Parkland

HOMES
Agenda

Agenda for the Board of Managers HOMES meeting of the Dallas County Hospital District is scheduled for Wednesday, November 15, 2023, at 12:30 PM at 5200 Harry Hines Blvd (WISH Building) Dallas, TX 75235, Conference Room 02-175. (If assistance is needed in locating the room, please see the Administration receptionist on the 4th floor, 04-131.) Videoconferencing access is also possible via Webex. That application is available at https://www.webex.com/downloads.html. Teleconferencing access is possible by calling +1-415-655-0001. Both virtual access forms require inputting (meeting number: 2632 152 5799; meeting password: 1234) to join the meeting. The Board of Managers HOMES reserves the right to exercise discretion and may convene in Executive Session as permitted by Texas Government Code §§551.071 (consultation with attorney), 551.072 (deliberations regarding real estate), 551.074 (personnel matters), 551.076 (deliberations regarding security devices or security audits), 551.078 and/or 551.0785 (deliberations by medical committee or by governmental body that administers a public insurance, health or retirement plan regarding individuals' medical or psychiatric records), 551.085 (deliberation by governing board of certain providers of health care services), 551.087 (deliberation regarding economic development negotiations), 551.088 (deliberation regarding test item); Texas Government Code §418.183 (deliberation of information under §§418.175 – 418.182 for purposes of disaster management or disaster planning); Texas Health & Safety Code §161.032 (medical committee or medical peer review committee records, information or reports; and/or medical committee or medical peer review committee proceedings under Tex. Health & Safety Code Chapter 161 and/or Tex. Occ. Code Chapters 151 and 160); and/or as otherwise authorized by law on any item listed below. The Board of Managers HOMES may consider any of the agenda items in open or executive session and may continue the meeting as necessary to accomplish the business at the time and place designated by the Chair to reconvene.

		PAGE	TIME (MIN)	PRESENTER(S)
I.	**Declare a Quorum Present/Call to Order/Mission Statement** ***Advance Wellness | Relieve Suffering | Develop and Educate*** **I CARE** **I**ntegrity **C**ompassion and Collaboration **A**ccountability **R**espect **E**quity **Public Comments Regarding Agenda Items** *See public comment registration information and rules at* *https://www.parklandhospital.com/board-of-managers*			Chair
II.	**Consent Agenda**			
A.	Approve Minutes 2023-10-25 HOMES	2	1	Chair
III.	**Reports Requiring Deliberation(s) or Approval(s)**			
A.	Operations Update	8	2	Kyla Rankin
B.	Management and Finance Update	10	2	
C.	Governance Update	11	2	
D.	HRSA Compliance Manual Requirements: The Big 20	12	2	
E.	HRSA Compliance Manual Requirements - Chapter 16: Billings and Collections	16	2	
F.	Approve Billing and Collection Policy	18	2	
G.	HRSA Recognition	30	1	
IV.	**Executive Session** Tex. Gov't Code §§551.074			
A.	Performance Appraisal of HOMES Project Director: Kyla Rankin	31	20	Chair
V.	**Action Items**			
A.	Board May Take Action on Any Agenda Item(s) Above			Chair
B.	Approve Performance Appraisal of HOMES Project Director: Kyla Rankin	32	1	Chair
VI.	**Adjourn**			
A.	Closing Remarks			
B.	Call to Adjourn			

Approve Minutes 2023-10-25 HOMES

Parkland

MINUTES

Dallas County Hospital District Board of Managers

HOMES
October 25, 2023

Minutes of the Board of Managers HOMES meeting of the Dallas County Hospital District, held Wednesday, October 25, 2023, scheduled for 12:30 p.m. in the WISH Building Conference Room (02-175) at Parkland Health and via WebEx. These minutes do not constitute a certified agenda from the meeting.

I. Attendance and Call to Order

Chair Marjorie Petty, JD, noted that a quorum was physically present and called the meeting to order at 12:30 p.m.

Board Member attendees included: Chair Marjorie Petty, JD; Eric G. Bing, MD, PhD; Byron Cryer, MD; Todd Furniss, JD; Reina Gonzalez, JD; Vincent Hall; Ramon Miguez, PE; Farida Minner, RN; Elizabeth Palacios, MD; and Lisa Sutter.

Board member John Proctor was not present.

Staff Present (via Webex and in-person) included:

Anthony Tarango, Employee Health Nursing Manager (in-person)
Donna Richardson, EVP & Chief Nursing Executive (in-person)
Donna Persaud, HOMES Medical Director (in-person)
Edmundo Castañeda, EVP & Chief Operating Officer (in-person)
Felicia Miller, EVP & Chief Talent Officer (in-person)
Forrest Stovall, Governance Program Manager (in-person)
Fred Cerise, President & Chief Executive Officer (in-person)
Jessica Hernandez, SVP Chief DEI Officer
Kyla Rankin, HOMES Project Director (in-person)
Melanie Roberts, SVP Chief Compliance & Ethics Officer
Pam Bryant, SVP Chief Supply Chain Officer
Rick Humphrey, EVP & Chief Financial Officer (in-person)
Roberto de la Cruz, EVP Chief Clinical Officer (in-person)
Saul Cordero, SVP & Chief Governance & Strategy Officer (in-person)
Steven Roth, EVP & Chief Legal Officer (in-person)
Vic Summers, Chief Audit Executive

II. Mission Statement

Chair began the meeting by stating the mission statement:
Advance Wellness | Relieve Suffering | Develop and Educate

III. Public Comments Regarding Agenda Items

No members of the public registered for comments regarding the agenda items.

IV. Conflicts of Interest

After review of the agenda, the Chair noted zero conflicts of interest for Board Members present.

V. Consent Agenda

A. Approve Minutes 2023-09-27 HOMES

B. Approve Minutes 2023-10-09 HOMES Advisory Board

Vincent Hall motioned for the approval of the Consent Agenda. Elizabeth Palacios, MD, seconded the motion. The motion passed unanimously.

VI. Reports Requiring Deliberation(s) or Approval(s)

The Board received information for the following updates presented by Kyla Rankin, HOMES Project Director.

A. Operations Update

Kyla Rankin reported on HOMES' staffing. There is currently one nurse, one dental assistant, one lead dental assistant, one mobile medical unit driver, and one community development specialist position posted. Kyla also informed the Board of telehealth services as well as anticipated changes for mobile medical unit parking.

The Board asked questions and received additional information related to the Operations Update.

B. Management and Finance Update

HOMES has seen 6,868 unduplicated patients to date. The annual goal is 9,675. Expenses remain over budget which is driven by the variance to budget in patient encounters. If visits continue to surpass the budget, there is a potential to remain over budget for the year.

The Board asked questions and received additional information related to the Management and Finance Update.

C. Governance Update

As done in prior years, the December Advisory Board meeting will combine with Population Health.

D. Quality Improvement Update

Dr. Donna Persaud provided the Quality Improvement Update. She reviewed the COPC Metric Scorecard, safety posts for the previous quarter, and the HRSA Quality Measures year to date. Dr. Persaud also reviewed improvement trends and action plans for opportunities. Dr. Persaud & Kyla also discussed the successes and opportunities specific to pilot development of telehealth services for enhancing access.

The Board asked questions and received additional information related to the Quality Improvement Update.

E. HRSA Compliance Manual Requirements: The Big 20
Kyla Rankin reviewed The Big 20 manual.

F. HRSA Compliance Manual Requirements - Chapter 10: Quality Improvement Assurance Plan
Kyla Rankin reviewed Chapter 10: Quality Improvement Assurance Plan. She reported on the HRSA requirements and how HOMES demonstrates compliance with the HRSA requirements.

G. Harris Health Visit
Kyla Rankin informed the Board that Harris Health's program visited HOMES recently. The organizations discussed strengths and weaknesses of their programs and opportunities for the future.

VII. Adjourn

With no further business to discuss, Chair Marjorie Petty, JD, adjourned the meeting at 1:03 p.m.

SO RECORDED:

Marjorie D. Petty, JD Chair	Steve Roth, JD, MPH Assistant Secretary

Parkland

Homeless Outreach Medical Services Program Monthly Update Report – November 2023

Kyla Rankin, Project Director

Agenda

- Operational Updates
  - Operations
  - Management and Finance
- Governance
- The Big 20
- Policy Approval
- HRSA Recognitions
- Project Director-Annual Performance Evaluation

Operations

- Staffing

Posted

- 1.0 FTE RN
- 1.0 FTE Community Development Specialist
- 1.0 FTE Dental Assistant
- 1.0 FTE Family Nurse Practitioner

Accepted

- 1.0 FTE Mobile Medical Unit Driver
- 1.0 FTE Lead Dental Assistant
- 1.0 FTE Dental Assistant

Operational Updates

- Outreach Events
  - Flu/COVID
    - 22 events
    - 425 vaccines
  - Community
    - Dental screenings

- Telehealth
  - Ongoing collaboration with IT and Virtual Care Team

Management & Finances – October 2023

Unduplicated	GY to Date	Annual Goal	% to Goal	% Year Complete
Patients	7486	9,675	77%	83%

FY	Month				Year to Date			
Metrics	Actual	Budget	Variance	% Var	Actual	Budget	Variance	% Var
Visits	3974	3738	236	6.3%	3974	3738	236	6.3%
Expenses	$798,174	$698,500	($99,674)	-14.3%	$798,174	$698,500	($99,674)	-14.3%
Charges	$2,294,291	$2,677,073	($382,782)	-14.3%	$2,294,291	$2,677,073	($382,782)	-14.3%
Revenue	$66,393				$66,393			
Commercial	$1445				$1445			
Medicaid	$41,372				$41,372			
Medicare	$23,576				$23,576			
FTE	62.20				62.20			
FTE - OT	1.66	1.07	(.59)	-55.4%	1.66	1.07	(.59)	-55.4%

- HRSA recommendation is claims billed in less than 30 days.
- HRSA grant year: January 1, 2023 to December 31, 2023

Governance

- Next Meeting:
  - Joint Community Advisory Board Meeting
    - Friday, December 1st, 11:30-1:00pm
    - Goodwill Industries

The Big 20

The HRSA Compliance Manual has 21 chapters which cover 19 requirements in the four (4) areas:

1. Need
2. Services
3. Management & Finance
4. Governance
5. Annual training was added as a 20th requirement

HRSA Health Center Program Compliance Requirements Summary for Board of Managers

HRSA Requirement	Description	Board Month
1. Needs Assessment (Ch. 3)	Demonstrates and documents the needs of its target population, updating its service area, when appropriate. Community Needs Assessment	September Every 3 years (2019)
2. Required & Additional Services (Ch. 4)	Provides all required primary, preventive, enabling health services and additional health services as appropriate and necessary, either directly or through established written arrangements and referrals.	August
3. Staffing (Ch. 5)	Maintains a core staff as necessary to carry out all required health services either directly or through arrangements and referrals. Staff must be appropriately licensed, credentialed, and privileged.	August
4. Accessible Hours of Operation / Locations (Ch. 6)	Provides services at times and locations that assure accessibility and meet the needs of the population.	August
5. Coverage for Medical Emergencies During & After Hours (Ch. 7)	Provides professional coverage for medical emergencies during regularly scheduled hours and when the center is closed.	March
6. Hospital Admitting Privileges & Continuum of Care (Ch. 8)	Physicians have admitting privileges at one or more referral hospitals, or other such arrangement to ensure continuity of care. In cases where hospital arrangements (including admitting privileges and membership) are not possible, health center must firmly establish arrangements for hospitalization, discharge planning, and patient tracking.	August and update as needed

HRSA Health Center Program Compliance Requirements Summary for Board of Managers

7. Sliding Fee Discounts (Ch. 9)	A system is in place to determine eligibility for patient discounts adjusted on the basis of the patient's ability to pay. • This system must provide a full discount to individuals and families with annual incomes at or below 100% of the Federal poverty guidelines (only nominal fees may be charged) and for those with incomes between 100% and 200% of poverty, fees must be charged in accordance with a sliding discount policy based on family size and income. • No discounts may be provided to patients with incomes over 200 % of the Federal poverty guidelines. • No patient will be denied health care services due to an individual's inability to pay for such services by the health center, assuring that any fees or payments required by the center for such services will be reduced or waived.	Annually to align with Federal Poverty Guidelines
8. Quality Improvement/ Assurance Plan (Ch. 10)	A Quality Improvement/Quality Assurance (QI/QA) program is in place which includes clinical services and management, and confidentiality of patient records. The QI/QA program must include: • A clinical director whose focus of responsibility is to support the quality improvement/assurance program and the provision of high-quality patient care; • periodic assessment of the appropriateness of the utilization of services, quality of services provided or proposed to be provided to individuals served by the health center; assessments shall: – be conducted by physicians or by other licensed health professionals under the supervision of physicians; – be based on the systematic collection and evaluation of patient records; and – identify and document the necessity for change in the provision of services by the health center where indicated.	Quarterly Metric Review: February or approval of annual UDS report August November December QAPI Policy: October
9. Key Management Staff (Ch. 11)	Maintains a fully staffed team as appropriate for the size and needs of the center. Prior approval by HRSA of a change in the Project Director/Executive Director/CEO position is required.	September and update as needed
10. Contractual/Affiliation Agreements (Ch. 12)	Exercises appropriate oversight and authority over all contracted services, including assuring that any subrecipient(s) meets Health Center program requirements.	October and ongoing
11. Collaborative Relationships (Ch. 14)	Makes effort to establish and maintain collaborative relationships with other health care providers, and health centers, in the service area of the center. The health center secures letter(s) of support from existing health centers in the service area or provides an explanation for why such letter(s) of support cannot be obtained.	March and ongoing
12. Financial Management and Control Policies (Ch. 15)	Maintains accounting and internal control systems appropriate to the size and complexity of the organization reflecting Generally Accepted Accounting Principles (GAAP) and separates functions appropriate to organizational size to safeguard assets and maintain financial stability. An annual independent financial audit is performed in accordance with Federal audit requirements, including submission of a corrective action plan addressing all findings, questioned costs, reportable conditions, and material weaknesses cited in the Audit Report.	July

HRSA Health Center Program Compliance Requirements Summary for Board of Managers

13. Billing and Collections (Ch. 16)	Systems in place to maximize collections and reimbursement for its costs in providing health services, including written billing, credit and collection policies and procedures.	November
14. Budget (Ch. 17)	Develops a budget that reflects the costs of operations, expenses, and revenues necessary to accomplish the service delivery plan, including the number of patients to be served.	HRSA approval
15. Program Monitoring & Data Reporting Systems (Ch. 18)	Have systems in place to accurately collect and organize data for program reporting and support management decision making.	March
16. Scope of Project	Maintains its funded scope of project (sites, services, service area, target population, and providers); including any increases based on recent grant awards.	Award notification & update as needed
17. Board Authority (Ch. 19)	Governing board maintains appropriate authority to oversee the operations of the center, including: • holding monthly meetings; • approval of the health center grant application and budget; • selection/dismissal and performance evaluation of the health center CEO; • selection of services to be provided and the health center hours of operations; • measure and evaluate the organization's progress in meeting its annual and long-term programmatic and financial goals and develop future plans for the organization by engaging in strategic planning, ongoing review of the organization's mission and bylaws, evaluating patient satisfaction, and monitoring organizational assets and performance; and establish policies for the health center.	December
18. Board Composition (Ch. 20)	Governing board is composed of individuals, a majority of whom are being served by the center and, this majority as a group represents the individuals being served by the center in terms of demographic factors such as race, ethnicity, and sex. Specifically: • Governing board has at least 9 but no more than 25 members, as appropriate for the complexity of the organization. • The remaining non-consumer members of the board shall be representative of the community in which the center's service area is located and shall be selected for their expertise in community affairs, local government, finance and banking, legal affairs, trade unions, and other commercial and industrial concerns, or social service agencies within the community. • No more than one half (50%) of the non-consumer board members may derive more than 10% of their annual income from the health care industry.	December
19. Conflict of Interest Policy (Ch. 13)	Bylaws or written corporate board approved policy include provisions that prohibit conflict of interest by board members, employees, consultants and those who furnish goods or services to the health center. No board member shall be an employee of the health center or an immediate family member of an employee. The Chief Executive may serve only as a non-voting ex-officio member of the board.	December
20. Annual Board Training	Annual training of governing board. New governing board members will be trained during board orientation.	December

For additional information on these requirements, please review:

- Health Center Program Statute: Section 330 of the Public Health Service Act (42 U.S.C. §254b)
- Program Regulations: 42 CFR Part 51c and 42 CFR Parts 56.201-56.604
- Grants Regulations: 45 CFR Part 74

HRSA Health Center Program Compliance Requirements – Chapter 16: Billings and Collections

Requirements

- Prepare a schedule of fees
- Fees reduced or waived to assure no patient denied services due to inability to pay
- Systems for eligibility determination and for billing and collections
- Make reasonable effort to collect reimbursement

HRSA Health Center Program Compliance Requirements – Chapter 16: Billings and Collections

Demonstrating Compliance

- HOMESPFS01: HOMES Billing & Collection Policy
- Fees have been established by PFS specific to HOMES
- Participate in Medicaid, CHIP, Medicare, and other private or public assistance programs

Approve Billing and Collection Policy

Policy Approval

HOMES Billing and Collection Policy

Updates to include

- Minor formatting changes
- Language changes for clarity and to align with actual operational practice

HOMES Billing & Collection Policy	HOMESPFS01	Published: 10/XX/23
PFS Accounts Receivable Manual		Page 1 of 6

PURPOSE:

This policy provides clear and consistent guidelines for billing and collection operations for Parkland's HOMES program.

SCOPE:

All Parkland Health ("Parkland") Workforce members in the HOMES and Patient Financial Services departments.

PROCEDURE:

1. Ability/Refusal to Pay

   A. No patient will be refused service based on their inability to pay due to a lack of financial means.

   B. Parkland reserves the right to limit or deny services to any patient with the documented ability to pay and the patient has refused to pay.

1. Reduced/Waived Payments
   A. Financial screening will be conducted to determine if a patient qualifies for any program including Affordable Care Act, grants, Sliding Fee Scale, Charity, or other funding programs.
      1) Patients will self-attest in writing to reasons for requesting reduced/waived fees. For those patients needing to provide verbal attestation (i.e., due to virtual visit), verbal attestation and reason for requesting the reduced/waived fees will be documented by staff in the patient's account. Criteria for reduced/waived fees include but are not limited to:
         a) Patients who lack housing (without regard to whether the individual is a member of a family).
         b) Patients whose primary residence during the night is a supervised public or private facility that provides temporary living accommodations.
         c) Patients who reside in transitional housing.

d) ~~Patients who reside in permanent supportive housing or other housing programs that are targeted homeless populations.~~Patients who reside in permanent supportive housing or other housing programs targeted at homeless populations.
e) Patients who reside in a domestic violence shelter.
f) Patients who have experienced a natural disaster.

C. Those who are determined to qualify for reduced/waived fees are automatically approved for Parkland's charity program, HOMES Parkland Financial Assistance, and Parkland will waive their co-pays for primary care services. Patients who are covered by third-~~ ~~~

C. Payment plans can be approved for patients indicating they may have difficulty paying their balance in a single installment.

D. Parkland is not required to accept patient-initiated payment arrangements and may refer accounts to a collection agency if the patient is unwilling to make acceptable payment arrangements, has defaulted on an established payment plan, or has not been responsive to previous collection attempts.

5. Collection Practice

A. In compliance with state and federal laws and in accordance with the provisions outlined in this FQHC Billing and Collection Policy, Parkland engages in collection activities to collect outstanding patient balances.

B. General collection activities include follow-up phone calls and statements.

~~A.~~C. All patient/guarantors will be sent a minimum of ~~three~~ two (~~3~~2) statements within a ~~120~~ 55 day~~s~~ period ~~starting within three (3) days of placement~~ service with the first statement being sent within 30 days of service date.

6. Accounts become eligible for outsource to Early Out Vendor 55 days after discharge date or 55 days after the residual balance is placed in the self-pay bucket and the insurance bucket balance is resolved.

A. Self-Pay; Self-Pay after Insurance, Payment Plan Default, Sliding Fee Scale, and Self-Pay discounted balances may all qualify for Early Out collection process.

7. Accounts become eligible for Bad Debt if collection efforts by the Early-Out Vendor for the patient/guarantor portion of the bill are unsuccessful, the account will be pulled from the Self Pay Vendor after 180 days from initial placement and placed with a Bad Debt Vendor.

A. All patient/guarantors will be sent at least three (3) statements within a ~~120~~120 day period starting within three (3) days of placement.

B. Vendor will give the patient/guarantor a minimum of 45 days to dispute the claim or provide additional information if applicable.

C. After 45 days, from the time of placement, and no dispute is received, the Vendor will report the account delinquent to all three credit reporting agencies.

D. If after 365 days and no payment is received, the account will be pulled from the Vendor and sent to Parkland clearing agency code. The Bad Debt Vendor will remove the account from all credit reporting agencies when the account is pulled.

8. Payment Plans

A. Payment plans can be approved for patients with difficulty paying their financial responsibility in a single installment.

B. Patients can set up a payment plan for a negotiated amount due monthly.

C. Statements will be sent monthly as a reminder of payment amount and date due.

D. Default of a payment plan will result in the outstanding patient balance being sent to a collection agency for collection within 45 days after the default date.

10. Patient disputes:

A. Patient complaint or dispute relating to charges, services, or quality of care.

B. Parkland Financial Services ~~FS~~ will be responsible for the researching and resolving "billing or collection" issues that occur.

C. Service or care related issues will be resolved by the operational department and resolution coordinated by Patient Relations.

D. If a patient calls regarding a service or care related issue, they will be instructed to contact Patient Relations at 469-419-0820. The person receiving the call will document in the patient accounting system that the patient has a service or care issue and was notified to call Patient Relations~~–~~.

E. If a written notice is received concerning a service/care related complaint from the patient; the notice is to be sent to Patient Relations for handling.

EQUIPMENT:

N/A

DEFINITIONS:

Bad Debt: Financial classification for accounts in which previous collection efforts have been unsuccessful.

Financial Assistance Policy: A separate policy that describes the Sliding Fee Scale discount program which includes specific criteria patients must meet to qualify for the Sliding Fee Scale discount.

Inability to Pay: No financial means to pay for services provided based on lack of income.

Insurance: Coverage program of the insured for the expenses incurred from illness, injury, preventative health care, or injury that pays for health care services directly to a provider.

Refusal to Pay: Documented proof of a patient's ability to pay for services and the patient refuses to pay.

Self-Pay Balances after Insurance: Insurance has paid their portion, and the remaining balance is the patient/guarantor's responsibility.

Self-pay Charity Discount: Dallas County and Non-Dallas County program for patients without a third-party funding source that are qualified for a percentage discount from gross charges.

Uncollectible Accounts: Accounts in which all collection efforts have ceased.

Workforce member: An employee, volunteer, member of the medical staff, contractor, vendor, trainee, or other person whose conduct, in the performance of work for Parkland, is under the direct control of Parkland, whether he or she is paid by Parkland.

REFERENCES:

N/A

HOMES Billing & Collection Policy	HOMESPFS01	Published: 10/26/22
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1. Reduced/Waived Payments
   A. Financial screening will be conducted to determine if a patient qualifies for any program including Affordable Care Act, grants, Sliding Fee Scale, Charity, or other funding programs.
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         c) Patients who reside in transitional housing.

d) Patients who reside in permanent supportive housing or other housing programs targeted at homeless populations.
e) Patients who reside in a domestic violence shelter.
f) Patients who have experienced a natural disaster.

C. Those who are determined to qualify for reduced/waived fees are automatically approved for Parkland's charity program, HOMES Parkland Financial Assistance, and Parkland will waive their co-pays for primary care services. Patients who are covered by third-party insurance (Medicare, Medicaid, or private insurance) for which Parkland is required to collect co-pays and deductibles are not eligible for waived fees or reduced payments.

2. Supplies and/or Equipment Not Provided by Clinic

A. Parkland maintains contractual agreements with third party vendors to supply special items or services not provided within the FQHC setting.

B. Services provided via a written contract/agreement will be bound to provide the same or greater discount as would be received if Parkland were to provide the service.

3. Insurance Billing

A. All patients seen by Parkland FQHC locations with a funding source such as private insurance, government program coverage, or any other form of third-party coverage will be billed as applicable for services provided.

B. If a claim is denied due to a provider error the patient is not held liable.

4. Patient Billing

A. Patients with a funding source that have co-pay, coinsurance, or deductible obligations will be billed when the funding source has adjudicated the claim and remitted payment.

B. Patients with a valid address on file will be billed directly and receive a statement as part of the organization's normal patient billing process.

C. Payment plans can be approved for patients indicating they may have difficulty paying their balance in a single installment.

D. Parkland is not required to accept patient-initiated payment arrangements and may refer accounts to a collection agency if the patient is unwilling to make acceptable payment arrangements, has defaulted on an established payment plan, or has not been responsive to previous collection attempts.

5. Collection Practice

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Uncollectible Accounts: Accounts in which all collection efforts have ceased.

Workforce member: An employee, volunteer, member of the medical staff, contractor, vendor, trainee, or other person whose conduct, in the performance of work for Parkland, is under the direct control of Parkland, whether he or she is paid by Parkland.

REFERENCES:

N/A

HOMES AWARDED 3 NATIONAL QUALITY RECOGNITION BADGES FROM HRSA!

Best overall Clinical Quality Measure (CQM) performance
Top 10%

- Earn HCQL
- 15% improvement in one or more CQM in back-to-back years
- At least 5% increase in total patients or patients receiving mental health, SUD, vision, dental or enabling services

- Qualify for Access enhancer
- At least 10% improvement on LBW, HTN or uncontrolled DM CQM
- Meet targets for racial/ethnic groups served

Performance Appraisal of HOMES
Project Director: Kyla Rankin

Approve Performance Appraisal of HOMES Project Director: Kyla Rankin

Questions?