideration of the community and population served by the CHW clinics, care and services provided, and infection surveillance data. Based upon the annual risk assessment, infection control goals and responsibilities will be established, measured, and reported upon to the Compliance Committee, the Governing Board Quality Assurance committee, and the Governing Board.

Table of Contents

SECTION 1: Standards and Guidelines

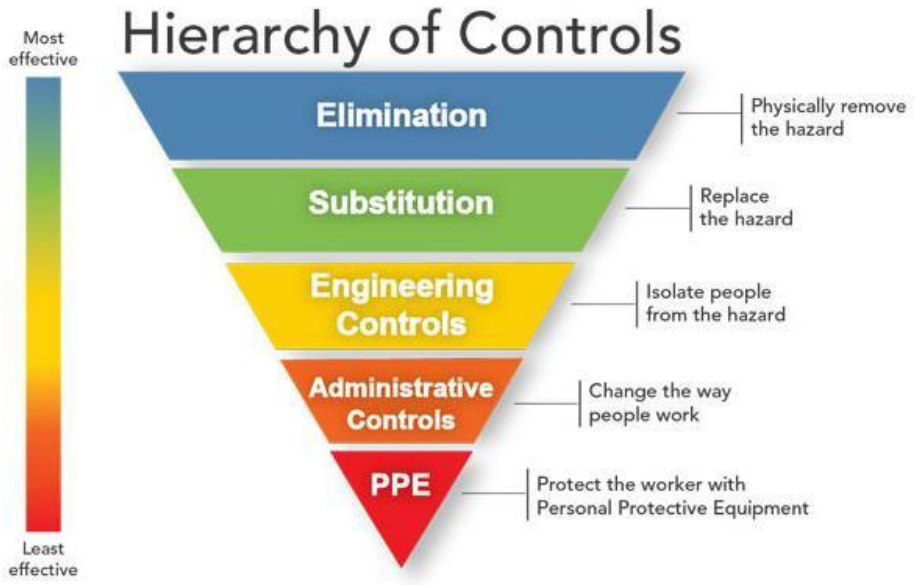
IC.02.01.01 The organization implements its infection prevention and control activities.

Coastal Health & Wellness (CHW) is a "healthcare setting" where healthcare is delivered in outpatient facilities. Standards and guidelines are designed to proactively prevent the spread of infection in healthcare settings. CHW utilizes guidelines from the Centers for Disease Control and Prevention (CDC), The National Institute for Occupational Safety and Health (NIOSH), Occupational Safety and Health Administration (OSHA) and the World Health Organization (WHO). Association for Advancement of Medical Instrumentation (AAMI) guidelines are utilized in the dental clinic.

A Hierarchy of Controls is used as a means to determine how to implement reasonable and effective controls as an infection control strategy to prevent transmission of pathogens in a patient-care delivery system.

Hierarchy of Controls as follows, from the most effective to the least effective:

- Elimination-physically removes the hazard.
- Substitution-replace the hazard.
- Engineering Controls-isolate people from hazards.
- Administrative Controls-change the way people work.
- PPE-Protect the worker with Personal Protective Equipment.



1.1 <u>Standard Precautions</u>

Standard Precautions are an infection control strategy to prevent transmission of pathogens and are recommended for all patient-care delivery settings. They are based on the concept that all blood, body fluids, secretions, excretions (except sweat), non-intact skin, and mucous membranes may contain transmissible pathogens. Based on principle of: All patients, all times, protecting yourself, protecting patients.

Standard Precautions are intended to address all modes of transmission by any type of organism. They are based on a risk assessment and make use of common-sense practices and personal protective equipment that protect healthcare providers from infection and prevent the spread of infection from staff to patient/patient to patient.

All occupational exposures to blood and or other potentially infectious materials (OPIM) place healthcare providers at risk for infection with bloodborne pathogens. Standard Precautions are designed to reduce exposure to blood and other potentially infectious material (OPIM).

Standard Precautions include the following:

Hand hygiene:
Hand hygiene is an institutional priority for all clinical and non-clinical staff. During the delivery of healthcare, it is advised that healthcare workers protect themselves and patients from potentially deadly pathogens by cleaning their hands the right way, at the right time.

- Hand Hygiene means cleaning your hands by:
  - Handwashing (washing hands with soap and water)
  - Antiseptic hand rub (alcohol-based hand sanitizer foam or gel, 60-90% alcohol).
  - Surgical Hand antisepsis using antimicrobial soap and water, handwashing, followed with alcohol-based hand sanitizer with fast acting and persistent activity.

- Wash hands with soap and water:
  - When hands are visibly dirty
  - After known or suspected exposure to patients with diarrhea
  - Before eating
  - After using a restroom

- Alcohol -Based hand sanitizer for everything else (ABHS)

- During routine patient care: 5 moments of hand hygiene:
  - Before patient contact
  - Before a clean/aseptic procedure
  - After body fluid exposure risk
  - After patient contact
  - After contact with patient surroundings

- Hand Hygiene:
  - Before donning gloves
  - After removing gloves
  - Before handling medication

- Surgical Hand antisepsis using antimicrobial soap and water **or** alcohol-based hand sanitizer with fast acting and persistent activity is recommended before donning sterile gloves when performing surgical procedures. Remove jewelry that could potentially tear sterile surgical gloves. Remove debris from under fingernails before starting hand hygiene.
  - Using an antimicrobial soap, scrub hands and forearms for the length of time recommended by the manufacturer, usually 2-6 minutes.
  - When using an alcohol-based surgical hand-scrub product with persistent activity, follow the manufacturer's instructions. Before applying the alcohol product, pre-wash hands and forearms and dry hands and forearms completely. After application of the alcohol-based product as recommended, allow hands and forearms to dry thoroughly before donning sterile gloves.

P**ersonal Protective Equipment (PPE):**

Use PPE whenever there is an expectation of possible exposure to infectious material/agents. CHW will have appropriate PPE available, and staff will be trained on its' use, when possible, exposure to infectious material exists. CHW will ensure that employee uses the appropriate PPE. Specialized equipment is to be worn by an employee for protection against infectious materials, to reduce the risk of infection. The availability of PPE at the point of use is critical based on unit need. Strategies for optimizing the supply of PPE during shortages: Conventional, contingency, or crisis capacity. Appropriate PPE is provided for employees as follows:

- Gloves- Protect hands and use when touching blood, body fluids, secretions, excretions, contaminated items, and for touching mucous membranes and non-intact skin. Wearing gloves is not a substitute for hand hygiene and hands should always be cleaned before donning and after removing gloves.

- Mask, eye protection and face shield- Wear a disposable face mask or a fluid resistant surgical mask and eye protection (goggles) or a full-face shield (covers full face below chin and wraps around sides of face). Alternatively, a mask with attached eye protection may be worn. This PPE will protect mucous membranes of the eyes, nose, and mouth during activities that are likely to generate splashes or sprays of blood or body fluids, secretions, and excretions.

- N-95 Respirators- NIOSH approved/fit tested, used for "aerosol-generating procedures" or "airborne transmission" with a full-face shield. Use of N-95 respirators due to response of international emergence of COVID-19 based on CDC guidelines. Fit testing at orientation of clinical staff needing to wear N95 respirator, yearly and as needed for weight loss or gain and facial alterations.

- Gowns- Wear a gown (fluid-resistant, when possible) to prevent soiling or contamination of clothing during procedures and patient care activities when contact with blood, body fluids, secretions or excretions is anticipated. Donning/Doffing per CDC.

- Hair Coverings- To contain hair and minimize microbial dispersal during the sterilization preparation process.

Respiratory Hygiene/Cough Etiquette:

- Employees, patients, and visitors are expected to contain respiratory secretions by covering the nose/mouth when coughing or sneezing, use tissues to contain respiratory secretions and dispose of used tissues in the nearest no-touch receptacle (foot-pedal-operated lid or open, plastic lined waste basket) and to perform hand hygiene after contact with respiratory secretions.

- Signs will be posted at entrances and common meeting areas with instructions for patients to cover their mouths/noses when coughing and sneezing, use and dispose of tissues, and perform hand hygiene after hands have been in contact with respiratory secretions.

- Respiratory stations will be stocked with masks, tissue and ABHS, cleaned, and maintained at the entrance to both clinics and medical waiting rooms.

- Staff will be instructed to provide masks to patients who are actively coughing when they present at the clinic for care, or if guideline for all to don face covering/mask when entry to clinic. Also, hand hygiene is encouraged before entry. Guidelines regarding masking for all who enter, are decided by administration, based on community risk/need and CDC guidelines.

- Patients suspected of having an airborne communicable disease should be placed in an area away from others, such as in an exam room, this is based on the Infectious Disease Guidelines/Nursing staff decision. See Infectious Disease Guidelines for room assignments.

- Avoid touching your eyes, nose, and mouth, and clean your hands often.

Ensure appropriate patient placement-
Include the potential for transmission of infectious agents in patient- placement decisions. Based on transmission-based precautions used in addition to standard precautions.

- Place patients who pose a risk for transmission to others in an exam room as soon as possible. This decision is based on Infectious Disease Guidelines/Nursing staff decision.

Properly handle and properly clean and disinfect patient care equipment and instruments/devices-Protocols and procedures should be established for containing, transporting, and handling patient-care equipment and instruments/devices that may be contaminated with blood or body fluids.

- Remove organic material from instruments/devices using recommended cleaning agents to enable effective disinfection and sterilization processes.

- Wear PPE (personal protective equipment), such as gloves and gowns according to the level of expected contamination, when handling patient-care equipment and instruments/devices that are visibly soiled or may have been in contact with blood or body fluids.

Clean and disinfect the environment appropriately-
Establish protocols and procedures for routine and targeted cleaning of environmental surfaces as indicated by the level of patient contact and degree of soiling.

- Clean and disinfect surfaces likely to be contaminated with pathogens, including those near the patient and surfaces in the patient-care environment that are frequently touched (doorknobs, light switches, chair arms), after each time on a more frequent schedule compared to that for other surfaces such as horizontal surfaces in waiting rooms, and employee workstations.

- Use EPA-registered disinfectants that have microbicide activity against the pathogens most likely to contaminate the patient care environment. Use according to manufacturer's instructions. Use Cleaning/Disinfecting Wipes: List N for Disinfectants for use Against SARS-CoV-2 (COVID-19), List Q for Emerging Viral Pathogens (Mpox), List K for C-diff, List P for candida auris, updated as needed.

Follow safe injection practices-
- Use clean or aseptic techniques, in clean, uncluttered, and functionally separate areas for product preparation to avoid contamination of medication and sterile injection equipment.

- During preparation, visually inspect the medication for particulates, discoloration, or other loss of integrity.

- Disinfect the rubber septum on a medication vial, with alcohol before piercing or according to medication IFU's.

- Do not re-use needles or syringes to enter medication vial or solution, even when obtaining additional doses for the same patient.

- Do not administer medications from a syringe to multiple patients.

- Needles, cannulas, and syringes are single patient use items.

- Single-dose vials, ampules or pre-filled syringes are intended for use on only one patient. Use whenever possible.

- If there are medications that do not come in single use vials, then the multidose vial must be discarded after the first use. Exceptions are specific vaccines, PPD skin test and Insulin. If necessary to use medication from multi-dose vial, it must be prepared in clean medication room, with label indicating name of medication, dose, lot number and expiration date. Then taken to patients' room for administration. With a 28-day expiration after opening.

- Do not use a single-dose vial or ampule for several patients or combine contents of several vials.

Ensure healthcare worker safety including proper handling of needles and other sharps-

Engineering, work practice, and environmental controls have all been developed to prevent and control the spread of infection related to the use of needles and other sharps in the healthcare setting. Refer to the CDC Workbook for Designing, Implementing, and Evaluating a Sharps Injury Prevention Program.

- Requirements for handling sharps state that: **contaminated sharps** are needles, blades (such as scalpels), scissors, and other medical instruments and objects that can puncture the skin. Contaminated sharps must be properly disposed of immediately or as soon as possible in containers that are closable, puncture-resistant, leak-proof on the sides and bottom, and color-coded or labeled with a biohazard symbol.

- Discard needle/syringe units without attempting to recap the needle unless it is unsafe to do so.

- Always activate self-capping needle protector.

- If a needle must be recapped, **never** use both hands. Use the single hand "scoop" method by placing the cap on a horizontal surface, gently sliding the needle into the cap with the same hand, tipping the needle up to allow the cap to slide down over the needle, and securing the cap over the needle with the same hand.

- Dental uses ProTector Needle Sheath Prop (One-Handed Recapper).

- Never break or shear needles.

- To move or pick-up needles, use a mechanical device or tool, such as forceps, pliers, or broom and dustpan.

- Dispose of needles in labeled sharps containers only; sharps containers must be accessible and maintained upright. When transporting sharps containers, close the containers immediately before removal or replacement to prevent spillage or protrusion of contents during handling or transport. Ensure that the closed lid is locked in place (secured with 2-inch tape) before transport.

- When transporting sharps containers, close the containers immediately before removal or replacement to prevent spillage or protrusion of contents during handling or transport.

- Fill the sharps container up to the fill line or two thirds full. Do not overfill the container.

- Sharps containers are secured in place while in use in the clinical area.

- In healthcare setting no sharing of fingerstick devices or insulin pens.

- Blood glucose meters must be cleaned and disinfected according to manufacturer's instructions (IFU's) between uses.

- Creation of a team to review and evaluate Sharps Injury Prevention Devices.

Transmission Based Precautions

In addition to Standard Precautions, which are used with all patients, some patients require additional precautions known as transmission-based precautions. Transmission-based precautions are measures to protect against exposure to a suspected or identified pathogen. There are three types (or combination) of transmission-based precautions: Contact, Droplet and Airborne.

Contact Precautions

Contact precautions are designed to minimize transmission of organisms that are easily spread by contact with hands or objects. CDC Contact Precautions are summarized below:

- Use of Personal Protective Equipment
  - Put gloves on upon entry into the exam room.
  - Put on a gown upon entry and remove and perform hand hygiene before leaving the exam room.
  - After removal of gown, ensure clothing and skin do not contact environmental surfaces in the patient-care area.

- Patient Transport
  - Limit transport and movement of patients outside of the exam room unless medically necessary.
  - If it is necessary to move the patient, ensure the infected area of the patient's body is covered.
  - Remove and dispose of contaminated personal protective equipment and perform hand hygiene prior to transporting, (leaving exam room).
  - Don clean personal protective equipment to handle the patient at the transport destination.

- Patient-Care Equipment and Instrument/Devices/Cleaning and disinfecting room
  - Handle equipment and instruments/devices according to Standard Precautions.
  - Use disposable equipment or implement patient-dedicated use. If common use is unavoidable, clean and disinfect before use on another patient.
  - Clean and disinfect contaminated reusable noncritical patient-care equipment.
  - Exam room/area cleaned and disinfected prior to use by another patient, focus on frequently touched surfaces and equipment.

Droplet Precautions

Droplet precautions are designed to prevent transmission of diseases easily spread by large-particle droplets produced when the patient coughs, sneezes, talks or during the performance of procedures.

- Place suspected infectious patients in an exam room as soon as possible and instruct patients to follow Respiratory Hygiene/Cough Etiquette recommendations.

- Source control: put a mask on the patient.

- Staff will wear a mask upon entry into the exam room, use PPE appropriately and limit transport of patient outside the room.

Airborne Precautions

Airborne Precautions are designed to prevent transmission of diseases spread by the true airborne route.

- Identify patients requiring Airborne Precautions.

- Put a surgical mask on the patient, instruct in respiratory hygiene/cough etiquette, and place in an examination room, based on Nursing recommendations for room assignment.

- Restrict the number of healthcare personnel from entering the room.

- Healthcare personnel use appropriate PPE, including a fit-tested NIOSH approved N-95 respirator, cover with full-face shield.

- Caregivers should wear a mask when entering the patient's room.

- Limit transport or movement of patient out of the room.

- Once the patient leaves, the room should remain vacant for two hours to allow full exchange of air. Exam room/area terminally cleaned and disinfected with an EPA registered disinfectant: Tuberculocidal used according to manufacturer instructions, prior to use by another patient.

1.2 Tuberculosis (TB) Exposure Control Plan

Tuberculosis has long been recognized as a risk in health care settings, and the emerging incidence of drug resistant and multi-drug resistant (MDR) TB illustrates the need to monitor for possible TB exposure in the CHW clinics. TB rates in the county are monitored by the Texas DSHS Tuberculosis Control Program and the GCHD TB Program.

The CHW clinics have been identified through a TB Risk Assessment (CDC, Texas DSHS form) as low risk settings where exposure to TB is unlikely. An annual assessment is conducted, and if any suspected/confirmed cases of TB are identified, a new assessment will be conducted at that time.

CHW follows the CDC TB Screening and Testing of Health Care Personnel (Updated August 30, 2022).

As a condition of employment, see Employee and Pre-hire Immunization and Screenings Policy (last approved UBOH 12/07/2022):

TB screenings for new employees: all new employees must provide a current (less than 12 months from date of hire) TST (tuberculin skin test) or IGRA (Interferon Gamma Release Assay) prior to their start date. In the event a new hire employee is a prior positive reactor, a chest X-ray (done less than 12 months from date of hire) will suffice for clearance. Any employee exposed to active TB will undergo post-exposure repeat screening.

Positive reactors will be evaluated by the GCHD TB Program Manager. Any employee found to have active pulmonary tuberculosis will be excluded from the workplace while contagious.

Texas DSHS recommendations reviewed 4/5/2023:
Annual TB testing using an IGRA or TST is not **routinely** recommended. Health care facilities should perform TB testing and complete a signs and symptoms assessment after known or ongoing exposure to TB or complete a signs and symptoms assessment annually for HCP with untreated TB infection. HCP should also be educated about TB treatment options for TB infection.

TB Screening and Testing of Health Care Personnel Updated, DSHS TX reviewed April 5, 2023.

Annual TB testing of health care personnel is **not** recommended unless there is a known exposure or ongoing transmission at a healthcare facility. Health care personnel with untreated latent TB infection should receive an annual TB symptom screen. Symptoms for TB disease include any of the following: a cough lasting longer than three weeks, unexplained weight loss, night sweats or a fever, and loss of appetite.

All health care personnel should receive TB education annually. TB education should include information on TB risk factors, the signs and symptoms of TB disease, and TB infection control policies and procedures.

OSHA refers to CDC for recommendations:

TB Exposure Control Procedures for Suspected or Known Active TB Cases
Provide a surgical mask for the person to wear to contain droplets. Recognize the signs and symptoms of active TB - these include hemoptysis, fatigue, fever, chills, night sweats, loss of appetite and weight loss.

- Once the patient leaves, the room should remain vacant for two hours to allow full exchange of air. Exam room/area terminally cleaned and disinfected with an EPA registered disinfectant: Tuberculocidal used according to manufacturer instructions, prior to use by another patient.

- Any suspected or known case of tuberculosis in a patient or employee must be reported to the GCHD TB Program (ext. 2217 or 2354). Contact 409-938-2220.

The examining room used as a holding area should be closed for 2 hours and terminally cleaned after the patient has left and then disinfected with an EPA registered disinfectant: Tuberculocidal used according to manufacturer instructions.

1.3 Bloodborne Pathogens in Healthcare Facilities Exposure
- Appendix A 2023 CHW Infection Control Plan.

1.4 Respiratory Protection Program
- Appendix B 2023 CHW Infection Control Plan.

SECTION 2: Medical Surveillance
Healthcare workers face risks to their own health when taking care of patients. The elements of a medical surveillance program are used to establish an initial baseline of workers' health and then monitor their future health as it relates to their potential exposure to hazardous agents. This information can be used to identify and correct prevention failures leading to disease. Early identification of health problems can also benefit individual workers.

2.1 Employee Health

- All employees will follow established policies regarding immunizations and tuberculosis skin tests. Refer to "Employee and Pre-Hire Immunizations" policy UBOH 12/07/2022.

- Employees who may be infected with a communicable disease transmitted through airborne or casual contact may not return to work until released by their medical provider who deems them non-infectious. Supervisors who suspect that an employee has a communicable illness may require the employee to seek medical attention and a release to return to work.

- Employees are strongly encouraged to obtain a yearly seasonal influenza vaccine; if an employee is unwilling or unable to be vaccinated, they will be required to wear a surgical mask while engaged in direct patient care during flu season. See addendum to UBOH Employee and Pre-hire Immunizations and screening policy UBOH 08/10/2022. The Declination of Influenza vaccine must be completed and submitted to their Supervisor, Immunizations Program manager and Human Resources.

2.2 Infectious Diseases and Occupational Health Strategies

Several standards and directives are directly applicable to protecting workers against transmission of infectious agents:

These include:

- Bloodborne Pathogens Training OSHA Standard 1910.1030 (see Appendix A for CHW BBP Plan).
- CDC Guidelines.
- Personal Protective Equipment.
- Respiratory Protection/OSHA Standard 1910.134 (See Appendix B for CHW Respiratory plan)

Bloodborne Pathogens Training

CHW provides bloodborne pathogens training for all workers who may encounter blood and other potentially infectious materials (OPIM) in their jobs, based on Occupational Safety and Health Standards (OSHA) 1910.1030 Bloodborne Pathogens.

- This training includes information on bloodborne pathogens and diseases, methods used to minimize risk and control occupational exposure, hepatitis B vaccine, and medical evaluation and post-exposure follow-up procedures.

- CHW offers this training for new hires, annually thereafter, and when new or modified tasks or procedures affect a worker's occupational exposure.

CDC Guidelines

- To prevent transmission of bloodborne pathogens to healthcare workers, the CDC recommends:
  - Strict adherence to sharps safety guidelines and Standard Precautions.
  - Hepatitis B vaccination of healthcare worker.
  - Post-exposure prophylaxis and counseling in the event of exposure incident.

Personal protective equipment

- Surgical masks are used as a physical barrier to protect the user from hazards, such as splashes of large droplets of blood or body fluids; they also protect other people against infection from the person wearing

the surgical mask. Such masks trap large particles of body fluids that may contain bacteria or viruses expelled by the wearer.

- When there is identified potential occupational exposures, staff will don appropriate PPE, including gloves, gowns, face shields, masks, and eye protection.

- Wear gloves (clean, nonsterile gloves are adequate) when touching blood, body fluids, secretions, excretions, and contaminated items. Put on clean gloves just before touching mucous membranes and non-intact skin. Change gloves between tasks and procedures on the same patient after contact with material that may contain a high concentration of microorganisms. Remove gloves promptly after use, before touching non-contaminated items and environmental surfaces, and before going to another patient, and clean hands immediately to avoid transfer of microorganisms to other people or environments.

- Wear a gown (a clean, nonsterile gown is adequate) to protect skin and to prevent soiling of clothing during procedures and patient-care activities that are likely to generate splashes or sprays of blood, body fluids, secretions, or excretions. Disposable gowns are utilized in the CHW clinics. Select a gown that is appropriate for the activity and amount of fluid likely to be encountered. Remove and dispose of soiled gowns as promptly as possible and clean hands to avoid transfer of microorganisms to other people or environments.

- Wear a mask and eye protection or a face mask to protect mucous membranes of the eyes, nose, and mouth during procedures and patient-care activities that are likely to generate splashes or sprays of blood, body fluids, secretions, and excretions.

- **Respiratory Protection**: N-95 respirators, OSHA Standard 1910.134

- **See Appendix B for CHW Respiratory Protection Plan**

    - N95/filtering facepiece respirator, (NIOSH-certified respirator) filter efficiency of 95%-is a personal protective device worn on the face, covers at least nose and mouth, and is used to reduce the wearer's risk of inhaling hazardous airborne particle (e.g.) dust and infectious agent(s). Intended use and purpose: reduces wearer's exposure to particles including small particle aerosols (only non-oil aerosols) and large droplets. Use N-95/surgical mask with a full- face shield as needed/required when performing aerosol-generating procedures.
    - N-95- Initial fit test for each HCP with the same model, style, and size respirator that the worker will be required to wear. Initial fit testing to determine if the respirator fits the worker and can provide the expected level of protection. Repeat fit test if changes in employees' physical condition that could affect respirator fit or need to change brand or model and yearly (when supplies are available).
    - Training during fit test procedure or general training.
    - Respirator Medical Evaluation Questionnaire prior to fit testing.
    - Qualitative fit testing: Saccharin or Bitrex Solution Aerosol Protocol.
    - Recordkeeping: retained in HR and infection Control.
    - N-95-tight-fitting face seal, User Seal Check required each time the respirator is donned.

2.3 <u>Exposure Control Plan</u>
Establish an exposure control plan and update annually.
See Appendix A for CHW Bloodborne Pathogen Protection Plan

- Use of Standard Precautions with all patients, especially hand hygiene.
- Use of additional transmission precautions (e. g., Contact, Droplet and Airborne).
- Vaccination (e.g., influenza and hepatitis B).
- Identify and use engineering controls.
- Identify and ensure the use of work practice controls.
- Provide Personal Protective Equipment (PPE).
- Post-exposure evaluation and follow-up.
- Communication of hazards to employees, use labels and signs.
- Provide information and training to staff, maintain records.
- Environmental hygiene to reduce exposure to pathogens in healthcare settings.
- For all sharp's and Bloodborne Pathogens exposures, WITHOUT DELAY, healthcare worker needs a post-exposure evaluation by a medical provider, which must include a discussion and documentation of the risks and benefits of post-exposure prophylaxis follow-up as indicated by the exposure. GCHD provides Worker's Compensation insurance to assist an employee who may have on-the-job exposure.
- Follow the process for needle stick/exposure to evaluate the circumstances surrounding an exposure incident including identifying and testing the source individual.

If a healthcare worker has an on-the-job exposure to a communicable disease, the Supervisor and HR Epidemiology Department at 409.938.2215 for any contaminated sharps injury.

2.4 Healthcare Workers and Communicable Diseases

Healthcare workers are responsible for reporting to their supervisor when they have any **signs or symptoms of a communicable disease**. Symptoms that should be reported and evaluated typically include:

- Fever.
- Unusual rash.
- Skin infections, such as boils and impetigo.
- Exudative (weeping) dermatitis.
- Sore throat with fever.
- Gastrointestinal symptoms (vomiting, diarrhea).
- Jaundice.
- Symptoms suggesting active tuberculosis (chronic cough with unexplained weight loss, fever, night sweats and hemoptysis).

Preventing transmission of infection is the responsibility of the facility and the individual healthcare worker.

2.5 Emergency Procedures for Exposure to Blood and Body Fluids

Employers are required to implement these preventative measures to reduce or eliminate the risk of exposure to bloodborne pathogens. OSHA Standard 1910.1030.

EMERGENCY STEPS FOLLOWING AN OCCUPATIONAL EXPOSURE

If an occupational exposure to blood or other body fluids occurs, the following CDC National Institute for Occupational Safety and Health (NIOSH), steps should immediately be taken:

1. Wash needle stick injuries and open wounds with soap and water.
1. Flush splashes to nose, mouth, or skin with water.
2. If exposed, irrigate eyes with clean water, saline or sterile irrigation.
3. Use eye wash stations if exposed in clinical areas. See Eye Wash Station Guidelines (08/03/2022).

4. Report the incident to a supervisor and HR.
5. Immediately seek medical treatment.

Emergency: Seek immediate medical care at the nearest facility or **call 911.**

Non-emergency: Find a provider within the *Alliance Directory* http://www.pswca.org.

During Business Hours: Immediately inform supervisor or manager and HR by phone or email (GCHD_HR@gchd.org).

After Business Hours: It is the employee's responsibility to seek **immediate** medical attention at a local emergency room for blood borne pathogen and/or chemical exposures. Notify your supervisor or designee immediately.

Injured Employee:

1. Get a prescription "First Fill Card" from your supervisor or HR if necessary.
2. Complete an Employee Incident/Injury Report even if no medical treatment is sought.
3. Labs for all hepatitis and HIV need to be drawn within the first 24 hours and then repeated based upon stated recommendations, usually in 3 months, 6 months and 1 year.
4. A notarized affidavit describing how the exposure occurred is required by the insurance provider and must be submitted to HR within 10 days.
5. If a medical evaluation of the injury was obtained, the employee will need to submit a Work Status Report obtained from the workers' compensation provider and submit it to HR before returning to work.

Supervisors:

1. Assist employees in obtaining medical attention.
2. Ensure notification to HR.
3. Ensure an Employee Incident/Injury Report is completed and sent through the e-communication chain, CHW_incidents@GCHD.org
4. Ensure that the Contaminated Sharps Injury form is submitted to GCHD Epidemiology Services.
5. If a worker sustains several occupational exposures, the direct supervisor and the worker should review the duties and procedures of the job.
6. Modifications of procedures and appropriate corrective action should be taken in accordance with policy and circumstances.
7. Work with HR on the employee returning to work.

Human Resources:

Coordinates reports of employee's medical care to the workers' compensation insurance carrier, notifies the Community Health Services Director or designee, the employees' supervisor/manager and informs the Epidemiology Manager about the exposure injury. The Director of Community Health Services will track and trend employee exposures and will work with Infection Control to review and or revise the exposure control plan yearly and as needed.

SECTION 3: Regulated Medical Waste Management

Regulated Medical Waste requires careful disposal and containment. Standards are designed to protect workers who generate medical waste and those who manage the wastes from point of generation (Generator) to disposal (Transporter). Personnel responsible for medical waste management must receive appropriate training in handling

and disposal methods. The transport of Regulated Medical Waste is regulated by the United States Department of Transportation (DOT). All affected employees (those who perform the functions of either packaging or signing the shipping papers) must complete DOT hazards material training initially and every three years, thereafter.

Regulated medical waste includes:

- Liquid or semiliquid blood or other potentially infectious materials.
- Items contaminated with blood or other potentially infectious materials (OPIM), and which would release these substances in a liquid or semiliquid state if compromised.
- Disposable PPE (gloves, gowns, eye protection), that is visibly contaminated with blood/OPIM.
- Items that are caked with dried blood or OPIM and are capable of released these materials during handling
- Contaminated sharps.
- Pathological and microbiological wastes containing blood or OPIM.

3.1 Handling Regulated Medical Waste

Regulated waste must be placed in containers that are:

- Closable.
- Constructed to contain all contents and prevent leakage of fluids during handling, storage, transport, or shipping.
- Labeled with Biohazard sticker/label or color-coded; red, or orange red.
- Closed prior to removal to prevent spillage or protrusion of contents during handling, storage transport, or shipping.
- Seal bottom and top of box with 2-inch clear tape.

If outside contamination of the regulated waste container occurs, it must be placed in a second container meeting the above standard.

3.2 Needles, Syringes and Other Sharp Objects

Sharps (any object that puncture the skin) should be placed in containers that are labeled with the universal biohazard symbol and the word *biohazard* or be color-coded red. Sharps containers must be maintained upright throughout use, locked in place, replaced routinely, and not be allowed to overfill. Sharps containers should not be filled past the marked "fill line", over ¾ full, or if there is any difficulty disposing of the sharp. Nothing should be allowed to hang outside or protrude outside of the sharp's container. Sharps are dropped into sharps container; fingers should never be used to "push" any sharps into the container.

Sharp materials must be placed in a puncture-resistant container designated for sharps waste. All sharps' containers must be properly closed "locked" prior to being placed in a secondary container. No loose sharps are permitted outside of sharps container.

3.3 Regulated Medical Waste

Containers must be:

- Closed immediately prior to removal or replacement to prevent spillage or protrusion of contents during handling, storage, transport, or shipping.

- Placed in a secondary container if leakage is possible; the second container must be:
  - Closeable.
  - Constructed to contain all contents and prevent leakage during handling, storage, transport, or shipping.
  - Labeled or color-coded.

- Reusable containers must not be opened, emptied, or cleaned manually or in any other manner that would expose employees to risk by percutaneous injury.

- All closed sharps containers: closed and locked, ¾ full or to fill line and small red biohazard bags (twisted and tied) are placed inside large red biohazard bag lining the cardboard box.

- When large box is ¾ full or at a maximum weight limit of full container 43 pounds, the red bag is to be twisted several times, folded over, and tied to prevent leakage. Bag may be twisted and folded over and secured with 2- inch pressure or poly tape, if not able to tie.

- Cardboard boxes (secondary containers) must be closed and sealed with 2-inch pressure or poly tape on the top and bottom. Closed bags must not be visible once the secondary container is closed, and the box must not be bulging. The outside of the box must be clearly labeled with a biohazard mark, and the clinic bar code label is attached to the outside of the box in the indicated area. Label has address of Generator and Transporter.

- All regulated medical waste is stored in a locked Biohazard room, (Texas City and Galveston), monitored by the Infection Control Nurse and Risk Management.

3.4 <u>Biohazard Warning Labels</u>

Biohazard warning labels are to be affixed to containers of regulated medical waste; refrigerators and freezers containing blood or OPIM; and other containers used to store, transport, or ship blood or OPIM. These labels are fluorescent orange, red or orange-red. Bags used to dispose of regulated waste must be red or orange-red, and they too must have the biohazard symbol in a contrasting color readily visible upon them.

3.5 <u>Practices and Controls</u>

In addition to the precautions described above, CHW has other practices and controls in place to prevent and control infection.

These include:

- Engineering Controls
- Work practice Controls
- Environment Controls

- **Engineering Controls** refer to measures that isolate or remove a hazard from the workplace and that must be used when feasible. These include the following:

  - Sharps disposal containers
  - Self-sheathing needles, and scalpels
  - Sharps with engineered sharps injury protections

- **Work practice controls** reduce the likelihood of exposure to pathogens by changing the way a task is performed, such as:

  - Practices for handling and disposing of contaminated sharps.
  - Handling specimens.
  - Cleaning and disinfecting contaminated surfaces and items.
  - Performing hand hygiene.

- **Environmental controls** help prevent the transmission of infection by reducing the concentration of pathogens in the environment. Such measures include but are not limited to:

  - General housekeeping
  - Cleaning and disinfecting strategies
  - Sterilizing patient equipment
  - Disposal of regulated medical waste
  - DOT Training

SECTION 4: Good Work Practices

4.1 Hand Hygiene

Hand hygiene shall be practiced before and after routine patient care activities, including entering and exiting the patient care environment, before and after removing gloves, and after hand contaminating activities.

- Hand hygiene shall be practiced before handling medication.
- Hand Hygiene before eating.
- All employees are required to wash, rinse, and dry their hands before beginning work, after using the rest room, and prior to leaving work.
- When not visibly soiled, an alcohol-based hand rub (ABHR) or alcohol-based hand sanitizer or alcohol-based hand sanitizing wipes may be used routinely for hand hygiene in place of soap and water handwash.
- Hands that are grossly contaminated must be washed with soap and water or antimicrobial soap and water.

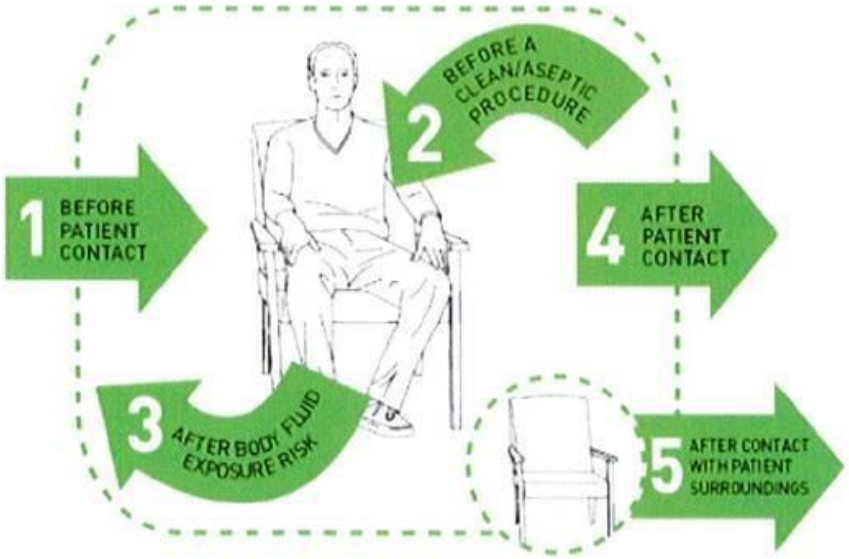
Procedures:

A. Handwashing procedure with soap and water:
   1. Wet hands first with warm water.
   2. Apply an amount of product recommended by manufacturer to hands.
   3. Rub hands together making lather for at least 20 seconds, covering all surfaces of the hands and fingers, front and back.
   4. Rinse thoroughly by keeping hands down so that soap and water runoff will drain into the sink and not down the arm, avoid use of hot water.
   5. Dry well with paper towels and use paper towel to turn off faucet.
   6. Use paper towel to open door to exit restroom and then:
   7. Discard paper towels into the appropriate container.

B. Hand antiseptic procedure with ABHR Alcohol Based Hand Rub.
   1. If hands are visibly soiled, wash hands with plain soap and water according to procedure prior to applying alcohol hand rub.
   2. Apply enough alcohol hand rub/sanitizer to cover the entire surface of hands and fingers based on manufacturer's IFU.
   3. Rub hands together with the solution into hands until dry.
   4. Alcohol based hand sanitizing wipes used according to manufacturer's IFU.
   5. Use of alcohol hand rubs may result in a sticky residue on the hands. Wash with soap and water periodically to remove the hand rub residue.

6. Nails should be kept clean and nail polish should be in good repair (no chipped nail polish). Attention must be given to cleaning around the base of the nails, cuticles, and nail tips when washing hands.
7. Fingernail care for direct patient care employees: Fingernails clean and good repair, non-chipped polish, with no embellishments. No longer than ¼ inch long past the end of the finger pad, measurement from the palm side of the hand.

C. Lotions
1. Use moisturizing lotion to maintain healthy hand skin integrity and prevent dryness or irritation.
2. Moisturizing lotion must be an approved hand lotion to avoid risk of incompatibility and/or inactivation of the active ingredients in hand hygiene products and gloves.



Process and Outcome Measurement
It is the responsibility of staff and managers to monitor and remind others of hand hygiene procedures. Hand hygiene audits are performed according to the 5 Moments of Hand Hygiene, as outlined in this procedure (see graphic).

Hand hygiene audits:
a. Should reflect a cross section of clinic staff.
b. Should reflect a cross section of the patient care episodes in a range of settings and not prolonged observation of single episode of patient care.
c. Audits will be reviewed in Compliance Committee and action plans will be developed to improve compliance, if indicated.

4.2 <u>Personal Protective Equipment</u>
Gloves are the most common type of PPE. They are used for patient care as well as environmental service. Gloves can be sterile or nonsterile and single use or reusable. Because of allergy concerns, latex products have been eliminated in the CHW clinics, and materials used for gloves are synthetics such as vinyl or powder-free nitrile.

Most patient-care activities require the use of a single pair of nonsterile gloves. Nitrile Vinyl gloves are frequently available and work well if patient contact is limited. However, some gloves do not provide a snug fit on the hand, especially around the wrist, and should not be used if extensive contact is likely. Use of Nitrile powder free gloves preferred. Gloves should not tear or damage easily. Gloves should be available in sizes to provide a snug fit on the person wearing the gloves; small, medium, large, and X-large.

Sterile surgical gloves are worn when performing sterile patient procedures.

Proper glove use includes:

- Working from clean to dirty.
- Limiting touch contamination (e.g., adjusting eyeglasses, touching light switches, etc.) when wearing gloves that have been in contact with the patient.
- Changing gloves during use if torn or when heavily soiled and after use on each patient.
- Disposing of gloves in proper receptacle.
- Performing hand hygiene before putting on and following removal of gloves.
- **Never** washing or reusing disposable gloves or applying ABHR or ABHS to clean the gloves.

The CDC describes when and how to wear gloves and states that wearing gloves is not a substitute for hand hygiene. Hands should always be cleaned after removing gloves.

- **Gloves**
  Steps for glove use:

  - Choose the right size and type of gloves for the task.
  - Wear disposable medical examination gloves for providing direct patient care.
  - Wear disposable medical examination gloves, use gloves with extended cuff or reusable utility gloves (with proper drying between uses per manufacturer's IFU) when using chemicals for cleaning the environment and medical equipment.
  - Put on gloves before touching a patient's non-intact skin, open wounds, or mucous membranes, such as the mouth, nose, and eyes.
  - Change gloves during patient care if the hands will move from a contaminated body site (e.g., perineal area) to a clean body site (e.g., face).
  - Remove gloves after contact with patient and/or the surrounding environment (including medical equipment) using proper technique to prevent hand contamination.
  - Clean hands before putting on gloves.
  - Change gloves between tasks and procedures on the same patient after contact with material that may contain a high concentration of microorganisms.
  - Remove gloves promptly after use and perform hand hygiene immediately.

- **Gowns**
  Wear a gown that is appropriate to the task to protect skin and prevent soiling or contamination of clothing during procedures and patient-care activities when contact with blood, body fluids, secretions, or excretions is anticipated.

  - Wear a gown for direct patient contact if the patient has uncontained secretions or excretions.
  - Remove gown and perform hand hygiene before leaving the patient's room.
  - Do not reuse gowns, even for repeated contacts with the same person.

- **Masks, Eye Protection and Face Shields**
  - Face and eye protection are used during patient-care activities likely to generate splashes or sprays of blood, body fluids, secretions, or excretions.
  - Masks protect the nose and mouth and should fully cover them (both ear loops or ties in place) to prevent fluid penetration. Masks when not in use need to be removed and discarded. No mask wearing under chin, top of head, or touching gown.
  - Goggles protect the eyes and should fit over and around them snuggly. Personal prescription glasses are not a substitute for goggles.
  - Face shields protect the face, nose, mouth, and eyes. A face shield should cover the forehead, extend below the chin, and wrap around the sides of the face.

- **Putting on and Removing PPE**
  - Specific procedures to be followed when putting on and removing PPE include:
  - See CDC sequence for putting on PPE and removal example 1 and 2. See Summary of recent changes 6/9/2020 PPE for COVID-19.
  - PPE should be donned in the following sequence:
    1. Gown
    2. Mask
    3. Face shield or goggles
    4. Gloves

  - Contaminated PPE should be removed in the following sequence: Either-
    1. Gloves
    2. Face shield or goggles
    3. Gown
    4. Mask or respirator

  Or
    1. Gown and gloves
    2. Goggles or face shield
    3. Mask or respirator

Hand hygiene must be performed immediately after removing all PPE.

4.3 Eyewash Station and Spill Clean Up Supplies

Employees will be trained where the emergency eyewash stations are in each clinical area. Eyewash stations are monitored, checked/tested weekly by clinical staff to ensure that water flows through each correctly and actions are logged appropriately. Staff are also trained on where the chemical (based on SDS) and biological (bodily fluids) spill supplies are located in each clinical area and where other safety equipment is located.

4.4 Refrigerators

There must be separate refrigerators for food, specimens, and medications Sign must be affixed to indicate its designated use. A biohazard label must be affixed to the outside of refrigerators used to store specimens. Refrigerators must be monitored for temperature and cleanliness, which includes daily or twice daily temperature checks, weekly and as needed cleaning, and routine inspection of contents. Laboratory specimens requiring refrigeration while awaiting transport may not be stored in the same refrigerator as medications, juices or water stored for the purpose of dispensing with medication. Refrigerators for lab specimens are in lab area only.

4.5 Food and Drink Precautions
Confine food and drink to designated employee break areas. Covered drinks may be acceptable in some non-patient care areas.

4.6 Storage of Sterile Solutions

Sterile solutions are one-time use, once open, used and remaining fluid discarded.
Follow manufacturer's IFU for storage requirements, temperature/humidity, and expiration dates.

SECTION 5: Cleaning, Disinfecting, and Sterilizing.

5.1 General Environmental Surface Cleaning
Environmental cleaning is critical for reducing pathogen contamination of surfaces. Environmental cleaning involves physical action of cleaning surfaces to remove organic and inorganic material, application of a disinfectant, and employing monitoring strategies to ensure that these practices are carried out appropriately.

- Healthcare environment surfaces can be divided into two groups: 1) those with minimal hand contact, such as floors and ceilings, and 2) those with frequent hand contact, such as doorknobs and light switches, that require cleaning and/or disinfecting more frequently than those with minimal hand contact.
  The number and type of pathogens present on environmental surfaces are affected by:

  - Number of people in the environment
  - Amount of activity
  - Amount of moisture
  - Presence of material able to support microbial growth
  - Rate at which organisms suspected in the air are removed
  - Type of surface and orientation (horizontal or vertical)

Horizontal surfaces with infrequent hand contact (e.g., windowsills, hard-surface flooring) in routine patient-care areas require cleaning on a regular basis, when soiling or spills occur. Disinfectants used in environmental cleaning are not sporicidal or tuberculocidal but can kill most other microorganisms.
Cleaning solutions should be replaced frequently, and soiled or disposable cloths and mop head should be replaced each time a bucket of detergent/disinfectant is emptied and refilled.

5.2 Cleaning up spills
All environmental and working surfaces must be cleaned and decontaminated after contact with blood or OPIM. Protective gloves and other PPE should be worn as necessary, and an appropriate disinfectant/germicidal should be used. EPA- registered antimicrobial products such as tuberculocidal, and label claim, or products registered against Bloodborne pathogens (HBV, HCV, and HIV).

- After putting on personal protective equipment:

  - Block off area to protect patients and other staff if the spill is large.
  - Wipe up the spill with paper towels or other disposable absorbent material and discard the contaminated materials in an appropriate, labeled biohazard container.
  - Use a spill kit to clean up the spill. If the spill contains sharps such as needles, scalpels, broken glass, blood tubes or capillary tubes, or if there is a large volume of liquid; properly dispose of sharps

immediately or as soon as possible in containers that are closable, puncture-resistant, leak-proof on the sides and bottom and color-coded or labeled with a biohazard symbol.
- Clean up all blood or OPIM thoroughly before applying the disinfectant.
- Apply the disinfecting solution, spray, or disposable wipes, onto all contaminated areas of the hard non-porous surface.
- Let surface remain wet, in contact with disinfectant for the number of minutes based on the manufacturer's directions. Bleach germicidal disposable wipe (sodium hypochlorite) is an appropriate disinfectant to use for decontaminating blood spills.

- If a spill involves a chemical, refer to SDS and follow appropriate procedures.

5.3 Medical Instruments

It is the practice of CHW to use only disposable instruments in the medical clinics; no sterilization of medical equipment is done. Any Single Use Device (SUD), intended to use on 1 patient during a single procedure, immediately discarded in appropriate disposal container after use. SUDs are not reprocessed in our facility.

5.4 Medical devices reprocessed based on Spaulding Classification

Items that touch intact skin for a brief period are usually considered non-critical surfaces. **Noncritical items** include environmental surfaces and equipment such as:

- Electrocardiogram
- Nebulizers
- Sphygmomanometer/Blood pressure cuffs
- Thermometers
- Pulse oximetry sensors
- Stethoscopes
- Otoscope/Ophthalmoscope
- Ear Lavage Systems

Most noncritical reusable items may be decontaminated where they are used. Virtually no risk has been documented for transmission of infectious agents to patients through noncritical items if they do not contact non-intact skin and/or mucous membranes.

- Noncritical items are disinfected using low-or intermediate-level disinfectants based on manufacturer's IFU's, which include:
  - Ethyl or isopropyl alcohol.
  - Sodium hypochlorite (Diluted household bleach solution).
  - Quaternary ammonium, germicidal detergent solution (low level only) Chemical name: dimethyl benzyl ammonium chloride.

5.5 Intermediate-level disinfection

Intermediate-level disinfection kills most viruses, bacteria and mycobacteria using a chemical germicide registered as tuberculocidal by the EPA. It does not kill bacterial spores. It is often used to clean up blood spills and other environmental cleaning and is not licensed for disinfection of patient-care equipment that touches mucous membranes. These disinfectants are typically labeled as tuberculocidal to give evidence that they kill the bacterium that causes tuberculosis as well as HBV and HIV. They may be available as a liquid or as disposable wipes.

Intermediate-level disinfectants include:

- Ethyl or isopropyl alcohol (70%).
- Sodium hypochlorite diluted household bleach solution.

5.6 Dental Equipment Procedures

Reusable devices become soiled and contaminated when used and must undergo reprocessing, which is a detailed, multistep process to clean and then disinfect or sterilize them. Devices can be safely used more than once if reprocessing is done correctly following labeled instructions/IFU's.

Reprocessing involves three steps:

1. Initial decontamination and cleaning at point of use to prevent drying of blood, tissue, other biological debris, and contaminants.
2. Transfer of the device to the reprocessing work area, where it is thoroughly cleaned.
3. Either disinfection or sterilization, depending on the intended use of the device, and the materials from which it is made. The device is then stored or routed back into use.

The dental clinic at CHW utilizes the Spaulding Classification System, which is an instrument classification system used for reprocessing decisions (see table below).

Classification	Definition	Examples	Requirements
Critical	Where there is entry or penetration into sterile tissue, cavity, or blood stream	• Extraction kit • Forceps • Burs (unless single use, disposed of after use) • Surgical handpiece • Periodontal scalers	Cleaning followed by Sterilization
Semi-Critical	Where there is contact with intact non-sterile mucosa or non-intact skin	• BOBCAT Pro Ultrasonic Scaler	Cleaning followed by High-Level Disinfection
Non-Critical	Where contact is made with intact skin	• Protective eyewear • Blood pressure cuff • Instrument trays • Chair controls • Environmental surfaces: Floors, walls, doors, handles, high-touch surfaces	Cleaning followed by Low-Level Disinfection

5.7 Sterilization/High level disinfection

Sterilization is required for reusable patient-care instruments that touch sterile tissue or the vascular system and require the absence of microbial contamination. Sterilization describes a process that destroys or eliminates all forms of microbial life. With some exceptions for more recent discoveries, such as prion disease.

Most of these should be purchased as sterile or be sterilized with steam.

Steam sterilization is the most widely used and the most dependable method. It is used whenever possible on all critical and semi-critical items that are heat-and moisture-resistant. Steam sterilization is rapidly microbicide, sporicidal, and rapidly heats and penetrates fabrics. Each item is placed in a steam sterilizer (autoclave) and exposed to direct steam at the required temperature and pressure for a specific time.

Sterilization will be performed by manufacturer's recommendation for the steam sterilizers accordingly along with manufacturer's recommendations of instrumentation.

A. All reusable instruments, equipment, and used surfaces will be decontaminated, disinfected, or sterilized prior to use on a patient. The infection control guidelines for cleaning, disinfecting and sterilization of patient care equipment, instruments and patient care environment will be determined according to the Spaulding Classification System.

B. Manufacturers' directions and facility policies and procedures for reprocessing reusable instruments and equipment, including directions for use of the reprocessing equipment will be followed.

C. Personnel
- Personnel wear clean scrub attire and no outerwear (i.e., jackets).
- Wear a fluid resistant cover gown (secured in back; at neck and waist).
- Gloves: For cleaning of patient care items in the decontamination area, disposable gloves should be puncture and chemical resistant with extended cuffs. Reusable general-purpose heavy duty utility gloves with extended cuff, if used, should be cleaned, and re-used in accordance with manufacturer's written IFU. General-purpose heavy duty utility gloves, if used, should be discarded if there is evidence of deterioration (e.g., punctures, peeling or cracking). Be allowed to air dry inside and out after cleaning. Heavy duty utility gloves if re-used, worn by one staff member only.
- Wear fluid-resistant disposable face mask and a full-length face shield over mask or mask with splash visor, to protect against splashes or sprays.
- Disposable hair cover, to protect against splashes or sprays.
- Staff will follow the hand hygiene guidelines.
- Personnel must have proper training on processing instruments with competency testing during orientation to their jobs and annually. Documentation of training should be maintained in the employee's personnel file. Continuing education (including training for all new instrumentation, devices, and equipment) is conducted at regular intervals.

Design: Location: Sterile processing area will be divided into two (2) areas, designated as "clean" and "dirty," physically divided, and the integrity of each area will be maintained through traffic and instrument/equipment flow.
- The "dirty" area will be used for decontamination of all soiled instruments.
- The "clean" area will be used for processing and sterilization of clean items, to include the preparation and packaging of instruments. Sterilizers are in this area.

Procedures:

A. Pre-Cleaning
Contaminated items should be wiped or sprayed at point of use to keep them moist prior to cleaning; they should not be cleaned or decontaminated in the scrub or hand sinks.

B. Transport
- Contaminated items will be contained during their transport from the point of use to the decontamination area in covered puncture-resistant containers marked as "Biohazardous."
- Sharps and delicate instruments should be kept separate from other items.
- Items will be kept moist until cleaning and decontamination can be performed.

C. Cleaning in decontamination area

- Cleaning of patient care items must occur prior to beginning of sterilization and/or decontamination, should remove all visible soil, and should occur as soon as practical after use. Cleaning solutions and/or detergents should be measured, mixed, labeled, and discarded appropriately according to the manufacturers' directions for use and should be compatible with the instruments and equipment for which they are used.
- Proper protective equipment (PPE) must be used when cleaning an item if a risk of aerosolization exists (spraying of particles into air) and for protection against exposure to the chemicals used as directed by the Safety Data Sheet (SDS).
- The manufacturers' specifications for the quality of water used for cleaning should be followed (i.e., sterile, distilled, de-ionized).
- Completely disassemble each item prior to cleaning; all jointed instruments must be open and/or unlocked from transport to the completion of sterilization.
- Disposable brushes are used for cleaning instruments and discarded after each use. Clean/brush immersible instruments under water to minimize aerosolization.
- Mechanical cleaning equipment should be used whenever possible according to IFU; test and maintain equipment as per manufacturer's instructions.
- If lubrication is necessary, instrument will be wiped down according to IFU and placed in lubricating/cleaning machine or a non-toxic or water-soluble spray will be used.
- **Appropriate sharps which are contaminated with blood or other potentially infectious materials should not be stored or processed in a manner which requires employees to reach by hand into the container where these sharps have been placed; rather, such instruments should be placed in drainage type baskets prior to submerging in cleaning solutions.**
- Traffic between the decontamination, preparation, and assembly areas must be minimized; decontamination attire should be removed, and personnel should wash their hands upon leaving the decontamination area.
- Visually inspect each item (using magnifying light if necessary) to be certain they are clean prior to placing it in dryer.
- If the item is visually soiled at the point of inspection, it will be manually cleaned and/or reprocessed in the ultrasonic machine.
- All items to be high-leveled disinfected or steam sterilized must be thoroughly cleaned prior to disinfection because failure clean the item could interfere with the disinfection and sterilization process.

D. Inspection

- Suitable lighting will be provided for optimal inspection.
- Instruments in disrepair or with compromised surfaces-such as oxidation, pitting, cracking or damaged from instrument marking-may not be able to be effectively sterilized.
- Each instrument needs to be clean and dry prior to packaging.
- Each item will be inspected for functionality, safety, and sharpness prior to packaging.
- If an item is not suitable to use, it will be removed from service. Packaging:
- Assure adequate drying time of instruments and equipment prior to packaging for sterilization.
- Review and follow the manufacturer's instructions for type of wrap, sterilization pouch, peel pack or container that may be used, shelf life, and storage recommendations; wrap all packages separately.
- Internal and external steam indicator will be used for all peel-pack pouches.

- A type 5, steam chemical integrator strip is placed inside the peel-pack pouch.
- Hinged instruments must be in open position when processed.
- Sharp items should be protected from damage. Tip protectors, if used, should be used according to manufacturer's written IFU.
- Peel packs should not be placed inside of packages or containerized sets.
- Document on the plastic side (on label) of sterilization pouches:
- Assistant's Initials.
- Cycle Number, including the name of the sterilizer.
- Operatory number.
- Date of Sterilization.

E. Sterilization
- Select the appropriate method of sterilization according to the instrument or equipment manufacturer's instructions.
- Steam is the preferred method for sterilization of critical instruments not damaged by heat.
- Loading of Sterilizer:
    - Positions biological indicator according to sterilizer and monitoring IFU.
    - Arrange on rack or carriage to present least possible resistance to the passage of steam: textile packages on top, peel pouches on edge, instrument sets flat, rigid containers under wrapped packages.
    - Do not overload sterilizer; items should never touch sterilizer chamber walls.
    - Basins, trays, test tubes, etc. must be set on edge or upside down so air will flow out freely as steam flows in.
- Removing Load from Sterilizer:
    - Proper temperature and exposure time must be known; chart and temperature gauge must be checked to see that these are achieved.
    - Load should be dry and cool when removed.
    - It is critical to follow the recommendations and time frames for drying the instruments and trays that have been sterilized.
    - **If packs are wet when removed, they must be repackaged and re-sterilized.**
    - Care must be taken to keep sterile items separated from non-sterile items.

F. Documentation
- The sterilizer identification.
- The type of sterilizer and cycle used.
- Load Contents.
- The critical parameters such as time, temperature, and pressure.
- The results of the sterilization process monitors.
- The operator's name, initials, or identification.
- The results of BI testing will be documented in the logbooks in the sterilization area.
- Immediate-Use sterilization will not be performed.

G. Storage and Distribution
- Integrity of clean and sterile equipment and supplies shall be assessed prior to use.
- Determination of shelf life of packaged items:
- Inspect all packages before use; if intact, they are considered sterile.
- Packaging will be considered non-sterile (compromised) when certain events occur:

- Holes/tears
- Broken or no seal
- Dropped
- Moisture
- Unsealed dust cover

- Store items in a manner that prevents crushing or binding together so packaging is not compromised.
- Place lighter items on heavier ones.
- Store items in closed cabinets; if this is not possible, store items on wire shelves in a restricted storage area with the bottom shelf being solid.
- Arrange storage areas in a manner that prevents splashing from personnel or housekeeping.
- Rotate stock so that older items are used first.
- Store liquids below dry sterile goods or in a separate section.
- Store materials at least 18" below the ceiling and/or sprinkler head.
- Stored at least 8 inches above the floor (with solid bottom), and 2 inches from outside wall.
- Do not store sterile items under plumbing values and traps.
- Cleaned delivery carts shall be used to transport clean and sterile supplies.
- Sterile storage area will be a well-ventilated area that provides protection against dust, moisture, insects, and temperature and humidity extremes.

H. Quality Assurance
- Monitoring
  - Mechanical (physical), chemical, and biological monitors must be used to assure that the sterilization process has been effective.
  - Physical monitors include time, temperature, and pressure gauges, displays, recorders, and digital printouts. At the end of each cycle, the operator should read and sign the printout to verify that:
    a. The printer is functioning properly.
    b. The cycle identification number has been recorded.
    c. All cycle parameters have been met.
  - Chemical indicators (internal and external) should be used with every load.
  - Use a biological indicator as follows:
    a. Steam sterilization: BI is performed daily when the clinic is open, and instruments are quarantined until the BI is read.
    b. Same lot number for biological indicator in the load and for the control.
    c. Biological control will be processed prior to disposal.
- Recall Process
    a. Upon notification that a physical, chemical, or biological indicator demonstrates a lack of sterility, or sterilizer cycle did not meet expectations, an incident report will be completed as soon as reasonably possible.
    b. Notify Dental Director and Dental Assistant Supervisor immediately.
    c. In the case of a failed spore test, remove the sterilizer from service; review sterilization procedures and work practices to determine whether the failed test could be the result of operator error.
    d. After correcting any identified procedural problems, retest the sterilizer by using biological, mechanical, and chemical indicators.

e. If the repeat spore test now verifies that mechanical and chemical indicators are within normal limits, put the sterilizer back in service.
f. If the repeat spore test also fails, do not use the sterilizer until it has been inspected and/or repaired.
g. Dental assistants will check all shelf supplies and instruments in the clinic and pull from inventory any item with a corresponding date, autoclave number, and cycle number, from all loads since last negative biological indicator.
h. All recalled supplies and instruments will be repackaged and re-sterilized.
i. For any supply or instrument that is not located, begin the investigation to identify potential patients that may have been affected by a breach of sterilization and notify the Dental Director. All instruments are quarantined.
j. The cycle/autoclave indicator tag will be retained and attached on the incident report as noted by positive biological indicator.
k. After reviewing all available data, the Dental Director or Dental Assistant Supervisor will determine if the autoclave remains in service or be taken out of service until causative factors are resolved through service, repair, and validation.
l. After correction of identified cause, immediately re-challenge.
m. Documentation of sterilizer details, causative factors, follow-up action and results of validation testing will be maintained in the sterilizer repair log, as well as on the sterilization log.

- Maintenance

Cleaning, maintenance, and record keeping/documentation of equipment will be performed according to manufacturer's IFU.

5.8 <u>Employee Competence</u>

SECTION 6: Specific Dental Practices

6.1 <u>Dental Unit Waterline Quality</u>

CHW routinely tests and documents dental unit water quality to verify the dental unit water measures less than or equal to 500 colony forming units of heterotrophic bacteria per milliliter (≤500 CFU/mL) of water, the standard set for drinking water by the Environmental Protection Agency (EPA).

- CHW employs multiple methods to aid in reducing the amount of biofilm in the dental unit water lines (DUWL's).

  - Use self-contained water bottle delivery systems.
  - Use spring water as the 'source water'.
  - Use sterile water or saline for the 'source water' when completing surgical procedures. Not used in the self- contained water system.
  - Discharge water and air for a minimum of 20-30 seconds after each patient from any device connected to the dental water system that enters a patient's mouth (handpieces, ultrasonic scalers).
  - Use approved products to complete periodic 'shocking' of DUWL's.
  - Use approved products to maintain DUWL's between shocking procedures.

- See “Protocol for Use of the A-Dec Self Contained Water System”, “Monitoring Waterline Quality procedures according to A-Dec recommendations” and “Procedure for collecting water sampling” for more information regarding specific procedures.

6.2 Dental Operatory Disinfection

- All members of the healthcare team will comply with the current Center for Disease Control and Prevention (CDC) recommendations for proper usage of surface disinfecting agents.
- Barriers must be used on clinical contact surfaces which are ‘difficult to clean’, including, but not limited to
  - Air/water control buttons
  - Suction control levers
  - Overhead light handles
  - Chair control buttons
  - Computer keyboards/mouse

- All clinical contact surfaces that are not barrier-protected are cleaned and disinfected by utilizing a two-wipe process after each patient.
  - Step 1: The first “cleaning” wipe removes visible debris and large numbers of microorganisms from surfaces.
  - Step 2: The second “disinfecting” wipe kills organisms on surfaces and items that cannot be heat sterilized. Follow manufacturer’s Instructions for Use (IFU) for the recommended contact time of how long the surface needs to remain “wet” to achieve the “Disinfects time”.
  - Between Step 1 and 2, gloves must be removed, hand hygiene performed, and new gloves must be done.

6.3 Dental Radiation Safety

- CHW follows Texas State guidelines to implement radiation safety through the ALARA (“as low as reasonably achievable”) principles.
- Dental radiographs are prescribed based on the American Dental Association dental radiographic recommendations.
- Individuals who operate only dental x-ray machines are exempt from individual monitoring requirements (Texas Administrative Code §289.232(d)).
- Appropriate barriers, PPE and patient shielding are used while taking x-rays.
- In order to maintain the integrity of the protective shields (aprons/capes), they should be hung with no crimping or folding.
- Visually inspected before each use.
- Apron inspections are performed annually using x-ray medical imaging.
- All dental radiation equipment is certified by a qualified radiation inspector on a regular basis.

SECTION 7: Medication and Safety Injection Practices

7.1 Sharps and Injection Related Practices and Controls

Engineering, work practice and environmental controls have all been developed to prevent and control the spread of infection related to the use of needles and other sharps in the healthcare setting.

7.2 Sharps Handling

Contaminated sharps are needles, blades (such as scalpels), scissors, and other medical instruments and objects that can puncture skin. Contaminated sharps must be properly disposed of immediately or as soon as possible in containers that are closable, puncture-resistant, leak-proof on the sides and bottom and color-coded or labeled with a biohazard symbol.

- Discard needle/syringe units without attempting to recap the needle whenever possible.
- If a needle must be recapped, NEVER use both hands. Use the single hand "scoop" method by placing the cap on a horizontal surface, gently sliding the needle into the cap with the same hand, tipping the needle up to allow the cap to slide down over the needle, and securing the cap over the needle with the same hand.
- Never break or shear needles.
- To move or pick-up needles, use a mechanical device or tool, such as forceps, pliers, or broom and dustpan.
- Dispose of needles in labeled sharps containers only; sharps containers must be accessible and maintained upright. When transporting sharps containers, close the containers immediately before removal or replacement to prevent spillage or protrusion of contents during handling or transport.
- When transporting sharps containers, close the containers immediately before removal or replacement to prevent spillage or protrusion of contents during handling or transport.
- Fill a sharps container up to the fill line or two thirds full. Do not overfill the container.

7.3 <u>Safe Injection Practices</u>

Unsafe injection practices put patients and healthcare providers at risk for infection. Safe injection practices are part of Standard Precautions and are aimed at maintaining a basic level of patient safety and provider protections.

Recommended practices for injection:

- To the extent possible, prepare medications in dedicated medication rooms.
  - ✓ Draw up medications in the medication room or a designated clean area, free of any items potentially contaminated with blood or body fluids (e.g., syringes, needles, blood collection tubes and needle holders).
  - ✓ Multi-dose vials should not be accessed in the immediate patient treatment area. If a multi-dose vial enters the immediate patient-care area, it should be dedicated to that patient and discarded after use. Avoid Multi-dose vials, if possible, use single-use vials that are discarded after single patient use.

- Use an aseptic technique to access parenteral medications.
- Perform hand hygiene before handling the medication.
- Disinfect the rubber septum with alcohol and allow alcohol to dry prior to piercing. This includes newly opened medication (either multi-vial or single dose) as well. Or according to medication IFU.
- Always use a new sterile syringe and sterile needle to draw up medication and avoid contact with a nonsterile environment during the process.
- Never leave a needle inserted into the septum, of a vial for multiple draws.
- Ensure that any device inserted into the septum is used in accordance with the discard medications:
  - ✓ According to the manufacturer's expiration date (even if not opened) and whenever sterility is compromised or questionable.
  - ✓ Single dose vials that have been opened or accessed should be discarded according to the manufacturer's time specifications or at the end of the case/procedure for which it is being used. Do not store it for future use.
  - ✓ Multi-dose vials that have been opened or accessed should be dated with the date opened and discarded within 28 days. The disposal date should also be included on the vial.

- Never administer medications from the same syringe to more than one patient, even if the needle is changed.
- Never enter a vial with a used syringe or needle.
- Never use medications packaged as single-dose vials for more than one patient.

- Assign medications packed in multi-dose vials to a single patient whenever possible. Safe injection practices include:
- Contaminated needles and other contaminated sharps shall not be bent, recapped, or removed except as noted below. Shearing or breaking of contaminated needles is prohibited.
- If an employer can demonstrate no alternative that is feasible or that such an action is required by specific medical or dental procedure, bending, recapping, or needle removal must be accomplished using a mechanical device or one-handed "scoop" technique.
- Immediately or as soon as possible after use, contaminated reusable sharps shall be placed in appropriate containers until properly reprocessed. Reusable sharps are that contaminated with blood or OPIM shall not be stored or processed in a manner that requires employees to reach by hand into the container.

SECTION 8: Specific Lab and Radiology Practices

- Standard Precautions.
- Cleaning/disinfecting all surfaces in blood draw stations and radiology table: Start of the day, end of the day and after every patient contact.
- Patients supplied with disposable paper gowns, paper shorts, and paper pillow covers for disposal after 1-time patient use.
- Positioning wedges (plastic) cleaned/disinfected after patient use.
- Vein Finder cleaned/disinfected after every patient use, according to manufactures instructions.
- Lab centrifuge, inspected daily and cleaned/disinfected every week, documented on centrifuge logbook.

SECTION 9: Reporting Communicable Diseases

The list of communicable notifiable conditions required by Texas Department of State Health Services to be reported is attached. See Texas Notifiable Conditions -2023, rev. 1/08/2023 expires 12/31/2023. In addition to these conditions, any outbreaks, exotic diseases, and unusual group outbreaks of disease must be reported. All cases shall be reported by name of patient, age, sex, race/ethnicity, DOB, address, telephone number, disease, date of onset, method of diagnosis, and name, address, and telephone number of providers.

The list indicates when to report each condition. Cases or suspected cases of illness considered being public health emergencies, outbreaks, exotic diseases, and unusual group expressions of disease must be reported to the GCHD epidemiology department immediately (ext. 2238, 2208, or 2215). These incidents are also to be reported to the Medical Director, Dental Director (if a dental patient), the COO and the Nursing Director. Other diseases for which there must be a quick public health response must be reported within one working day. All other conditions must be reported to the epidemiology department within one week, Monday-Friday 8:00am-5:00pm., reporting number is 409-938-2215. After hours reporting number is 409-220-1523.

SECTION 10: Emergency Management and Planning

Emergency management of infectious patients is directed at early detection and swift isolation. In the event an emergency results in the inability of the facility to continue providing services in a safe manner, CHW will initiate its plan for continuity of services as described in the "CHW Emergency Operations Plan".

References:

a. Guide to Infection Prevention for Outpatient Settings: Minimum Expectations for Safe Care, Center for Disease Control, version 2.3-September 2016
b. AAMl- Association for the Advancement of Medical Instrumentation. ANSI/AAMI ST 79-Comprehensive Guide to Steam Sterilization and Sterility Assurance in the Health Care Facilities. Arlington, VA: Association for the Advancement of Medical Instrumentation; 2017.

c. Infection Prevention Check list for Dental Settings: Basic Expectations for Safe Care, Center for Disease Control
d. Updated U.S. Public Health Service Guidelines for the Management of Occupational Exposures to HBV, HCV and HlV and Recommendations for Post exposure Prophylaxis, MMWR June 29,2001/Vol.50/ No. RR-II
e. Guidelines MMWR June 6, 2000/Vol. 52/No.RR—10
f. http://www.nnoha.org/nnoha-content/uploads/2018/1O/IPC-NNOHA-Power-Point-2018.pdf
g. https:/www.cdc.gov/sharpssafe ty/pdf/sharpsworkbook2008.pdf
h. https:/www.dshs.texas.gov/lDCU/disease/tb/forms/PDFS/TB-600.pdf
i. https://www.gchd.org/home /showpublisheddocument?id=8805
j. https://dshs.texas.gov/lDCU/investigation/Reporting-forms/Notifiable-Conditions-2021-Color.pdf
k. https://www.dshs.texas.gov/lDCU/disease/tb/forms/PDFS/TB-600.pdf
l. https://www.dshs.texas.gov/disease/tb/faq.shtm#HCW
m. https://www.cdc.gov/nchhstp /newsroom/2019/recommendations- for-tb-screening.html
n. https: //www.cdc.gov/tb/topic/ testing/healthcareworkers.html

Appendices:

a.
   i. https://www.gchd.org/home/showdocument? id= 5 l08
   ii. https://www.gchd.or g/home/showdocument ?id=6069
   iii. https://www.gchd.org/home /showdocument ?id=5 l 94
   iv. https://www.gchd.org/home/showdocument ?id=4570
b. U.S. Public Health Service Guidelines for the Management of Occupational
   i. http://www.cdc.gov/mmwr/preview/mmwrhtml/rr50llal.htm
   ii. www.gchd.org/notify
c. CHW Emergency Operations Plan
   i. https://www.gchd.org/home/showdocument?id=6l5l

Forms:

1. Employee Incident or Injury Report:
   a. http://www.gchd.org/home/showdocument? id= 5448
2. Infectious Disease Reporting Form:
   a. www.gchd.org/reports
3. Notifiable Conditions:
   a. www.gchd.org/notify
4. DSI IS ComHcl!ateSettings *Tuberculosis Risk Assessment* form

Annual reviews conducted by Compliance Committee, GB QA Board Committee.

X

Samantha Robinson, RN
Chairman, Coastal Health & Wellness Gover...

Date _____

See Appendix **A** CHW Bloodborne Pathogens

2023 Coastal Health & Wellness
Bloodborne Pathogen Exposure Control Plan

Based on OSHA's Blood borne Pathogen Standard 29 CFR 1910.1030
Appendix to the CHW 2023 Infection Control Plan

All the requirements of OSHA's Bloodborne Pathogen standard can be found in Title 29 of the Code of Federal Regulations at 29 CFR 1910.1030. The standard states what employers must do to protect workers who can reasonably be anticipated to come in contact with blood or other potentially infectious materials (OPIM).

In general, the standard requires employers to:

Establish an exposure control plan, update annually, and a written plan that describes how the employer will eliminate or minimize occupational exposures. At a minimum the following three elements must be present in exposure control plan:

Exposure determination:

1. Listing of job classifications in which employees will be exposed or may occasionally be exposed.

   Policy: Employee and Pre-hire Immunizations and Screenings UBOH last Approved 8/11/2022.

   Category 2; Health Care Employees performing tasks involving exposure to blood of blood- contaminated body fluids. For example, nurses, medical assistants, providers, lab technicians, dentists, dental assistants, EMS, and WIC staff.

2. **Vaccine Responsibility**: Hepatitis B vaccine is required for state licensing. Pre-hire must show proof of beginning series, GCHD will provide remaining dosages after hire date.
   Post-Exposure evaluation and follow-up communication of hazards to employees, and recordkeeping.

3. The procedure for the evaluation of circumstances surrounding exposure incidents. Describe what constitutes an exposure incident, immediate treatment, medical follow-up, and reporting.

Other Key Requirements:

- Providing education and training
- Providing personal protective equipment (PPE)
- Identifying and use of engineering controls
- Making hepatitis B vaccination available to workers with occupational exposure
- Making available post-exposure evaluation and follow-up to any occupationally exposed worker who experiences and exposure incident
- ***Proper*** waste disposal
- ***Communication*** of hazards
- Housekeeping and laundry practices
- Recordkeeping

Providing annual employee education and training:

- An accessible copy of the regulatory text of the standard and an explanation of its contents.
- A general explanation of the epidemiology and symptoms of bloodborne pathogens.
- An explanation of the employer's exposure control plan and how the employee can obtain a copy of the written plan.

- An explanation of the appropriate methods for recognizing tasks and other activities that may involve exposure to blood and OPIMs.
- An explanation of the use and limitations of methods that will prevent or reduce exposure including appropriate engineering controls, work practices, and PPE.
- Information on the types, proper use, location removal, handling, and disposal of PPE.
- An explanation of the basis for selection of PPE.
- Information of the HBV vaccine, including information on its efficacy, safety, method of administration, the benefits of being vaccinated, and that the vaccine and vaccination will be offered free of charge.
- Information on the appropriate actions to take and persons to contact in an emergency involving blood or OPIMs.
- An explanation of the procedure to follow if an exposure incident occurs, including method of reporting the incident and the medical follow-up that will be made available.
- Information on post-exposure evaluation and follow-up that the employer is required to provide for the employee following an exposure incident.
- An explanation of the warning signs and labels and/or color coding; and
- An opportunity for interactive questions and answers with the person conducting the training session.

Providing Personal Protective Equipment (PPE):

- Single use gloves
- Masks, eye protection and face shields
- Gowns and other protective clothing

Engineering and administrative controls:

- Puncture resistant sharps containers, biohazard waste containers, self-sheathing needles, medical devices for increased safety
- Work practice controls: hand washing policies, sharps handling procedures, proper waste disposal techniques, and more to reduce the likelihood of exposure through the alteration of the way the task is performed.
- CHW Staff will take part in biannual *or as needed* Sharp Injury Prevention Committee meetings facilitated by the CHW Infection Control Nurse or designee.

Waste disposal:

- All blood or OPIMs contaminated items that could release infectious materials must be placed in appropriate sharps containers or closable, color-coded or properly labeled leak-proof biohazard waste containers or bags. Regulated medical waste must be disposed of in accordance with federal, state, and local regulations.

Communication of Hazards

- Warning labels must be attached to all containers used for the storage or transport of potentially infectious materials. The labels must be orange or red-orange with biohazard symbol in a contrasting color.

Housekeeping:

- A schedule for periodic cleaning and appropriate disinfecting to ensure the worksite is kept clean and sanitary.

Record keeping:

- The employer must maintain medical and training records for each employee who faces the possibility of being exposed or who has been occupationally exposed to a bloodborne pathogen.
- Employers are also required to establish and maintain a sharps injury log.

Making available post-exposure evaluation and follow-up to any occupationally exposed worker who experiences and exposure incident:

- **An exposure incident is a specific eye, mouth, other mucous membrane, non-intact skin, or** parenteral contact with blood or OPIM.
- The evaluation and follow-up must be at no cost to the worker.

Reporting at CHW:

- Occupational illnesses and or exposures which require post exposure management will be handled in accordance with the District's *Infection Control Plan,* which outlines prevention, reporting and follow-up requirements. See Workers' Compensation Policy GCHD plans UBOH last approved 2/22/2022.

- If an exposure occurs, immediately stop what you are doing, remove PPE, and wash the site of injury with soap and water, if possible.

- Notify your supervisor and HR 409-938-2260 or email (GCHD_HR@gchd.org)

- Supervisor or HR will assist employee with the following.

- Open a Workers' Compensation claim and connect the employee with CHN for post-exposure counsel.

- **Access the "What to Do If You Have an On-The- Job Injury/Exposure" This 1-page flyer will give you directions/steps of what to do.** (Employee Extranet/Safety & Emergency Information/ Risk and Safety/ Injury Accident/Exposure Flyer).

- Access the Employee Incident or Injury report and "First Fill" for Proscriptions. (On Employee Extranet).

- CHW "Process for needle stick/ exposure". (Or other sharps injury that penetrates the skin). Has process for blood draw from "source patient" (Employee Extranet Homepage/Safety and Emergency information/Risk and Safety/CHW Process for needle stick/ exposure.

- Log of the sharp's injuries will be maintained by a Community Health Services representative.

- Forward the completed, Contaminated Sharps Injury form to Epidemiology Services.

Reporting the Contaminated Sharps Injury:

- ✓ Reported to Department of State Health Services/Infectious Disease Control. https://www.dshs.state.tx.us/1DCU/health/infectioncontrol/bloodbornepathogens/Reporting.aspx

- ✓ The facility where the injury occurs should complete the form: Contaminated Sharps Injury Form (Pub No EF 59-10666 (6/04)
- ✓ The completed form is submitted to GCHD: Epidemiology Services Fax- 409-938 -2399 or call 409-938-2215 for information. The report will be logged on the Galveston County Spread Sheet.
- ✓ GCHD/The Local Health Authority, acting as an agent for the Texas Department of State Health Services will receive and review the report for completeness and submit the form to Texas Department of Health Services in Austin.

See Appendix **B** CHW Respiratory Protection Plan 2023

Coastal Health & Wellness
Respiratory Protection Plan

Based on OSHA's Occupational Safety and Health Standards
Personal Protective Equipment and Respiratory Protection 1910.134
Appendix to the CHW 2023 Infection Control Plan

The purpose of this Respiratory Protection Plan (RPP) is to maximize the protection afforded by N95 respirators when they must be used. An RPP establishes procedures necessary to meet the regulatory requirements described in OSHA's Respiratory Protection standard (29 CFR 1910.134).

This program applies to all employees and contractors who are required to wear respiratory protection due to the nature of their work at Coastal Health & Wellness (CHW).

Key Requirements of a Respiratory Protection Program:

- Written program with specific guidelines and standard operating procedures
- Program Administrator
- Hazard evaluation and respirator selection
- Medical evaluation for respirator wearers
- Respirator Fit Testing: initial, annual, or after any physical changes that may affect fit
- Proper respirator: use, storage, maintenance, repair, and disposal.
- Training
- Program evaluation
- Recordkeeping

Written program with Policies and Procedures:
Compliance to OSHA Standard 29 CFR 1910.134 as it applies to N95 Filtering Facepiece respirators.

Program administrator:

- The Respiratory Program administrator (RPA) is knowledgeable about the requirements of the OSHA Respiratory Protection standard and all elements of the respiratory protection program that need to be implemented to be effective. The designated Program administrator is the Nursing Director.
- Facility administration has the ultimate responsibility for all aspects of this program and has given Nursing Director full authority to make the necessary decisions to ensure its success. This authority includes, but is not limited to, conducting hazard assessments for selecting appropriate respiratory protection, purchasing the necessary equipment and supplies, and developing and implementing the policies and procedures described in this written RPP.
- Supervisors, employees, infection control nurse, employee health nurse or occupational/ risk management to participate in the hazard evaluation and respirator selection for facility staff. Based on the hazards to which employees may be exposed.

Hazard evaluation & respirator selection:

- The RPA will select the types of respirators to be used by facility staff based on the hazards to which employees may be exposed and in accord with OSHA regulations and Centers for Disease Control and Prevention (CDC), and other public health guidelines. With input from the respirator

user, the RPA and supervisor will conduct a hazard assessment for each task, procedure, or work area with the potential for airborne contaminants.

- Staff may have the potential to be exposed to ATD pathogens (Aerosol Transmissible Diseases). This RPP covers the use of N 95 respirators only.
- A review of work processes to determine levels of potential exposure for all tasks and locations. For example, patients undergoing cough-inducing or aerosol-generating procedures in the dental or medical clinical areas.
- All N 95 particulate filtering face piece respirators shall be approved by the National Institute for Occupational Safety and Health (NIOSH) for the configuration and environment in which it is going to be used. NIOSH-approved respirators have an approval label on or within the packaging and abbreviated approval on the respirator. All respirators are verified by the approval number on the NIOSH Certified Equipment List (CEL). Verification before any N95's are fit tested and used by staff. Or any indication that the N95 is counterfeit or notice from NIOSH or CDC that an approval has been removed by NIOSH.
- The RPA will revise and update the hazard assessment any time an employee or supervisor identifies or anticipates a new exposure or changes to existing exposures.
- Occupational exposure is defined in this regulation as "exposure from work activity or working conditions that is reasonably anticipated to create an elevated risk of contracting any disease caused by ATPs.

Medical Evaluation for respirator wearers:

- The employee will complete a Medical Clearance Questionnaire (Appendix C to Sec.1910.134: OSHA Respirator Evaluation Questionnaire, mandatory). The healthcare professional (HCP) will review and make a medical determination as to whether the employee can wear a respirator safely. The HCP may make this determination based on the questionnaire alone but may also require a physical examination of the employee and any tests, consultations, or procedures the HCP deems are necessary before determination is made.
- To ensure the confidentiality of medical information, the medical evaluation should not be conducted by the employee's immediate supervisor and others in the employee's direct line of authority. The questionnaire will be secured in HCP office until time that it is secured in HR, separate from the employees HR file.

Respirator Fit Testing: initial, annual, or after any physical changes that may affect fit:

- There is no requirement for certification of fit testers, but you must be sure that the person doing the fit testing understands and follows the fit test protocol and understands how to train the wearer to don the respirator properly and do a user seal check.
- Use the same make, model, style, and size of N95 as will be used in the facility.
- Employees will be offered a selection of several models and sizes of N95 respirators, based on availability, from which they may choose the one that correctly fits and is most acceptable/comfortable. An initial fit test and annual thereafter or any physical changes a fit test must be completed.
- After employee completes and passes the fit test, the supervisor and employee will be notified by e-mail what brand, size, model number that the employee has been cleared to use. Only that N95 respirator can be used unless request is made by employee or facility to change. At that time the fit test will need to be repeated for the change of N95 respirator.
- A log is maintained and updated by the fit tester by department, for each employee that is in that department, indicating date of fit test, brand/size/model. The log is e-mailed to supervisor and staff ordering for the department and laminated for posting, so correct N95 respirator is available and worn by employee. Also, for annual re-fit testing date.

- A qualitative fit test may be used for all wearers of N95 filtering facepiece respirators. The qualitative test will follow the protocol for: • Saccharine • Bittrex• solutions found in Appendix A of the OSHA Respiratory Protection standard (29 CFR 1910.134).
- Consideration proposed for another available test is the quantitative ambient aerosol condensation nuclei counter (CNC) fit testing protocol and this test can be used to replace the qualitative test: For employees that cannot tolerate the Qualitative test. At this time the test would need to be performed by outside agency or purchase and training for CNC machine.

Proper respirator: use, storage, maintenance, repair, and disposal:

- Disposable filtering facepiece respirators are generally a one-time use item. The respirator must be discarded when it is no longer in its original working condition, whether that condition results from contamination, structural defects, or wear.
- Disposable filtering facepiece respirators that will be reused inpatient care areas should be stored in a breathable container such as a paper bag labeled with the user's name.
- Disposable filtering facepiece respirators are not repaired. Defective disposable respirators will be discarded and replaced with a new N95 respirator.
- New N95 respirators will be stored in original packaging, with clean supplies/PPE.

Training:

- Training shall be provided at the time of initial assignment to respirator use, but before actual use, and annually thereafter. Additional training will be provided when there is a change in the type of respiratory protection used, or when inadequacies in the employee's knowledge or use of the respirator indicate that he or she has not retained the requisite understanding or skill.
- The employee will also receive training during the fit testing procedure that will provide an opportunity to handle the respirator, have it fitted properly, test its facepiece-to-face seal, wear it in normal air to familiarize themselves with the respirator, and finally to wear it in a test atmosphere. Every respirator wearer will receive fitting instructions, including demonstrations and practice in how the respirator should be worn, how to adjust it, and how to perform a user seal check according to the manufacturer's instructions. See training power point.
- Employees will be given the opportunity during training, annual retraining and throughout the year to provide feedback on the effectiveness of the program and suggestions for its improvement.

Program evaluation:

- The RPA will conduct a periodic/annual, evaluation of the RPP to ensure that all aspects of the program meet the requirements of the OSHA Respiratory Protection standard and that the RPP is being implemented effectively to protect employees from respiratory hazards.
- Program evaluation will include a review of the written program. And a review of feedback obtained from employees (to include respirator fit, selection, and use that will be collected during the annual training session.
- Any other methods used for program evaluation at facility.

Recordkeeping:

- Personnel medical records such as medical clearance to wear a respirator shall be retained by: HR, but not as part of the HR file. Medical clearance records must be made available in accord with the OSHA Access to Employee Exposure and Medical Records standard (29 CFR 1910.1020) and maintained for a minimum of thirty (30) years after an employee's separation or termination.
- Documentation of training and fit testing will be kept, stored with respiratory protection plan: until the next training or fit test

- A copy of this RPP and records of program evaluations and revisions shall be kept by and made available to all affected employees, their representatives, and representatives of OSHA upon request.

Back to Agenda

Governing Board
July 2023
Item#11
Consider for Approval Coastal Health & Wellness Revised Credentialing and Privileging Policy

-Approved: 2/16/2023
- 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, Chief Operating Officer, Compliance & Risk Management Officer, 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, 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 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* Immunizations/Communicable disease screenings that are verified according to GCHD Employee and Prehire Immunization Policy	Copy of immunization records/status in 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 performance reviews or other comparable methods.	Supervisory evaluation per job description.

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 because 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 because 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
July 2023
Item#12
Consider for Approval Forvis Review Project

Samantha Robinson, BSN
Chair, Governing Board

Philip Keiser, MD
Executive Director

Coastal Health & Wellness

www.coastalhw.org

July 24, 2023
GB Finance Committee

Re: Review and Approve the FORVIS 2023_2024 RCM Project – Phase II

Service	Estimated Cost	Return
Medicare and Medicaid Cost Report Preparation and PPS Rate Appeal	$15 - $20 K	Would allow for us to appeal for an updated Medicaid PPS Rate (reimbursement rate) Current Rate $174.84 per visit Potential Updated Rate $300 per visit
Fee Schedule Assessment Project	$11K plus 5% administrative fee	Bring our fees up to what other FQHCs are being reimbursed at. Renegotiate payer fee schedules based on assessment results. Review and update Charge Master in NG. Reimbursement increased to payer allowed amounts.
MA Wrap Payment Application	$10K	Current Reimbursement for Medicare Advantage is ~$65/visit. Filing for PPS Wrap payment allows for CHW to be reimbursed the full PPS rate, $174.84 as opposed to $65.

Project timeline – 6 – 8 months.

TEXAS MEDICAID SUPPLEMENTAL PAGES TO THE MEDICARE COST REPORT
TEXAS MEDICAID & HEALTHCARE PARTNERSHIP
TEXAS MEDICAID (TITLE XIX) PROGRAM

DETERMINATION OF FQHC COST-BASED RATE

FQHC NAME:	TPI NUMBER:	REPORTING PERIOD:	RATE WORKSHEET
Coastal Health & Wellness		10/1/21 TO: 9/30/22	MEDICARE COST REPORT (__) Audited (__) As Filed

DETERMINATION OF FQHC COST-BASED RATE	
1. TOTAL ALLOWABLE COST OF FQHC SERVICES (EXHIBIT 1)	7,713,467
2. TOTAL VISITS BY EMPLOYED AND CONTRACT HEALTH CARE PROVIDERS (EXHIBIT 2)	25,429
3. FQHC COST-BASED RATE PER VISIT (LINE 1/LINE 2)	303.33

REPORT PREPARER CONTACT INFORMATION

NAME : _____

Phone Number : 417-865-8701

Email Address : _____

TEXAS MEDICAID SUPPLEMENTAL PAGES TO THE MEDICARE COST REPORT
FQHC Name: Coastal Health & Wellness TPI Number:
DETERMINATION OF FQHC MEDICAID REIMBURSEABLE COST
YEAR ENDED September 30, 2022
EXHIBIT 1

		FQHC COST (DIRECT)	NON-FQHC AND NON-REIMB. COST (DIRECT)	TOTAL DIRECT COST	TOTAL OVERHEAD (INDIRECT COST)	GRAND TOTAL COST
	LINES	9 + 37 + 50	70 + 80		13 - 9	100
	TOTAL COST PER MEDICARE FQHC COST REPOR WORKSHEET A, COLUMN 7	2,462,896	2,219,249	4,682,145	6,256,282	10,938,427
				-		-
	RECLASSIFICATION OF EMR COSTS FROM OVERHEAD TO DIRECT			-	-	-
	RECLASSIFICATIONS TO MEDICAID FQHC COST: (OBTAINED FROM MEDICARE FQHC COST REPORT LINES 60-79 AS APPROPRIATE)					
67+77	PHARMACY	-	-	-		-
60	DENTAL	1,661,298	(1,661,298)	-		-
61	LABORATORY	231,460	(231,460)	-		-
62	RADIOLOGY	76,285	(76,285)	-		-
	SUBTOTAL COST	4,431,939	250,206	4,682,145	6,256,282	10,938,427
	ADD: MEDICAID COSTS ADJUSTED OUT OF MEDICARE FQHC COST REPORT WORKSHEET A-2:					
	PHARMACY COGS	-		-		-
	CONTRACTED LABORATORY	-		-		-
	CONTRACTED RADIOLOGY	-		-		-
	GRAND TOTAL COST	4,431,939	250,206	4,682,145	6,256,282	10,938,427
	FQHC OVERHEAD GUIDELINE AMOUNT				3,281,528	
	ALLOWABLE OVERHEAD COST	3,281,528				
	TOTAL ALLOWABLE COST OF FQHC SERVICES	7,713,467				

* PLEASE DESCRIBE THE SPECIFIC TYPE OF SERVICES BEING REPORTED ON THIS LINE.

TEXAS MEDICAID SUPPLEMENTAL PAGES TO THE MEDICARE COST REPORT
Provider Name: Coastal Health & Wellness TPI Number:
VISIT RECONCILIATION - EMPLOYED & CONTRACT PROVIDERS
YEAR ENDED September 30, 2022
EXHIBIT 2

TOTAL VISITS PER MEDICARE FQHC COST REPORT WORKSHEET B, PART I, COLUMN 2, LINE 11	17,606
DENTAL VISITS	7,823
VISITS BY EMPLOYED & CONTRACT HEALTH CARE PROVIDERS	25,429

* PLEASE DESCRIBE THE SPECIFIC TYPE OF SERVICES BEING REPORTED ON THIS LINE.

FORVIS

Coastal Health & Wellness
Scope of Work & Fee Estimate
July 6, 2023

The below proposed scope of work and fee estimate will provide a summary of the work performed to help support a health center in a review of their fees. In addition to the fee range as outlined below there is a 5% administrative fee.

Fee Schedule Assessment

For our fee schedule assessments, we use Fair Health Data for prevailing rate that is specific to a client's location based on zip code. Our analysis evaluates current charge by procedure code and utilization for a 12-month period for all payors as well as a carve out for Traditional Medicare, which allows us to do a deep dive on Medicare G code charges compared to geographically adjusted PPS rates. Additionally, we use cost report data and Relative Value Units (RVU's) to take cost into consideration. Both elements (prevailing rate and cost) are identified by HRSA in the compliance manual to consider when setting charges. As an option, we can incorporate any activity that providers render in a hospital setting and a review of private payor allowed amounts compared to charges. This assessment is performed for all services such as medical, behavioral health, dental, etc. that are provided to your patients.

At the conclusion of the assessment, we will provide you with a file of the results and conduct a call to discuss the outcome. Usually from the time we receive the data we complete these in about 4 - 6 weeks. Finally, after the review call, if there are any modifications you would like performed to model fees, we can assist with that as well.

Fee Estimate $9,000 - $11,000

Back to Agenda

Governing Board
July 2023
Item#13
Consider for Approval Benefit Package for UKG

ORDER FORM

Quote#: Q-179378
Expires: 30 Jul, 2023
Sales Executive: James Haskins
Effective Date: Effective as of the date of last signature of this Order

Order Type: Amendment
Date: 30 Jun, 2023

Customer Legal Name:
COUNTY OF GALVESTON

Customer Legal Address:
9850 EMMETT S LOWRY EXPY STE A114, TEXAS CITY, TX 77591-2122 USA

Bill To Contact:

Bill To: Galveston County Health District
PO BOX 939
LA MARQUE, TX 77568-0939 USA

Ship To Contact: Chris Davis

Ship To: COUNTY OF GALVESTON
9850 EMMETT S LOWRY EXPY STE A114
TEXAS CITY, TX 77591-2122 USA

Ship to Phone: 4099382221
Ship to Mobile:
Contact: Chris Davis
Email: cdavis@gchd.org

Currency: USD
Customer PO Number:
Solution ID: 6185033
Term: Co-Term
Uplift Percent: 4 %

Shipping Terms: Shipping Point
Ship Method: FedEx Ground
Freight Term: Prepay & Add
Renewal Term: 12 months
Payment Terms: Net 30 Days

Billing Start Date: Upon Signature of Order Form

Subscription Services

Billing Frequency: Annual in Advance

Subscription Services	Quantity	PEPM	Monthly Price
UKG READY BENEFITS	375	USD 3.46	USD 1,297.50
Total Price			**USD 1,297.50**

One Time Setup Fee

Billing Frequency: Billed 100% upon signature of the order form

Item	Total Price
One Time Setup Fees	**USD 2,700.00**

Quote Summary

Item	Total Price
Minimum Monthly SaaS Service & Equipment Rental Fee	USD 1,297.50

Item	Total Price
Minimum Annual SaaS Service & Equipment Rental Fee	USD 15,570.00

Item	Total Price
Total One Time Fees	USD 2,700.00

Order Notes:

The Professional Services Engagement Overview attached to this Order Form is a summary for the implementation services to be provided by UKG for the UKG Ready Setup Fees set forth on this Order Form.
This order entered into between the Customer and Kronos SaaShr, Inc., a UKG company, is subject to the terms and conditions of the Master Agreement Reference #18221 dated March 18th, 2019 between the Lead Agency (acting as "Owner") and Kronos SaaShr, Inc. (as the "Contractor"), as amended (collectively referred to as the “US Communities Agreement #18221”).

IN WITNESS WHEREOF, the parties have caused this Order to be executed by their authorized representatives and shall be effective as of the date of the last signature below.

COUNTY OF GALVESTON		**Kronos SaaShr, Inc.**	
Signature:	_____	Signature:	_____
Name:	_____	Name:	_____
Title:	_____	Title:	_____
Date:	_____	Date:	_____

The monthly price on this Order has been rounded to two decimal places for display purposes. As many as eight decimal places may be present in the actual price. Due to the rounding calculations, the actual price may not display as expected when displayed on your Order. Nonetheless, the actual price on your invoice is the true and binding total for this Order for purposes of amounts owed for the term.

Back to Agenda

Governing Board
July 2023
Item#14
Consider for Approval June 2023 Financial Report
Submitted by Trish Bailey

COASTAL HEALTH & WELLNESS

Governing Board

FINANCIAL SUMMARY

For the Period Ending

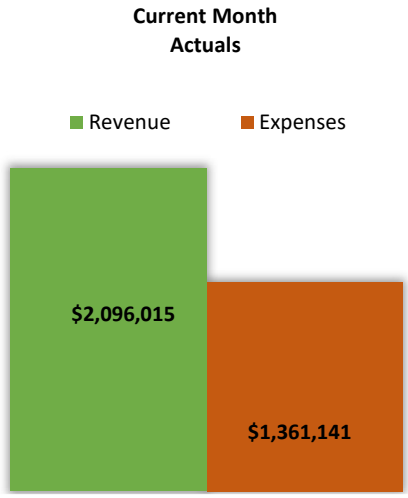
June 30, 2023

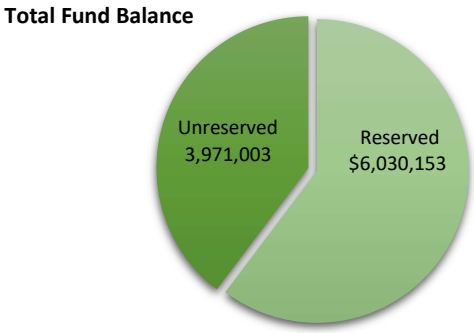
GCHD Board Room | 9850-A Emmett F. Lowry Expy. | Texas City, TX 77591

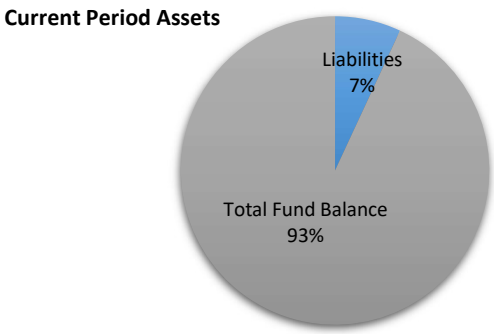
CHW - BALANCE SHEET

as of June 30, 2023

	Current Month Jun-23	Prior Month May-23	Increase (Decrease)
ASSETS			
Cash & Cash Equivalents	$6,388,692	$5,731,756	$656,937
Accounts Receivable	4,697,440	4,608,320	89,120
Allowance For Bad Debt	(741,387)	(693,592)	(47,795)
Pre-Paid Expenses	284,092	102,755	181,337
Due To / From	116,213	364,083	(247,869)
Total Assets	**$10,745,050**	**$10,113,321**	**$631,729**
LIABILITIES			
Accounts Payable	$133,372	$127,077	$6,294
Accrued Expenses	585,881	417,431	168,450
Deferred Revenues	24,642	302,531	(277,889)
Total Liabilities	**$743,894**	**847,039**	**($103,145)**
FUND BALANCE			
Fund Balance	$9,447,489	$9,447,489	0
Current Change	553,667	(181,207)	734,874
Total Fund Balance	**$10,001,156**	**$9,266,282**	**$734,874**
TOTAL LIABILITIES & FUND BALANCE	**$10,745,050**	**$10,113,321**	**$631,729**



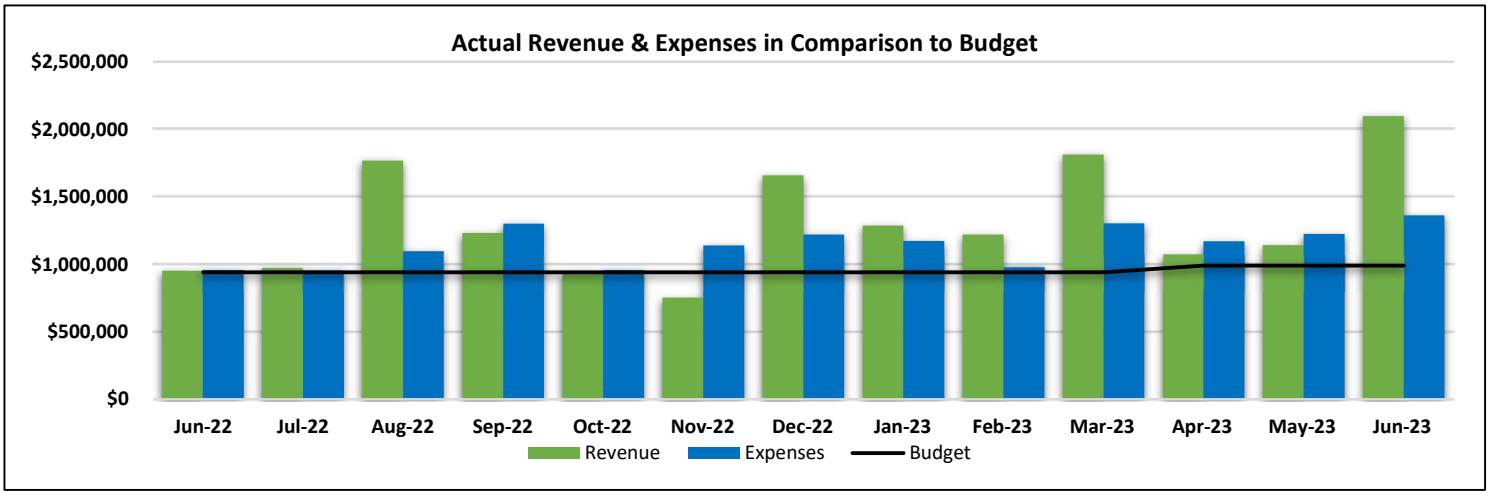


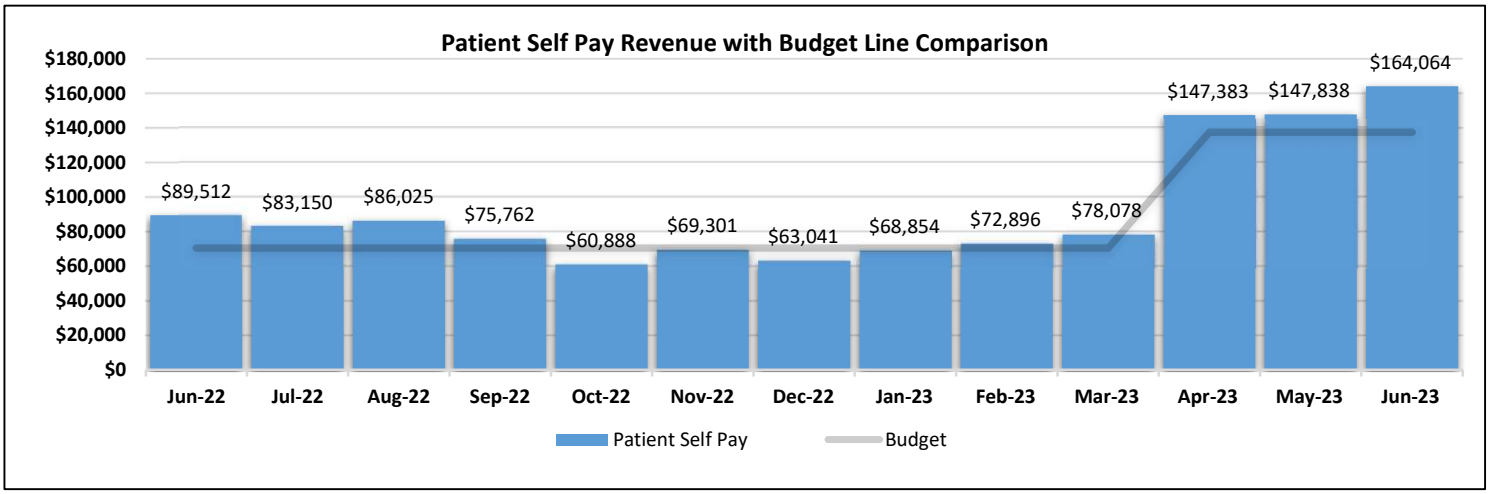


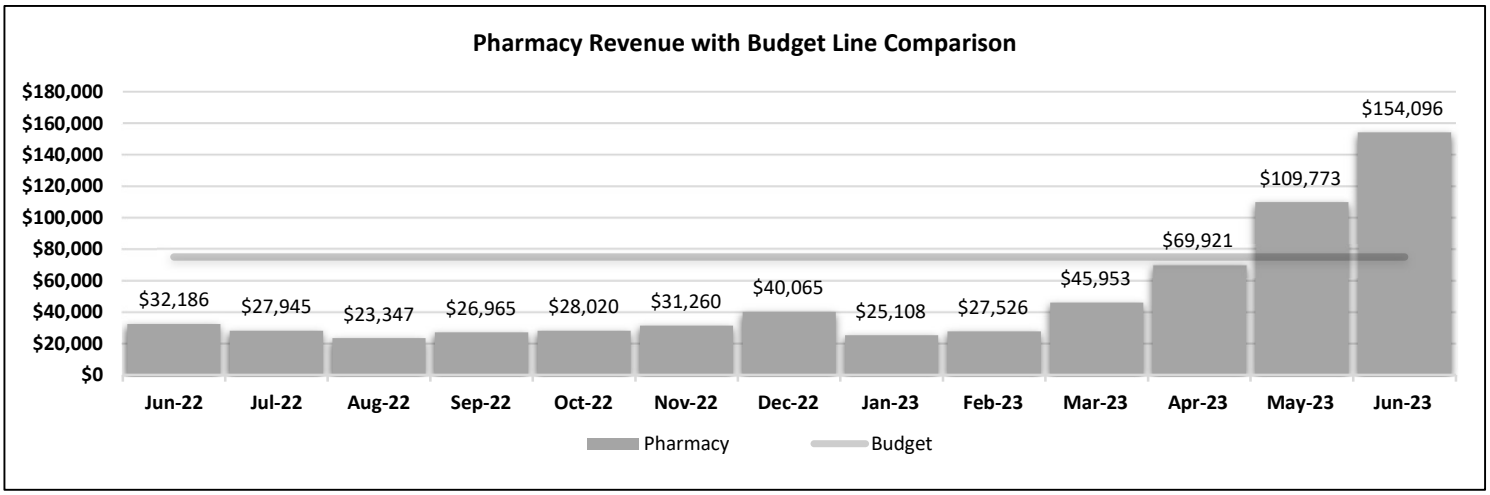
CHW - REVENUE & EXPENSES

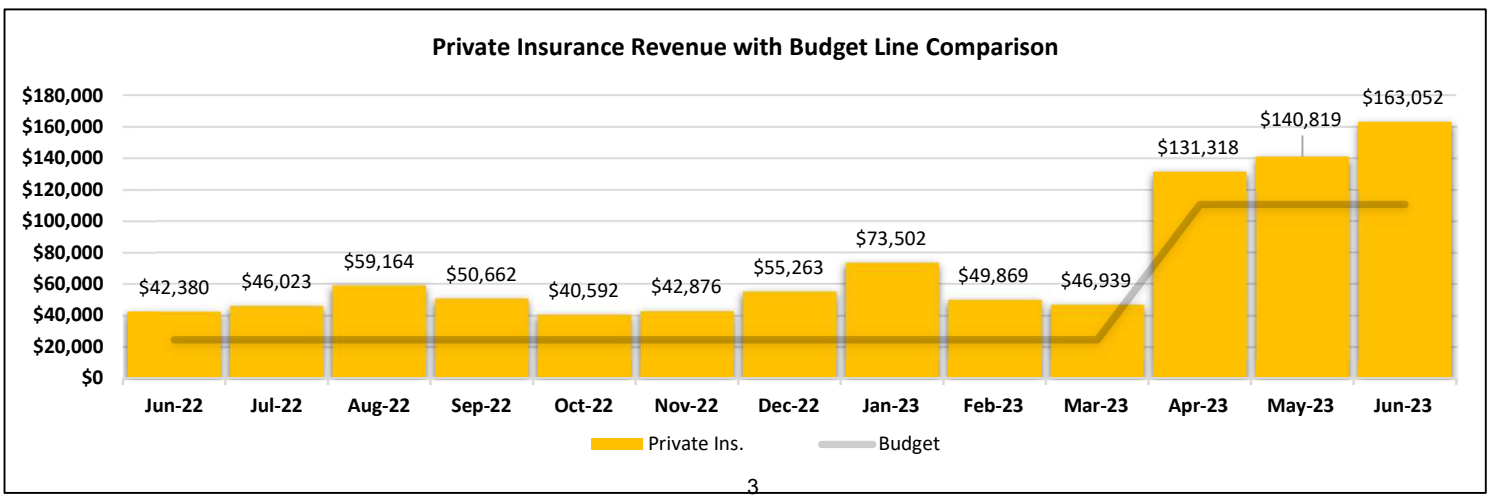
as of June 30, 2023

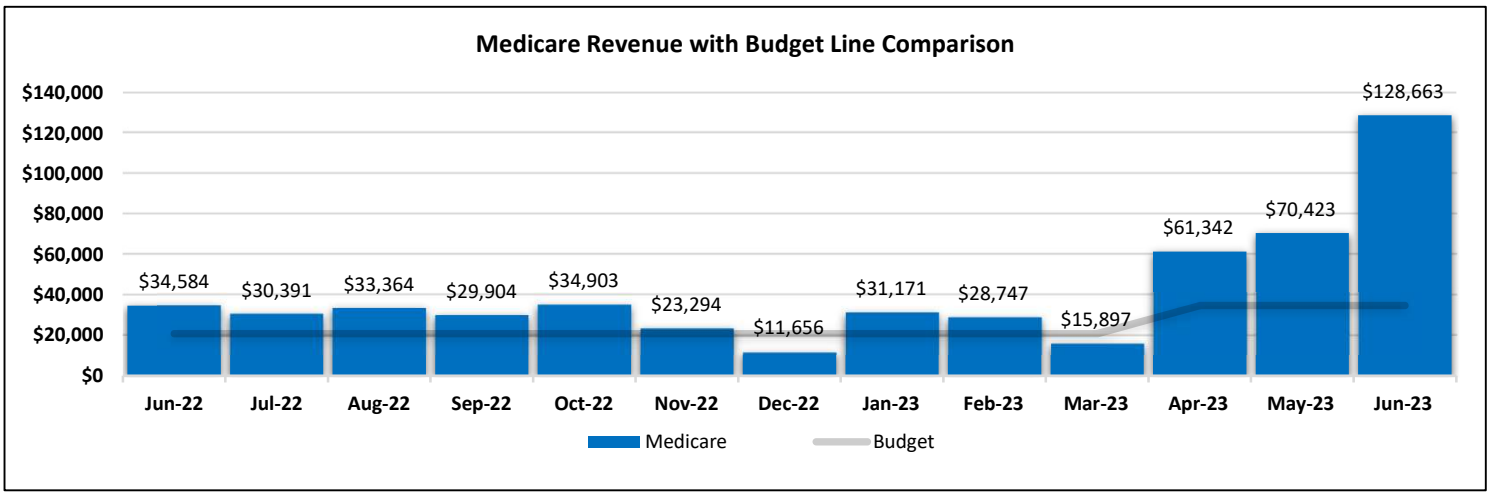
	MTD Actual Jun-23	MTD Budgeted Jun-23	MTD Budget Variance	YTD Actual thru Jun-23	YTD Budget thru Jun-23	YTD Budget Variance
REVENUE						
County Revenue	$277,889	$277,889	$0	$785,142	$833,667	(48,525)
DSRIP Revenue	0	0	0	0	0	0
HHS Grant Revenue	1,078,130	269,783	808,346	1,637,965	809,350	828,615
Patient Revenue	731,339	437,585	293,754	1,826,378	1,312,755	513,623
Other Revenue	8,657	29,406	5,074	57,163	10,750	46,413
Total Revenue	**$2,096,015**	**$1,014,663**	**$1,107,174**	**4,306,648**	**$2,966,522**	**1,340,126**
EXPENSES						
Personnel	$835,330	$852,583	$17,253	$2,406,811	$2,557,748	$150,936
Contractual	171,415	89,342	(82,073)	380,602	268,027	(112,576)
IGT Reimbursement	0	0	0	0	0	0
Supplies	116,745	94,645	(22,100)	428,493	283,936	(144,557)
Travel	1,512	767	(746)	5,916	2,300	(3,616)
Bad Debt Expense	47,795	48,151	356	137,818	144,454	6,635
Other	188,344	129,873	(58,470)	393,340	389,620	(3,720)
Total Expenses	**$1,361,141**	**$1,215,361**	**($145,779)**	**3,752,980**	**$3,646,084**	**($106,896)**
CHANGE IN NET ASSETS	**$734,874**	**($200,698)**	**$1,252,953**	**553,667**	**($679,562)**	**1,447,022**

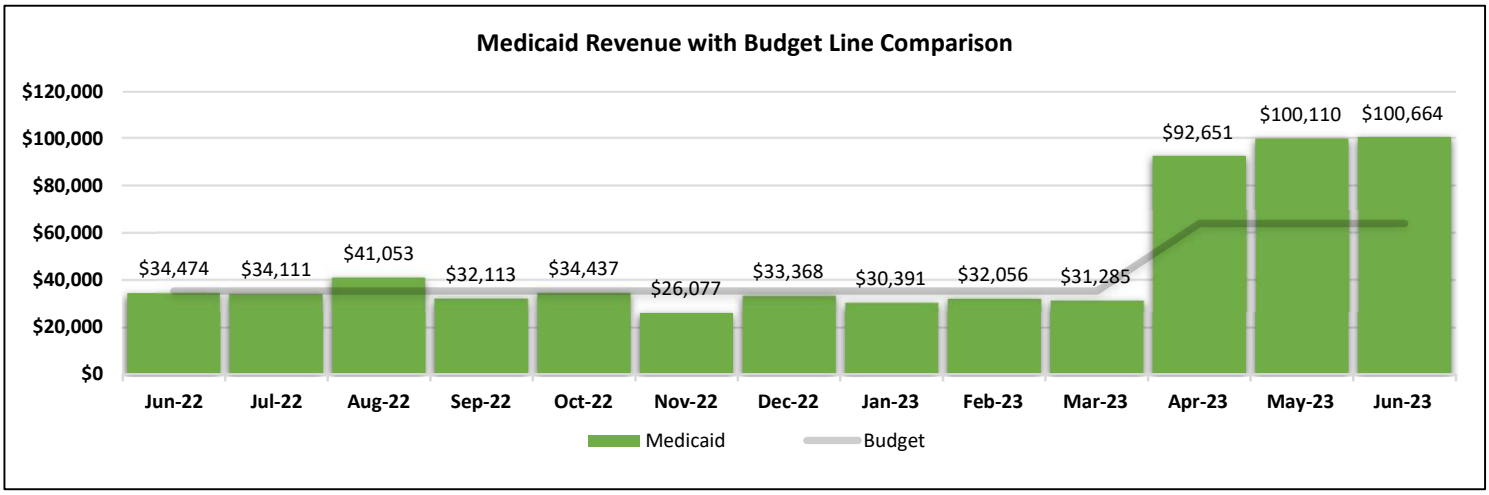

Actual Revenue & Expenses in Comparison to Budget
$2,500,000
$2,000,000
$1,500,000
$1,000,000
$500,000
$0
Jun-22
Jul-22
Aug-22
Sep-22
Oct-22
Nov-22
Dec-22
Jan-23
Feb-23
Mar-23
Apr-23
May-23
Jun-23
Revenue
Expenses
Budget

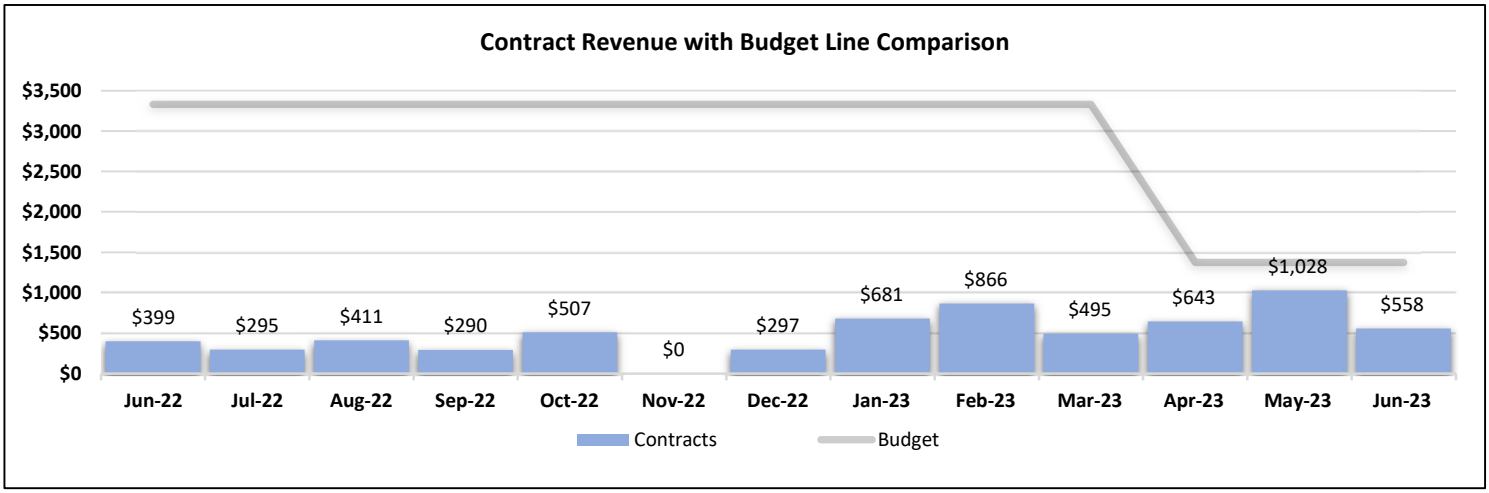

Patient Self Pay Revenue with Budget Line Comparison
$180,000
$160,000
$140,000
$120,000
$100,000
$80,000
$60,000
$40,000
$20,000
$0
$89,512
$83,150
$86,025
$75,762
$60,888
$69,301
$63,041
$68,854
$72,896
$78,078
$147,383
$147,838
$164,064
Jun-22
Jul-22
Aug-22
Sep-22
Oct-22
Nov-22
Dec-22
Jan-23
Feb-23
Mar-23
Apr-23
May-23
Jun-23
Patient Self Pay
Budget


Pharmacy Revenue with Budget Line Comparison
$180,000
$160,000
$140,000
$120,000
$100,000
$80,000
$60,000
$40,000
$20,000
$0
$32,186
$27,945
$23,347
$26,965
$28,020
$31,260
$40,065
$25,108
$27,526
$45,953
$69,921
$109,773
$154,096
Jun-22
Jul-22
Aug-22
Sep-22
Oct-22
Nov-22
Dec-22
Jan-23
Feb-23
Mar-23
Apr-23
May-23
Jun-23
Pharmacy
Budget


Private Insurance Revenue with Budget Line Comparison
$180,000
$160,000
$140,000
$120,000
$100,000
$80,000
$60,000
$40,000
$20,000
$0
$42,380
$46,023
$59,164
$50,662
$40,592
$42,876
$55,263
$73,502
$49,869
$46,939
$131,318
$140,819
$163,052
Jun-22
Jul-22
Aug-22
Sep-22
Oct-22
Nov-22
Dec-22
Jan-23
Feb-23
Mar-23
Apr-23
May-23
Jun-23
Private Ins.
Budget







Back to Agenda

Governing Board
July 2023
Item#15
Coastal Health & Wellness Updates

a) Current Public Health Concerns and Status; COVID/Flu/Monkey Pox Submitted by Executive Director
b) Operational Updates/Coastal Wave Submitted by Chief Operating Officer
c) Dental Updates Submitted by Dental Director
d) Medical Updates Submitted by Medical Director

Coastal Health & Wellness *Q2 2023* Health Center Update

Coastal Health & Wellness
Galveston County's Community Health Center

Providing access to high-quality primary care to any and all individuals in need.

coastalhw.org

Start with "Why"

Mission

Providing high quality healthcare to all

Vision

Healthy people in healthy communities

Coastal Health & Wellness
Galveston County's Community Health Center

Providing access to high-quality primary care to any and all individuals in need.

coastalhw.org

Pat on the Back

Besides better patient outcomes, the health center model of care decreases the use of costly care choices, such as **visits to emergency departments and hospitals**. Health center patients also had **24% lower spending** compared to non-health center patients across all services provided.

Qtr. 2 2023 Operational Report *(Visits)*

Department	* YTD Total Visits 2023	2022	% Change
Medical	12,845	7,829	64%
Dental	4,706	4,117	14%
Counseling	473	545	-13%
Total	**18,024**	**12,491**	**44%**

Total Visits by Financial Class	June 2023	June 2022	% Change	* YTD Average 2023	2022	% Change		* YTD Payor Mix 2023	2022	% Change
Self Pay	1,900	1,509	26%	1,802	1,360	32%		60.0%	66.3%	-6.4%
Medicare	254	108	135%	216	111	94%		7.2%	5.4%	1.8%
Medicaid	309	223	39%	324	215	50%		10.8%	10.5%	0.3%
Contract	89	67	33%	83	60	37%		2.8%	2.9%	-0.2%
Private Insurance	540	259	108%	480	264	82%		16.0%	12.9%	3.1%
Title V	120	39	208%	100	40	151%		3.3%	2.0%	1.4%
Total	**3,212**	**2,205**	46%	**3,004**	**2,050**	47%		**100%**	**100%**	

Coastal Health & Wellness
Galveston County's Community Health Center

Providing access to high-quality primary care to any and all individuals in need.

coastalhw.org

Qtr. 2 2023 Operational Report *(Patients)*

Unduplicated Visits	** YTD Total Users*		*%*
	2023	*2022*	*Change*
Medical	6,016	4,400	37%
Dental	1,828	1,523	20%
Counseling	122	153	-20%
Total	**7,966**	**6,076**	**31%**

Q2 New Pts. By Financial Class	
Payor - Financial Class	**Q2 2023 # of New Pts.**
CIHCP	2
Commercial - Dental	11
Commercial - Medical	180
Medicare Advantage	7
Medicaid - Medical	50
Medicaid - Dental	1
Medicare	51
Self Pay	494
Title V Medical	26
Title V Dental	6
Total New Pts. Q2 2023	**837**
Total New Pts. Charges Q2 2023	**$266,053.54**

Coastal Health & Wellness
Galveston County's Community Health Center

Providing access to high-quality primary care to any and all individuals in need.

coastalhw.org

Year to Date Payor Mix

	YTD Current Period				YTD Prior Year			
Payor	Visits	Payor Mix	Net Revenue per Visit	(Net Billed) Net Revenue	Visits	Payor Mix	Net Revenue per Visit	(Net Billed) Net Revenue
Self Pay	10,810	60.0%	$52.41	$566,574	8,159	66.3%	$58.07	$473,792
Medicare	1,296	7.2%	$207.48	$268,897.47	668	5.4%	$146.08	97,582
Medicaid	1,941	10.8%	$242.36	$470,427.43	1,290	10.5%	$180.62	233,003
Contract	497	2.8%	$253.30	$125,889.65	362	2.9%	$343.06	124,187
Private Insurance	2,878	16.0%	$144.46	$415,745.90	1,581	12.9%	$130.87	206,910
Title V	602	3.3%	$136.78	$82,340.00	240	2.0%	$135.97	32,632
Total	18,024	100%	$107.07	$1,929,875	12,300	100%	$94.97	$1,168,107

Charges & Collections	June 2023	June 2022	% Change	* YTD 2023	YTD 2022	% Change
Billed	$1,053,110	$737,133	43%	$5,967,302	$4,131,621	44%
Adjusted	(658,118)	(535,340)	23%	($4,037,427.31)	$ (2,963,513.45)	36%
Net Billed	$394,992	$201,793	96%	$1,929,875	$1,168,107	65%
Collected	$557,001.00	$226,729	146%	$ 2,489,899.01	$1,236,363	101%
% Net Charges collected	141%	112%	26%	129%	106%	22%

Qtr. 2 2023 Financial Report

Progress

% of Gross Self Pay Charges Collected									
2013	2014	2016	2017	2018	2019	2020	2021	2022	2023
11.90%	14.10%	13.10%	12.90%	11.20%	11.90%	14.20%	17.90%	20.10%	22.30%

October **2022** implemented Phreesia - front office collection platform / interface.

November **2022** brought billing in-house.

Projections & Payor Mix

5

4/1/23-3/31/24 Projected

Based on 4/1/23-6/30/23 patients and 4/1/23-5/31/23 ledger... all annualized

Payor	Unduplicated Patients	Payor Mix (% undup)	Visits	Ledger (Revenue)	Per visit	Avg # Visit per Patient
Medicaid	2,304	11%	3,708	1,156,568	311.91	1.61
Medicare	1,624	7%	2,744	790,586	288.11	1.69
Title V	776	4%	1,224	130,740	106.81	1.58
Contract	472	2%	1,028	10,026	9.75	2.18
Private	3,788	17%	5,972	1,632,821	273.41	1.58
Self Pay	12,924	59%	21,896	1,771,326	80.90	1.69
	21,888	100%	36,572	5,492,067	1,070.90	1.67

4/1/24-3/31/25 Projected

FY24 projected with payor mix goal and estimated avg visits per undup patients

Payor	Unduplicated Patients	Payor Mix (% undup)	Visits	Revenue	Per visit	Avg # Visit per Patient
Medicaid	4,378	20%	8,807	2,746,848	311.91	2.01
Medicare	2,627	12%	10,518	3,030,392	288.11	4.00
Title V	876	4%	1,381	147,507	106.81	1.58
Contract	438	2%	953	9,299	9.75	2.18
Private	4,815	22%	9,641	2,636,094	273.41	2.00
Self Pay	8,755	40%	14,833	1,199,963	80.90	1.69
	21,888	100%	46,134	9,770,102	1,070.90	2.11

Partnering with Public Health

Public Health nurses toured SBHC Clinic with CHW staff in support of the new School Base Health Clinic.

GCHD Public Health Nurses working with CHW Community Health Workers to revamp and launch an approved (onsite)Diabetes Education Program for CHW patients.

GCHD Public Health Nurses partnered with CHW on providing Naloxone for SUD patient families as well as offered skills training for CHW SUD staff.

The Community Engagement Team "CET" participated and/or hosted,

- 3 community health/resource fairs
- Conducted 7 health screening outreaches
- Facilitated 1 HEAL class at Hitchcock Public Library
- Provided CHW and GCHD presentations for Texas City-La Marque Chamber of Commerce Leadership Class, ADA House and ROSC.
- CET also provided resource information at ADA House, MI Lewis, Goodwill and Community Conversations with the Mayor event in Texas City.
- CET attended 7 community partner/stakeholder meetings to discuss collaborations and upcoming events and facilitated a focus group training.

2023 Project Forecast

NextGen Optimization	Pharmacy in-house Texas City	Two new Counselor offices – Texas City	Launch School-Based Health Center Q3
Launch Senior Care Program Q2	Expansion of SUD Program Q3	Phreesia and i2i …Software to Support Population Health	Joint Commission Survey, BE READY!!

2022-2025 Strategic Health Plan Q2 2023 Update

- **Priority 1**
- 1.1 Recruit and retain top talent.
- 1.2 Expand facility resources.
- 1.3 Maintain excellent care that is patient centered.
- **Priority 2**
- 2.1 Expand access to specialties.
- 2.2 Grow child health.
- 2.3 Grow patient population.
- **Priority 3**
- 3.1 Deliver care that is patient centered and responsive to community.
- 3.2 Identify and address disparities.
- **Priority 4**
- 4.1 Expand and maintain strategic partnerships with other organizations and community leaders.
- 4.2 Execute activities with attention to maximizing impact.
- **Priority 5**
- 5.1 Upgrade CHW technology for care improvements and efficiency.
- 5.2 Develop or update processes enhancing communication and work performance.
- 5.3 Leverage existing technologies.

Works in Progress "W.I.P"

- More effective communication.
- Continue offering learning opportunities for all departments.
- Drafting SOPs for each department, finish by Q4.
- Work with CHW budget and finances on a more granular level.
- Continue to grow and evolve into an innovative health center!

Thank you!!!

Dental Clinic Board Update 7/27/2023

- Visit Numbers
    - Quarterly Visit numbers reported by COO. However, I would like to highlight that the dental clinic had 952 encounters for the month of June, which is the highest number of encounters in a single month in the last 5 years. This was despite a full-time provider being out for half of the month.
    - We continue to see walk in patients in pain as we can fit them into our schedule
- Current projects, plans, department overview for dental
    - Sterilization Renovation – We are meeting with the vendor this week to review the proposed design for the sterilization area in Texas City. This will allow us to add two more sterilizers to be more efficient and help meet sterilization needs.
    - The new dental chairs for Galveston are on order and scheduled to be installed August 14th and 15th.
    - Our x-ray images from the previous software have now been successfully transferred to our new Cloud based software.
    - Dr. Lindskog continues to serve on the COM Hygiene School Advisory Board. As previously reported, their application for accreditation has been submitted to CODA and they are hoping to enroll their first class of students for Fall 2024.
    - The bill related to dental hygienists administering anesthesia was signed by the Governor. We will stay informed of any education opportunities to train our dental hygienists to administer local anesthesia. The Texas State Dental Board is meeting in August and we expect these education requirements to be discussed at that meeting.
    - Dr. Lindskog recently had the privilege of attending the Academy of General Dentistry Meeting. As Chair of the Dental Education Council, she gave the charge to the Fellowship and Mastership awardees as well as LLSR recipients.
- Provider Education Opportunities
    - All providers continue to select and participate in continuing education of their choice. They also share knowledge from these courses with the other providers during monthly meetings.
- Barriers or Needs (if applicable)
    - Provider Staffing: As reported last month, our new hygienist began patients on her own with a modified schedule on 6/22/2023. We have received many positive comments from her patients as well as staff. She will begin seeing a full schedule in August.
    - Assistant Staffing: We currently have one dental assistant opening. This position has been open since March 2023, but our Dental Assistant Supervisor was out on FMLA. She returned in June and a job offer was extended, but the tentative start date has been moved to August due to a licensing delay.

GB Meeting July 27, 2023

1. School- based program
    - FQHC school-based program offers comprehensive primary care services to students, including acute and chronic care, vaccinations, health assessments, preventive care, mental health services, dental care, health education, and care coordination.
    - Integrating healthcare into the on-site school program can play a crucial role in improving overall student health outcomes, promoting students' overall health and well-being
    - Convenience, affordability, and accessibility to students and their families

2. House call program for home-bound patients
    - Dr. Grumbles had 27 patient visits, and Pam Cable had 25 patient visits in June.
    - Plan for 40 patient visits per provider in the month of July

3. Remote care management (Patient engagement center/care coordination)
    - Teresa Garcia, RN care coordinator, 108 patients census
    - Patient engagement, and promoting self-care
    - CCM (chronic care management), TCM (transitional care management), AWV (annual wellness visits), BHI (Q4/ 2023, Level 4 Behavioral health /primary care integration with GCC)

4. Managed care incentive program
    - Quality measures, the star rating is improving
    - Pay for performance bonus
    - Engagement with MCOs, provider education

Coastal Wave
Coastal Health & Wellness
Serving. Healing. Caring. Providing high quality medical, dental and counseling services to everyone.

Back-to-School Block Party on July 29, Aug. 5

Coastal Health & Wellness (CHW), Galveston County Health District and ARC Pet Allies are partnering to host a Back-to-School Block Party on Saturday, July 29, 10 a.m.-12 p.m. at the Doyle Convention Center and Saturday, August 5, 9-11 a.m. at Moody Gardens.

The event is open to students in pre-school through 12th grade.

We're giving away school supplies while they last (children must be present) and we'll have FREE back to school student physicals, vision screenings, and immunizations (vaccine pricing will vary).

You can also register for Women, Infants and Children (WIC), get assistance applying for SNAP, Medicaid and other services and get registered and schedule an appointment with a primary care physician at our CHW medical and dental clinics.

CHW joins the League City Regional Chamber of Commerce

Coastal Health & Wellness celebrated joining the League City Regional Chamber of Commerce with a ribbon cutting ceremony on July 20.

CHW partners with Texas City ISD to open school-based clinic

Coastal Health & Wellness and Texas City Independent School District have partnered to open a school-based clinic at the Calvin Early Childhood Center Campus in Texas City.

The clinic will provide a broad range of medical services, including immunizations, routine exams, sports physicals, acute illness treatment, injury, mental health services and more. Patients who are uninsured, underinsured and fully insured are welcome.

By offering comprehensive health care on-site, Coastal Health & Wellness aims to improve health outcomes, increase convenience and reduce absenteeism among students.

Join us for a ribbon cutting to celebrate the grand opening of the clinic on Aug. 8 at 10:00 a.m. at the Calvin Vincent Early Childhood Center Campus, 1805 13th Ave N., Texas City, TX 77591. Scan the QR code below or click here to visit our website and register as patient.

National Health Center Week, Aug. 6-12

Coastal Health & Wellness will celebrate National Health Center Week, Aug. 6-12. This year's theme is Community Health Centers: The Roadmap to a Stronger America and is a time to raise awareness about the mission and accomplishments of CHW and other health centers.

CHW is accredited by The Joint Commission is a recognized Patient-Centered Medical Home committed to providing access to high-quality, affordable primary care to everyone. Services include dental and primary medical care, pediatric care, behavioral health and a substance use disorder- mental health program.

Add immunizations to your back-to-school list

Back-to-school prep season is here. While most supply lists include things like pencils, notebooks, crayons and other classroom items, parents still have time to ensure their children have the most important supply on hand - protection against vaccine-preventable diseases.

Vaccines are the best way for parents to protect their children – and themselves – from 16 potentially harmful diseases that can often be extremely serious, especially in infants and young children.

These diseases include measles, whopping cough, chickenpox and some cancers. Parents should check with their child's doctor and school to learn about vaccine requirements.

Call Coastal Health & Wellness at 409.938.2234 to see if your child is up-to-date on their immunizations.

5 questions to ask at your child's back-to-school dental visit

School will be back in session before you know it. Whether your child will be in the classroom or learning from home, a healthy smile is still a back-to-school essential.

Check out these five questions you should ask at your child's back-to-school dental visit.

BLOOD DRIVE

Galveston County Health District

Tuesday, August 22
8:00 am - 11:00 am

Coach Bus

Free Pint of Blue Bell Ice Cream & Stack of Pancakes from IHop!!!

Sponsor Code: Q326

IHOP

Appointments preferred. Walk-ins welcome.

Mia, blood recipient

Gulf Coast Regional Blood Center

EAT. DRINK. BRING I.D.

Save lives on the go with CFL EXPRESS PASS

Complete your Health History Interview before you come in for your donation.

Go to https://cflexpress.giveblood.org/ and complete the same day as your appointment.

Back to Agenda

Governing Board
July 2023
Item#16
Comments from Board Members

Back to Agenda