City of Cincinnati Primary Care Board of Governors Meeting

August 12, 2026

Agenda

Deirdre Beluan	Michelle Burns	Timothy Collier	Robert Cummings
Alexius Golden Cook	John Kachuba	Dr. Phil Lichtenstein	Luz Schemmel
Debra Sellers	Jen Straw	Erica White-Johnson	Dr. Bernard Young

Meeting Reminders*: Please raise your virtual hand via Zoom when asking a question and please wait to be acknowledged and always remain muted, unless actively speaking/presenting (With the exception of the Board Chair).*

6:00 pm – 6:05 pm Call to Order and Roll Call

6:05 pm – 6:06 pm Moment of Silence

Vote: **Motion to approve** the Minutes from July 8, 2026, CCPC Board Meeting.

Leadership Updates

6:06 pm – 6:35 pm Ms. Joyce Tate, Chief Executive Officer

- CEO Report – ***document***
- Vote: Approval of Board Policies - *documents*
- HRSA – Site Visit Update
- Service Area Zip Code Review
- Service Awards from HRSA – 2025 UDS Performance
- Patient/User of Service Board Members
- Standing Committees
- National Health Center Week – Success
- Facility Updates
- Strategic Plan - Discussion

6:35 pm – 6:45 pm Mr. Mark Menkhaus Jr., Chief Financial Officer

- CFO Report – ***documents***

New Business

6:45 pm – 6:50 pm Public comments

6:55 pm Adjourn

Documents in the Packet but not presented.

Efficiency Update is included in the packet. Please contact Dr. Geneva Goode (Efficiency Update) with any questions/concerns.

Next Meeting – September 9, 2026

Mission: *To provide comprehensive, culturally competent, and quality health care for all.*

CCPC Board of Governors Meeting Minutes
Wednesday July 8, 2026

Call to order at 6:05 pm

Roll Call

CCPC Board members present –Ms. Michelle Burns, Mr. Timothy Collier, Mr. Robert Cummings, Mr. John Kachuba, Ms. Luz Schemmel, Ms. Erica White-Johnson, Dr. Benard Young

CCPC Board members absent – Ms. Deirde Beluan, Ms. Alexius Golden Cook, Dr. Phil Lichtenstein, Ms. Debra Sellers, Ms. Jen Straw

Others present – Ms. Marla Hurston Fuller, Ms. Joyce Tate, Mr. Mark Menkhaus Jr., Mr. David Miller, Ms. Courthney Calvin, Ms. Bethany Shisler

Board Documents:

Topic	Discussion/Action	Motion	Responsible Party
Call to Order/Moment of Silence	The meeting was called to order at 6:05 p.m. The board gave a moment of silence to recognize our two most important constituencies, the staff, and patients.	n/a	Mr. Kachuba
Roll Call	7 Present, 5 Absent Quorum	n/a	Ms. Marla Hurston Fuller
Minutes	**Motion:** The City of Cincinnati Primary Care for June 20, 2026, CCPC Board Meeting.	**M**: Ms. Schemmel **2nd:** Ms. Burns **Action: Passed** **Yes:** 7 **Abstain**	Mr. Kachuba
Executive Committee			
Updates and Committee Assignments	John Kachuba provided updates on the board contact list and committee members, asking members to verify the information. He mentions the evaluation forms for the CEO, due by August 15. Mr. Kachuba discussed the possibility of an in-person meeting with HRSA on August 12, suggesting a hybrid format. A show of hands indicates that four members can attend in person, with the rest potentially joining via Zoom.	n/a	Mr. Kachuba, Ms. Tate
Old Business			

CEO Updates	**Site Visit Preparation** Joyce Tate provided updates on the upcoming site visit by HRSA, scheduled for August 11-13. The kickoff meeting will be held at the Price Hill Health Center, with tours of North Side and Ambrose sites. Ms. Tate introduced the team members who will be present, including clinical consultant Pat Fairchild and fiscal officer Mr. Mark Menkhaus. She emphasized the importance of the board members' roles and the CEO evaluation during the site visit. ***Introduction of New Board Clerk and Staff*** Ms. Tate introduced Bethany, the new board clerk, who shares her background in finance, banking, and project management. Ms. Shisler expresses her excitement about joining the team and her commitment to helping others achieve their goals. Ms. Tate thanked Marla Fuller for her temporary role as board clerk and acknowledged the contributions of other staff members. Elizabeth Summers, the new public information officer, is introduced, highlighting her role in the executive team.	n/a	Ms. Tate
CCPC Clinical Pharmacy Presentation	***Financial Impact of 340B Program Changes*** David Miller discussed the financial impact of changes to the 340B program due to the Inflation Reduction Act. He explained the increase in costs for certain medications, such as Eliquis, Jardiance, and Farsiga, due to new pricing policies. Miller outlined strategies to mitigate these costs, including switching to generic drugs and optimizing specialty pharmacy programs. He emphasized the need for advocacy to address	n/a	Mr. Miller

	these changes and protect the 340B program.		
Finance Update	CFO Report - Mr. Mark Menkhaus Jr. reviewed the financial data variance between FY25 and FY26 for the month of June 2026. **Financial Overview and Revenue Trends** Mr. Menkhaus presented the financial figures for the month of May, showing a 8% increase in revenue compared to the previous year. He highlighted the significant increase in Medicaid and self-pay revenues, as well as the reliance on city subsidization. Menkhaus discussed the trend of decreasing Medicaid payer mix and increasing self-pay, which could impact revenue collection. He noted the high level of accounts receivable and the need to monitor this closely.	n/a	Mr. Menkhaus
	New Business		
Conclusion	***Facility Updates*** Ms. Tate asked Mr. Menkhaus for a preliminary update on facility changes and potential closures. Menkhaus provided updates on the Ambrose Clement Health Center, Price Hill Health Center, and North Side Health Center renovations. He mentioned the acquisition of a new administrative building to consolidate admin staff. Ms. Tate thanked Mr. Menkhaus for the updates and adjourned the meeting, noting the next meeting on August 12.	n/a	Mr. Kachuba
Public Comments	• No Public Comments.	n/a	Mr. Kachuba, Ms. Fuller
Documents in the Packet but not presented.	Efficiency Update is included in the packet. Please contact Dr. Geneva Goode (Efficiency Update) with any questions/concerns.	n/a	n/a

Meeting adjourned: 6:58 pm

Next meeting: August 12, 2026, at 6:00 pm.

The meeting can be viewed and is incorporated in the minutes:

_____	_____
Date: 7/8/2026	Date: 7/8/2026
Clerk, CCPC Board of Governors	Mr. John Kachuba, Board Chair

CCPC Board of Governors

Cincinnati Health Department
July 8, 2026

Board Members	Roll Call	6/10/2026 Minutes
Ms. Deirde Beluan	Excused	
Ms. Michelle Burns	X	2nd
Mr. Timothy Collier	X	
Mr. Robert Cummings		
Ms. Alexius Golden Cook	X	
Mr. John Kachuba	X	
Dr. Philip Lichtenstein	Excused	
Ms. Luz Schemmel	X	M
Ms. Debra Sellers		
Ms. Jen Straw		
Ms. Erica White-Johnson	X	
Dr. Bernard Young	X	
Motion Result:	**QUORUM**	**PASSED**

X	***Present***
	Yay
	Nay
	Absent
	Present but didn't vote
M	***Motion***
2nd	***Second***
	Abstain
	Delayed

roll call timothy collier name mr. no tms

STAFF/Attendees	
Marla Fuller (temp clerk)	X
Joyce Tate	X
Geneva Goode, DNP	
Mark Menkhaus Jr	X
BOH Rep	
David Miller	X
Yury Gonzales, MD	
Angela Mullins	
Anna Novais, MD	
Stephanie Courtney	
Courthney Calvin	X
Nick Taylor	
Ian Diog	
Britnie Herndon	
Debi Smith	
Alvenia Ross	
Bethany Shisler	X

DATE: August 12, 2026

TO: City of Cincinnati Primary Care Board of Governors

FROM: Joyce Tate, CEO

SUBJECT: CEO Report for August 2026

Approval of Board Policies

- Review and recommend approval of updated board policies to ensure compliance with HRSA Health Center Program requirements and current organizational practices. Discussion may include any revisions made during the Operational Site Visit preparation process, board governance expectations, and documentation requirements.

HRSA - Site Visit Update

- The HRSA Operational Site Visit is scheduled for August 11-13.
- Staff have been working diligently to prepare required documentation, coordinate interviews, and ensure all compliance areas are adequately represented.
- Thank the Board members and staff for their participation and responsiveness throughout the preparation process
- Executive Committee asked if additional Guidelines or guidance can be given to them so that they can be more prepared for the questions that HRSA may ask them as Board members. Bethany to send out additional Board Authority guidelines and some practice questions they may potentially ask.

Service Area Zip Code Review

- As part of the separation from Christian Community Health Services, CCPC validated its service area zip codes. No changes were identified except for the Harrison area and a few smaller zip codes that were reassigned (reassigned to Crossroad Health Center or Christian Community Health Services, the former sub-recipient).

Patient/User of Services Board Members

- Review HRSA's board composition requirement that at least 51% of board members must be active patients of the health center who have received

services within the past 24 months. Discuss current compliance status, upcoming membership renewals, and strategies to support board members who may need assistance verifying patient status or maintaining eligibility.

- Sent Form 6A to Executive Committee members and will share information with Board

Standing Committee Update

- Evaluate the structure, membership, and effectiveness of standing committees. Discussion may include committee vacancies, responsibilities, reporting expectations, meeting schedules, and opportunities to increase board engagement through committee participation.
- Luz Schemmel expressed interest in wanting to be part of the Clinical and Quality Assurance Committee

National Health Center Week Promotions

- Review activities planned for National Health Center Week, including community outreach events, public awareness campaigns, social media engagement, patient appreciation activities, and recognition of staff and board members. Discuss opportunities for board participation and promoting the impact of CCPC services within the community.

Facility Update

- Planning continues for the new facility at 2800 Gilbert Avenue and for renovations at several existing health center locations. Architectural planning is underway, and renovation projects may require temporary relocation of services or staff during construction. At this time, no relocation plans, timelines, or durations have been finalized. Leadership will provide additional information as project scopes and construction schedules are confirmed.

DATE: July 14, 2026

TO: City of Cincinnati Primary Care Governing Board

FROM: Mark Menkhaus, Jr., CFO

SUBJECT: Fiscal Presentation June 2026

Fiscal Presentation
Fiscal Presentation for June 2026

- For FY26, as of June 2026, Cincinnati Primary Care had a net loss of $405,107.93.
- In FY25, June had a gain of $197,507.21. Comparing FY26 with FY25 shows a decrease of $602,615.14. This decrease is due to expenses increasing more than the revenue.
- Revenue increased by $2,791,528.32 from FY25. The increase is due to higher Medicaid and Medicaid Managed Care revenue. We received the Medicaid Maximization, in the amount of $5,593,757.03, in December. The FY24 Medicaid Maximization was received in February in the amount of $4,489,660.19.
- 7100-Personnel increased by 6.72% (7.72% in May). 7500-Fringes saw a corresponding increase of 9.17% (7.65% in May). The increase is attributed to the increase in the employer contribution retirement rate (this increased from 19.79% to 23.83%). This is also attributable to the 5% COLA all AFSCME and CODE employees received. CODE and AFSCME employees also received a $1,500 one-time bonus.
- Non-Personnel expenses increased by $1,410,650.89 ($1,788,672.39 in May) from FY25. The increase is due to some FY25 invoices being paid in FY26 ex: Cardinal Health was paid $2,199683.60 FY25 but $2,765,195.75 was paid in FY26. Also, LabCorp was paid $1,181,791.32 in FY25 but in FY26 was paid $1,681,991.07. However, in FY25 we spent $231,049.50 in temporary personnel costs but, in FY26 we spent $158,204.57 on temporary personnel.
- Here are charges for disaster regular hours and overtime as it relates to COVID-19, Measles and Monkey Pox for FY26 and FY25 for June.

Clinics		
Type Labor Cost	**FY26**	**FY25**
Disaster Regular	$785.88	$15,726.19
Disaster Overtime	$ 0.00	$ 0.00
Total	$785.88	$15,726.19

School Based		
Type Labor Cost	**FY26**	**FY25**
Disaster Regular	$0.00	$0.00
Disaster Overtime	$0.00	$0.00
Total	$0.00	$0.00

June Payor Mix Highlights:

	Medicaid	Commercial	Medicare	Self-Pay
Medical	-6%	-4%	0%	-2%
Dental	3%	4%	0%	-8%
School-Based Medical	-9%	0%	0%	8%
School-Based Dental	-2%	4%	0%	-2%
Behavioral Health	0%	-9%	0%	7%
Vision	-6%	-1%	1%	4%

Accounts Receivable Trends:

- The accounts receivable collection effort for June for 90-days is 32% and for 120-days is 24%. Our aim for the ideal rate percentage for 90-days is 20% and our 120-days is 10%. The rate for 90-days increased by 6 days and 120-days increased by 6 days from the previous month.

Days in Accounts Receivable & Total Accounts Receivable:

- The number of days in accounts receivable has decreased from the prior month by 2.9 days. The days in accounts receivable are lower than the average (by 5.1 days) of the past 13 months at 36.6 days.

Pharmacy Profit and Loss:

PHARMACY PROFIT AND LOSS				
	FY23	FY24	FY25	FY26
Revenue	$ 6,300,690.56	$ 5,238,764.29	$ 5,502,799.47	$ 6,025,419.65
Fund 416 Expenses	$ 289,436.68	$ 300,781.28	$ 349,159.40	$ 261,679.79
Expenses	$ 3,181,993.51	$ 3,698,117.59	$ 3,884,826.49	$ 4,897,414.84
	$ 3,408,133.73	$ 1,841,427.98	$ 1,967,132.38	$ 1,389,684.60

City of Cincinnati Primary Care
Profit and Loss with fiscal year comparison
June 2025 - June 2026

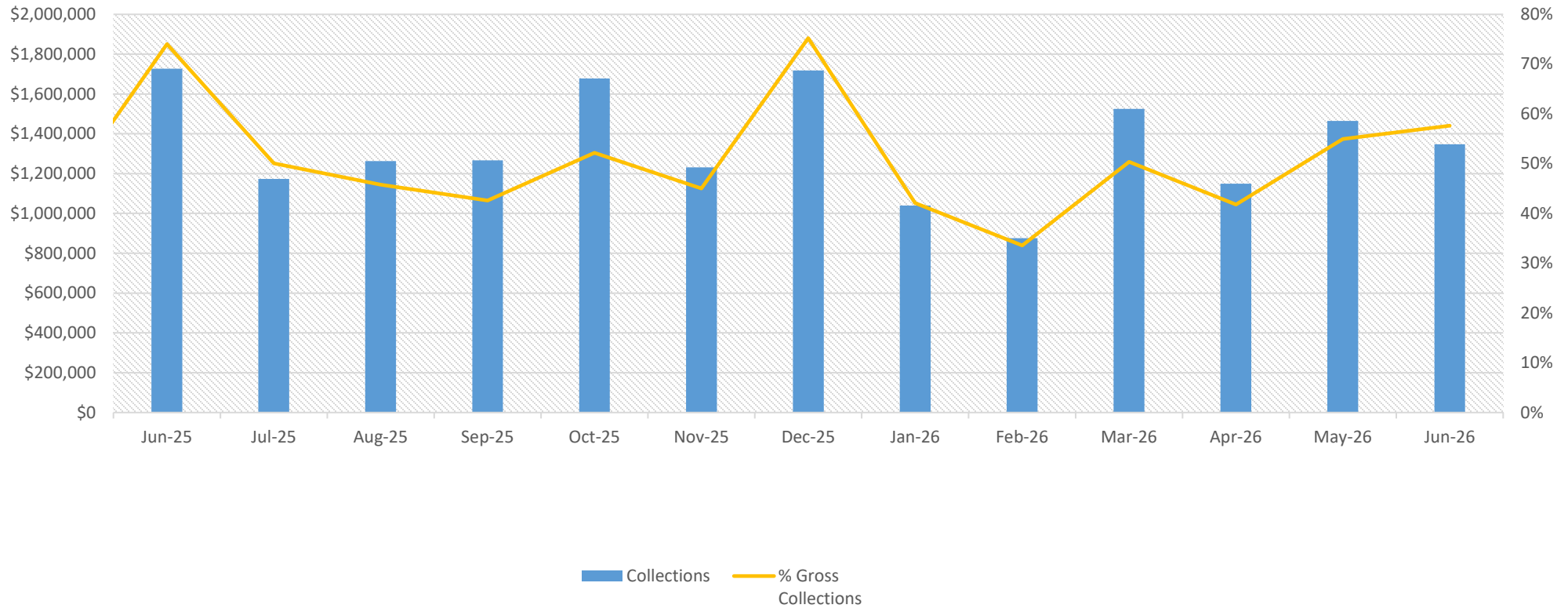
	FY26 Actual	FY25 Actual	Variance FY26 vs FY25
Revenue			
8556-Grants\Federal	$2,774,105.30	$5,577,900.53	-50.27%
8571-Specific Purpose\Private Org.	$0.00	$14,000.00	-100.00%
8617-Fringe Benefit Reimbursement	$0.00	$0.00	0.00%
8618-Overhead Charges - Indirect Costs	$60,700.00	$61,340.00	-1.04%
8733-Self-Pay Patient	$987,264.69	$970,112.38	1.77%
8734-Medicare	$5,717,580.19	$5,160,670.05	10.79%
8736-Medicaid	$12,388,807.65	$9,996,980.90	23.93%
8737-Private Pay Insurance	$1,401,983.82	$1,249,284.15	12.22%
8738-Medicaid Managed Care	$9,385,493.50	$8,522,567.62	10.13%
8739-Misc. (Medical rec.\smoke free inv.)	$217,998.42	$121,842.69	78.92%
8932-Prior Year Reimbursement	$49,552.50	$59,229.25	-16.34%
416-Offset	$7,601,378.47	$6,059,408.65	25.45%
Total Revenue	$40,584,864.54	$37,793,336.22	7.39%
Expenses			
71-Personnel	$20,980,945.88	$19,660,486.03	6.72%
72-Contractual	$5,650,043.95	$5,294,576.17	6.71%
73-Material	$4,120,159.86	$3,488,851.86	18.10%
74-Fixed Cost	$2,349,075.24	$1,925,200.13	22.02%
75-Fringes	$7,889,747.54	$7,226,714.82	9.17%
Total Expenses	$40,989,972.47	$37,595,829.01	9.03%
Net Gain (Losses)	**($405,107.93)**	**$197,507.21**	**-305.11%**

CHD/CCPC Finance Update

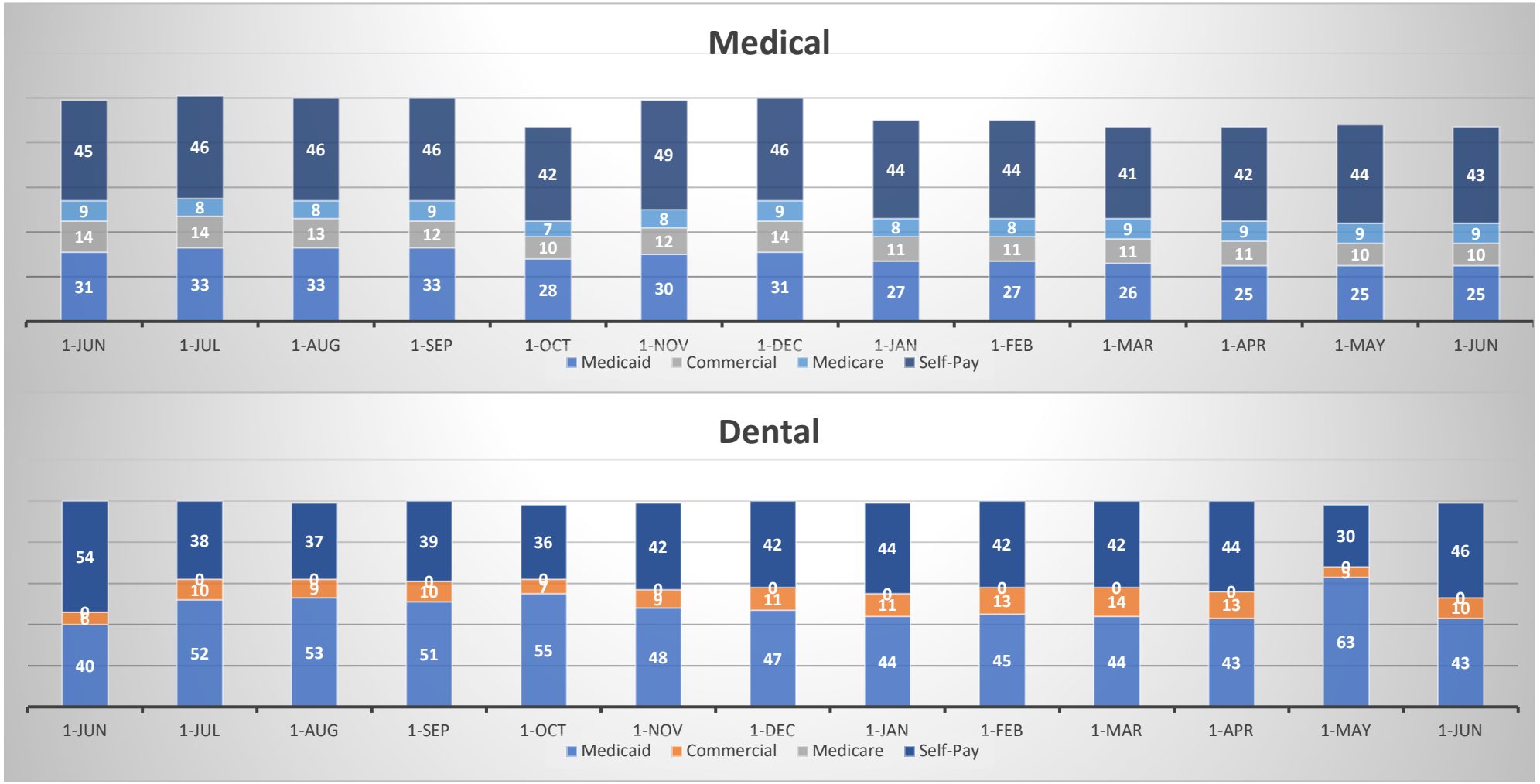
July 14, 2026

Revenue Presentation

Monthly Visit Revenue



Payor Mix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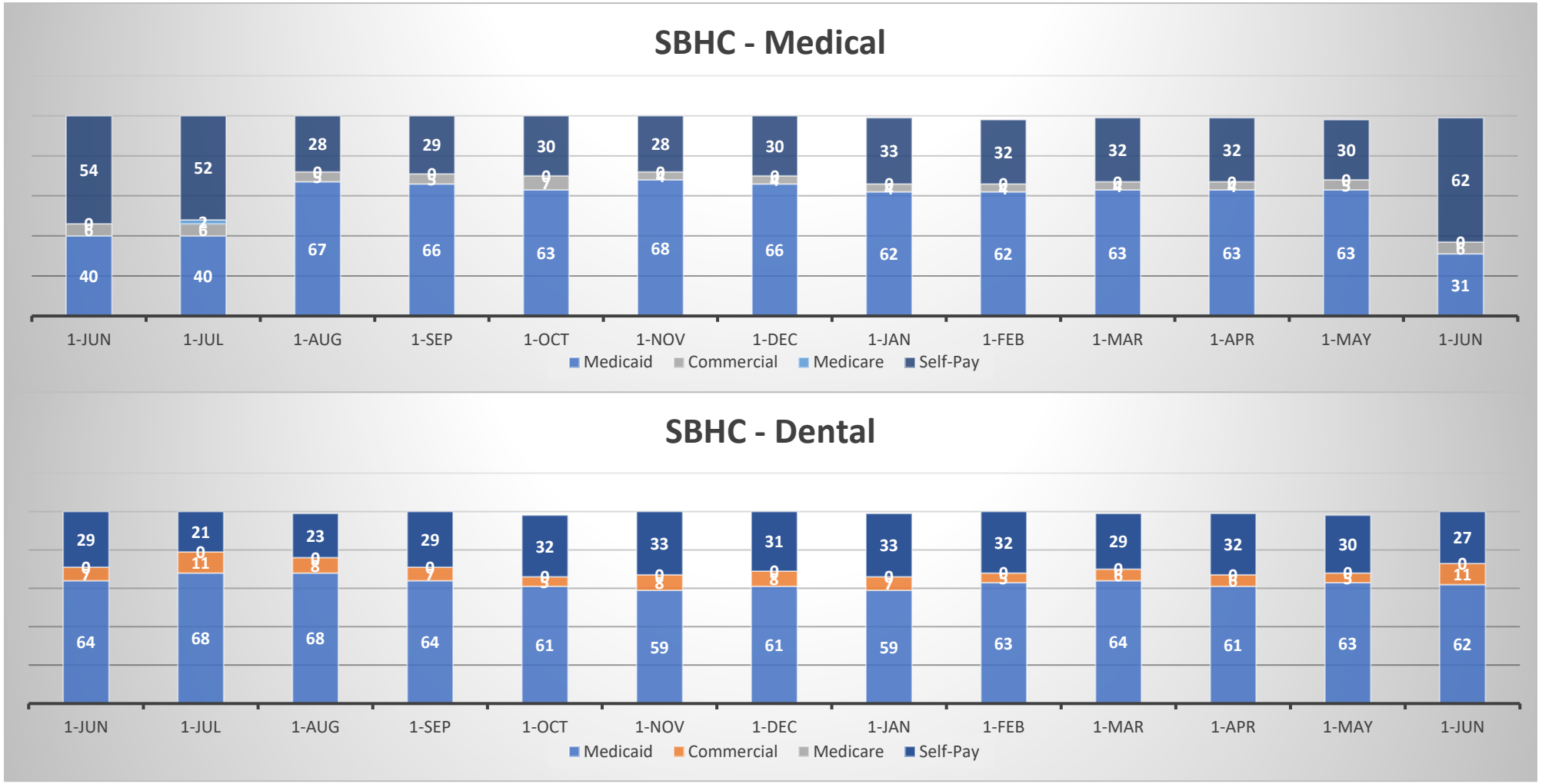
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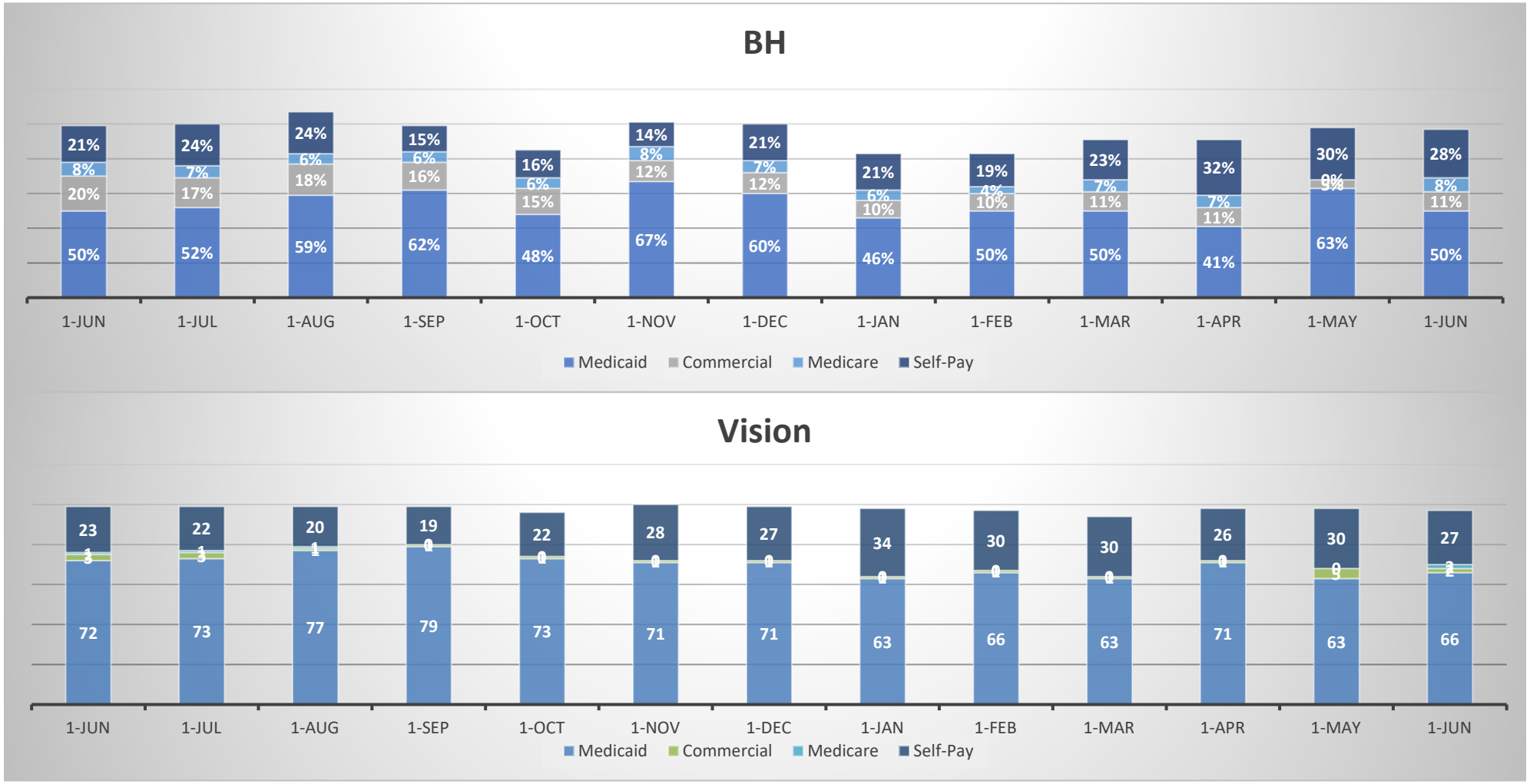
Payor Mix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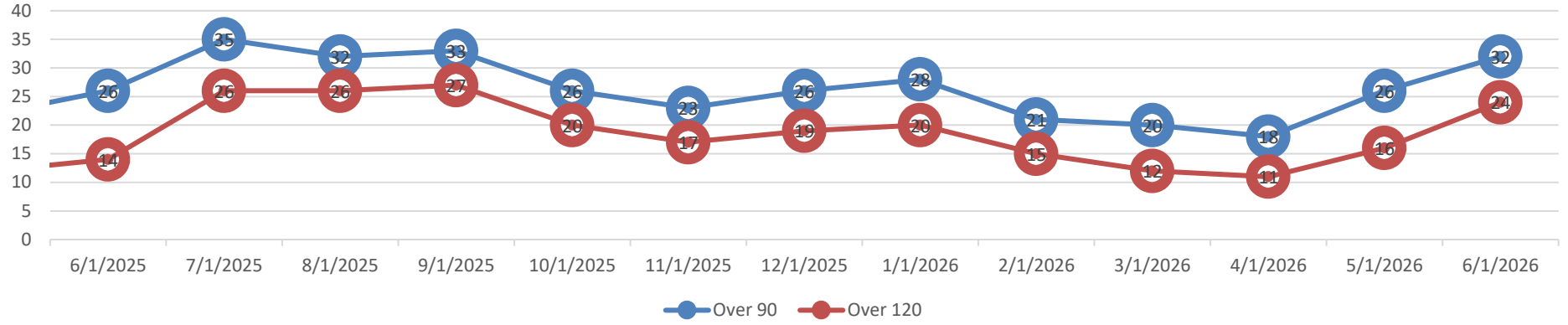
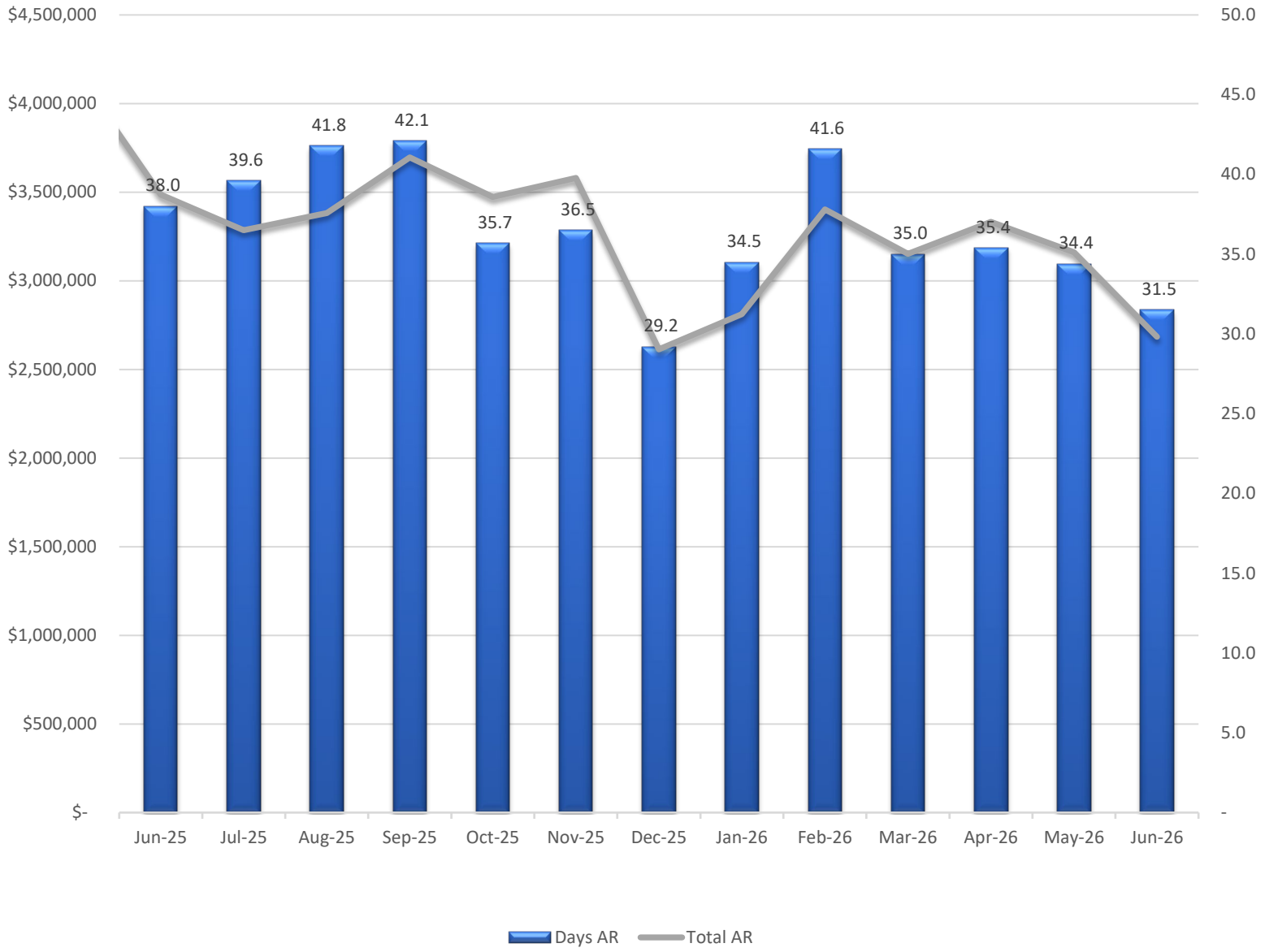
AR Trends



Aging Period	Insurance June	Patient - All June	Patient - On Pmt Plan June	Patient - Not on Pmt Plan June	Total June	% Total June
0 - 30	$1,090,699	$130,207	$2,317	$127,890	$1,220,906	45.48%
31 - 60	$145,608	$153,464	$2,713	$150,751	$299,072	11.14%
61 - 90	$134,246	$158,616	$1,952	$156,664	$292,863	10.91%
91 - 120	$77,934	$145,335	$2,334	$143,001	$223,269	8.32%
121 - 150	$74,191	$119,693	$1,532	$118,161	$193,884	7.22%
151 - 180	$51,555	$93,736	$781	$92,955	$145,291	5.41%
181 - 210	$9,652	$68,576	$1,012	$67,564	$78,228	2.91%
211+	$210,412	$20,422	$5,224	$15,198	$230,833	8.60%
Total	**$1,794,296**	**$890,049**	**$17,864**	**$872,185**	**$2,684,345**	
% > 90	**24%**	**50%**	**61%**	**50%**	**32%**	
% > 120	**19%**	**34%**	**48%**	**34%**	**24%**	

Day in AR & Total A/R



Policies Pending CCPC Board Review – August 2026

Policy: *Credentialing and Privileging**

1. The "National Association Board of Pharmacy Identification (NABP)" and eLicense Ohio Professional Licensure Look-Up have been added to number one on page three.
   Rationale
   Primary source - eLicense Ohio Professional Licensure Look-Up
   Pharmacy request- National Association Board of Pharmacy Identification (NABP)

2. Language was added to page three "Clinical staff member's identity for initial credentialing using a government-issued picture identification"
   Rationale: Health Resources and Services Administration (HRSA) requirement

3. Sentence two ("Staff are responsible...") p.3 moved from policy statement to responsibility section.

4. Added the word "renewal" to Letter A p. 3

5. Number three p. 4; Added picture identification

6. Letter A p.4 added; "documentation of required immunizations

Policy: *Hospital and Emergency Department Discharge Follow-up*

1. Nurse Navigator support added p.3.
   Rationale
   Nurse Navigators support hospital follow-up and care coordination

2. School Based Health Center section created p. 3.
   Rationale
   To support continuity of care and follow up for this unique patient population

3. Clear specific timeframes added for follow-up p.4.
   Rationale
   To enhance workflow, streamline processes, HRSA requirement

4. Identify staff member responsibilities by title
   Rationale
   Role clarity, streamline workflow, HRSA requirement

Policy: Tracking Labs and Diagnostic Imaging *

1. Added "The provider will review and **sign** diagnostic results before providing the RN/MA with instructions to follow up with the patient.
   Rationale
   Process step to mitigate missed result(s)

Policy: *Referral Tracking**

1. Glossary of terms moved to appendix
   Rationale
   To simplify and provide a concise read

2. Specific timeframes added
   Rationale
   Enhance workflow, streamline processes, HRSA requirement

3. Identify staff member responsibility by title
   Rationale
   Role clarity, streamline workflow, HRSA requirement

4. Updated headings in bold p. 8.
   Rationale
   To simplify and provide a concise sequential read

Policy: *Patient Satisfaction Survey**

1. Updated headings
   Rationale
   To simplify and provide a concise sequential read

2. Survey delivery via paper and QR code
   Rationale
   To reflect electronic survey delivery implementation

3. Survey availability in English and Spanish changed to "multilingual"
   Rationale
   Additional language(s) translation pending

4. Survey delivery throughout the year with minimum 30 surveys per provider
   Rationale
   To reflect updates to survey delivery methods designed to collect a minimum of 30 surveys per provider each year.

5. Qualitative surveys added
   Rationale
   To reflect the addition of qualitative surveys, a Patient Centered Medical Home (PCMH) requirement

Policy: *Standards of Medical Care**

1. Removed monthly Uniform Data System (UDS) data review
   Rationale
   Covered in QI/QA plan

2. Removed exceptions to standard screening/care guidelines (#4 previous policy)
   Rationale
   Common practice, language not required

Policy: *Huddle Policy and Procedure **

1. Simplified policy and procedure statement
   Rationale
   To simplify and provide a concise read

2. Glossary of terms removed
   Rationale
   Covered in policy language

3. Roles and responsibility language condensed
   Rationale
   To simplify and provide a concise read

Policy: *Termination of Provider Patient Relationship**

1. Title changed from "physician" to "provider"
   Rationale
   To include other disciplines, i.e. nurse practitioners, clinical pharmacists

2. Purpose statement added
   Rationale
   To provider clarity and maintain consistency with other policy formatting

Policy*: Patient Eligibility*

1. No changes – Pending board review for updated review date

Policy*: Sliding Fee Discount*

1. No changes – Pending board review for updated review date

Policy*: Patient Collections*

1. No changes – Pending board review for updated review date

Policy: *Waiver Reduction Patient Fees*

1. Financial Hardship Waiver Request Form added (see attached)

Policy: *Clinical Safety Event Reporting*

1. Policy title changed from "Incident Reporting" to "Clinical Safety Event Reporting"

2. Electronic summary of investigation submission (p.3 number one) changed from 2 business days to 3 business days.

Policy: *Patient Complaints and Grievances*

1. Combined Patient complaints and grievances into one policy.

2. Paper forms only used for patients, only electronic if needing to submit to the HIPPA privacy officer.

Policy: *Peer Review*

1. Changed format of the policy.

2. Took off the appendix for the checklists.

3. Changed the number of charts reviewed to 5-10.

Policy: *Clinical Risk Management Plan*

1. Grammatical updates and re-wording to improve readability and flow

2. Definitions/glossary moved to Appendix A

3. Committee examples added to functional interfaces p.4 number nine

city of CINCINNATI
HEALTH DEPARTMENT

City of Cincinnati Primary Care (CCPC)

Credentialing and Privileging

Effective Date: August 12, 2026

POLICY/ SYSTEM MANAGER

Review: 6/10; Revised 7/3/19, 8/9/22, 8/3/23,7/12/24,5/25,7/26

Biennial review required by the Chief Executive Officer (CEO).

_____ _____

Board of Governors Chair CCPC Date

_____ _____

Chief Executive Officer CCPC Date

_____ _____

Chief Medical Officer CCPC Date

_____ _____

Chief Operations Officer CCPC Date

_____ _____

Director of Clinical and Community Nursing Date

_____ _____

Health Commissioner Date

I. PURPOSE

To ensure all Licensed Independent Practitioners (LIPs), Other Licensed or Certified Health Care Practitioners (OLCPs), and Other Clinical Staff (OCS) are appropriately credentialed and privileged to provide safe, high-quality care.

II. POLICY

All healthcare practitioners, whether employed, contracted, or volunteering at the City of Cincinnati Primary Care (CCPC), must meet CCPC standards as defined by the Health Resources and Services Administration (HRSA) in the Health Center Program Compliance Manual. Before engaging in patient care, all licensed, unlicensed, or certified healthcare staff must undergo credentialing with primary source verification. The Chief Executive Officer (CEO) oversees credentialing and privileging for all LIPs, OLCP, and OCS. The credentialing/privileging date is the approval date provided by the Chief Medical Officer (CMO) or delegate, as defined in the CCPC Board resolution or bylaws.

III. PROCEDURE

Responsibility

CCPC will tailor credentialing and privileging verification to each practitioner's specialty and services. Staff are responsible for meeting initial and renewal credentialing and privileging criteria, including maintaining all required unexpired licensure, certification, and HRSA-mandated requirements. The CEO, with Board oversight, manages credentialing for all practitioners, delegating implementation to the CMO and file management to the credentialing specialist. The dental, pharmacy and nursing directors will review and sign an attestation attached to the application packets. The directors will make recommendations for approval or disapproval with the CMO holding ultimate authority to approve or deny. The credentialing and privileging date is the approval date by the CMO or delegate. A supervisory evaluation may be conducted before granting privileges.

Implementation

A. The credentialing specialist will manage the initial and renewal credentialing and privileging process for LIP, OLCP, and OCS, utilizing primary and secondary source verification.
B. Primary source verification will be used to verify the following:
    1. Current licensure, registration, or certification (e.g., Board of Nursing or Board of Medicine, eLicense Ohio Professional Licensure Look-Up or National Association Board of Pharmacy [NABP])
    2. Education, training, residency, and board certification (e.g., National Student Clearinghouse or the registrar's office of the appropriate institution American Medical Association and the American Nurses Credentialing Center for the Advanced Practice Registered Nurse)

3. Identity using a current government issued picture identification

C. Verification of information will be obtained to support the following credentialing requirements:
    1. Provider involvement in government healthcare programs and history (National Practitioner Data Bank (NPDB) Query)
    2. Drug Enforcement Administration (DEA) registration (if applicable)
    3. Current documentation of Basic Life Support (BLS) for the healthcare provider
D. Verification and information will be obtained to support the following privileging requirements:
    1. Current documentation of Basic Life Support (BLS) for the healthcare provider
    2. Fitness for duty to assess to ensure all clinical staff have the physical and cognitive ability to safely perform their duties. A "No" response to the health status question in the Council for Affordable Quality Healthcare (CAQH) Medical Condition attestation confirms health fitness.
    3. Immunization and communicable disease status: A copy of the applicant's TB test (PPD or IGRA) and/or TB risk assessment (see TB policy for positive assessment or test results), Hepatitis B immunity or Hepatitis B, Tdap or Td, Chickenpox (varicella) and MMR immunization is required. Flu and Meningococcal vaccines are recommended.
    4. Current clinical competence (two (2) peer references, competency – clinical, hospital admitting privilege attestations from applicable practitioners are acceptable as credential source documentation).
    5. A copy of the applicant's current malpractice insurance.
E. The CMO will review all renewals for final determination.
F. Practitioners must maintain current licensing, DEA registration, and basic life support training.
G. Failure to comply with credentialing and privileging or to submit the necessary documentation may result in corrective action.
H. Practitioners may submit a written request to the CMO for modifying clinical privileges. Requests must include documentation supporting their competence, such as advanced education, clinical practice information from other institutions, or references.
I. The CCPC Board will evaluate compliance with the credentialing and privileging policy. The CEO will report to the CCPC Board annually, or more frequently if requested, providing documentation to demonstrate compliance.

Renewal Process

A. Privileges for LIPs, OLCPs, and OCS will be renewed every two years. This includes:
    - Primary source verification of credentials
    - Peer review results
    - Current documentation of Basic Life Support (BLS) for the healthcare provider (this vendor is approved by CCPC)
    - Performance improvement (evaluations) summaries
    - Competency skills assessment checklist (RN, MA)
    - Documentation of required immunizations

Documentation Management

To ensure the security of credentialing records, the credentialing specialist will keep the documentation in a secure location.

References

Bureau of Primary Health Care. (n.d.). Credentialing and privileging. Health Resources and Services Administration. Retrieved March 21, 2025, from https://bphc.hrsa.gov/compliance/site-visits/site-visit-protocol/credentialing-privileging

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Ohio Department of Health. (n.d.). https://odh.ohio.gov/know-our-programs/infectious-disease-control-manual/section3/section-3-mumps

Appendix A

Definitions

Licensed Independent Practitioner (LIP): An individual permitted by law to provide care and services without direction or supervision, within the scope of the individual's license and consistent with individually granted clinical privileges. CCPC defines LIPs as:

- Physicians
- Dentists
- Nurse Practitioners
- Physician Assistants
- Licensed Independent Social Workers
- Licensed Professional Certified Counselors
- Optometrist

Other Clinical Staff (OCS): An unlicensed individual who is registered or certified to support the work of physicians, nurse practitioners, and other health professionals.

- Medical Assistants
- Dental Assistants
- Community Health Worker
- Optometric Technicians

Other Licensed or Certified Health Care Practitioner (OLCP): An individual who is licensed, registered, or certified but is not permitted by law to provide patient care services without direction or supervision. CCPC defines OLCPs as:

- Nurses
- Social Workers
- Pharmacy Technicians
- Dental Hygienists
- Expanded Function Dental Assistants (EFDA)
- Laboratory Technicians
- Opticians
- Pharmacists

Primary Source Verification (PSV) is verification by the original source of a specific credential to determine the accuracy of a qualification reported by an individual health care practitioner. PSV is completed, at a minimum, for the following:

- Current Licensure;
- Relevant education, training, or experience (work history since the completion of
- medical school - account for all time with all gaps accounted for);
- Current competence; and
- Health fitness (confirmed statement)

Secondary Source Verification (SSV) uses methods to verify credentials when PSV is not required. SSV is completed for the following:

- Government issued picture identification;
- Drug Enforcement Administration registration (DEA) (as applicable);
- Hospital Admitting Privileges (as applicable);
- Immunization and tuberculin Purified Protein Derivative (PPD) status; and
- Basic Life Support Training (as applicable)

Credentialing is the process of assessing and confirming the qualifications of a licensed or certified health care practitioner.

Privileging is the process of authorizing licensed or certified health care practitioners specific scope and content of patient care services. This is performed in conjunction with an evaluation of an individual's clinical qualifications and/or performance.

city of CINCINNATI
HEALTH DEPARTMENT

City of Cincinnati Primary Care (CCPC)

Hospitalization and Emergency Department Discharge Follow up

Effective Date: March 05, 2026

POLICY/ SYSTEM MANAGER

Nursing Administration / Quality Improvement & Assurance

Review: 07/26

A biennial review is required by the Chief Executive Officer (CEO).

_____	_____
Board of Governors Chair CCPC	Date
_____	_____
Chief Executive Officer, CCPC	Date
_____	_____
Chief Medical Officer, CCPC	Date
_____	_____
Chief Operations Officer, CCPC	Date
_____	_____
Director of Clinical and Community Nursing	Date
_____	_____
Health Commissioner	Date

Pending Approval

I. PURPOSE

To ensure patients receive follow-up care with a Cincinnati Primary Care (CCPC) provider after discharge from the hospital or Emergency Department (ED).

II. POLICY

A member of the CCPC care team will contact patients after their discharge from the hospital or ED to begin follow-up and schedule an appointment with a CCPC provider.

III. PROCEDURE

All patients will be contacted within 2–3 business days after discharge from the hospital or emergency department and scheduled for a follow-up appointment to occur within 7 business days of discharge when appropriate.

1. An external monitoring platform will be used for receiving information regarding Hospital or ED admissions/discharges. Information will include patient information, date of admission, date of notification, and reason for visit.
    A. Nursing Navigators
    Nurse navigators will run and review the Hospital Inpatient Discharges and the Hospital ED Discharge Reports for the last 4 days in Epic every three business days.
        a. Both the navigators and health center clinical staff are responsible for contacting all patients following hospital discharge.
        b. Patients evaluated for a mental health condition will be connected to a mental health provider.
    B. Health Center Staff
    Providers are alerted to unplanned hospital admissions via Care Everywhere (CE) daily in real time.
        a. Health center staff will run a hospital admission/ED discharge report in Epic weekly. Both the navigators and health center clinical staff are responsible for contacting patients to schedule follow-up appointments.
        b. CCPC providers and support staff will use CE to share and receive necessary patient treatment information to determine the patient's discharge follow-up needs while coordinating care with outside facilities through bidirectional communication.
    C. School Based Health Center (SBHC) Staff
    During the months of August through May, patients on the report that have SBHC providers as their PCP will be separated from the remainder of the report.
        a. This list will be sent to the SBHC supervisor and/or designee. The supervisor or designee will be responsible for the follow up and scheduling of these patients in conjunction with the SBHC provider.
        b. During times when the SBHC staff are not working, the list will be managed by the Nurse Navigators.

Pending Approval

2. Nurse Navigators and/or assigned staff will use Care Everywhere for chart reviews to determine the patient's discharge follow-up needs.
3. Nurse Navigators and/or assigned staff will contact the patient/parent/legal guardian to discuss follow-up care, review medications, and schedule an appointment with a CCPC provider.
4. If unable to reach the patient/parent/legal guardian after three attempts using multiple modes of communication (i.e.: telephone call, MyChart, Arterra message) a letter (.unabletoreachletter) will be sent to the patient's address requesting a call to the health center.
5. All patient contact is to be documented in the EHR as a telephone encounter with the title ED/hospital follow-up.

Pending Approval

REFERENCES

Campbell, N. (2022). *Effective policies and procedures: A step-by-step resource for clear communication*. Harper Collins Leadership.

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Pending Approval

city of CINCINNATI
HEALTH DEPARTMENT

City of Cincinnati Primary Care (CCPC)

Tracking Labs and Diagnostic Imaging Policy & Procedure

Effective Date: June 10, 2026

POLICY / SYSTEMS MANAGER

Review: 07/2026

A biennial review is required by the Chief Executive Officer (CEO).

_____	_____
Board of Governors Chair CCPC	Date
_____	_____
Chief Executive Officer CCPC	Date
_____	_____
Chief Medical Officer CCPC	Date
_____	_____
Chief Operations Officer CCPC	Date
_____	_____
Director of Clinical and Community Nursing	Date
_____	_____
Health Commissioner	Date

PURPOSE
To standardize tracking and follow up procedures for diagnostic laboratory and imaging tests.

POLICY
City of Cincinnati Primary Care (CCPC) clinical personnel will monitor, track and follow up on diagnostic imaging and laboratory tests as outlined below.

PROCEDURE
The following procedures will be followed when CCPC patients receive a lab or diagnostic imaging order.

Diagnostic, Imaging and Laboratory Test Tracking

1. All orders and communication with the patient will be documented in the patient's electronic health record (EHR), including date and time of notification, mode of communication, and the recipient of the communication.
2. Patients will receive instructions regarding where, when, or how to complete the orders before the end of the encounter.
3. The health center may receive ordered laboratory and diagnostic imaging results through telephone, fax, Care Everywhere, and/or the EHR.
4. The ordering provider and assigned RN/MA receive laboratory results in the EHR result box. Critical laboratory results are communicated to the provider or on call provider by telephone immediately after the result is available.
5. The registered nurse (RN) or medical assistant (MA) will track laboratory orders weekly and diagnostic, imaging orders monthly, using the EHR, patient care lists, reports and Care Everywhere.
6. If a patient has not followed through on their orders, the RN/MA will:
    a. Contact the patient to determine the reasons for non-completion and document the patient's feedback in the EHR.
    b. Provide information on the importance of completing the diagnostic or laboratory testing appointment.
    c. Notify the patient's provider.
7. The provider will review and sign diagnostic results before providing the RN/MA with instructions to follow up with the patient. If the provider contacts the patient, they will document this in the EHR.
8. The provider or RN/MA will inform patients about abnormal laboratory and diagnostic imaging results within two to three business days of receiving the results; normal results will be communicated within 10-14 business days of receiving the results.
9. The provider or RN/MA will make one attempt to reach patients with normal results and three attempts for abnormal results. Contact attempts will be documented in the EHR and will include the following steps until the patient is reached or the outreach is closed.
    a. Phone
    b. MyChart

    c. Letter (.unabletoreachletter) as the final attempt
10. Critical laboratory, diagnostic, imaging results will be reviewed immediately upon receipt by the ordering or on call provider and communicated to the patient. Attempts to communicate with patients will be documented in the EHR and will include the following steps until the patient is reached or the outreach is closed.
    a. Two telephone calls to the patient,
    b. One telephone call to the patient's emergency contact(s)
    c. One MyChart message (if enrolled)
    d. One letter (.unabletoreachletter)
11. If a patient cannot be reached regarding an abnormal result or critical result within 24 hours, the RN or MA will notify the ordering provider who will decide whether any additional attempts are needed to reach the patient.
12. Review of diagnostic imaging and laboratory tracking will be reviewed during the quarterly quality improvement (QI) meetings.

REFERENCES

Braithwaite, J., Wears, R. L., & Hollnagel, E. (2013). *Resilient health care*. Ashgate Publishing Group.

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city of CINCINNATI
HEALTH DEPARTMENT

City of Cincinnati Primary Care (CCPC)

Referral Tracking

Effective Date: August xx, 2026

POLICY/ SYSTEM MANAGER

Review: 7/2026

Biennial review required by the Chief Executive Officer (CEO).

_____	_____
Board of Governors Chair CCPC	Date
_____	_____
Chief Executive Officer CCPC	Date
_____	_____
Medical Director CCPC	Date
_____	_____
Chief Operations Officer CCPC	Date
_____	_____
Director of Clinical and Community Nursing	Date
_____	_____
Health Commissioner	Date

I. PURPOSE

To establish and maintain a uniform process for tracking referrals in the electronic health record (EHR).

II. POLICY

City of Cincinnati Centers for Primary Care (CCPC) personnel will track referrals to ensure follow-up and continuity of care in a timely manner.

III. PROCEDURE

Referral Order

A. The provider will initiate a new referral (internal and external) with pertinent demographic and health information.

Eligibility and Referral Appointment Scheduling

B. When possible, the RN/MA/designee will arrange the patient's referral appointment during their visit. Scheduled appointments will be noted in the EHR in the referral notes section and maintained in patient lists, either in a folder or a spreadsheet, for tracking purposes.

C. If prior authorization is required, the RN/MA/designee who initiates the process will track the pending authorization until a final decision is made including approval and appointment scheduling or authorization denial. If authorization is denied, the RN/MA/designee will notify the provider to determine the next steps.

Documentation in the EHR

D. The referral status will be updated accordingly, with notes (i.e. results received), to one of the following categories in the EHR when exiting the patient, or before the end of the business day. Pending [1], Authorized [2], and Closed [3]. (See Appendix C)

Tracking Process

E. The RN/MA/designee will print a list of open referrals ***every 30 days*** and contact patients to verify they have scheduled their appointments, and reports have been received. A minimum of three attempts will be made (i.e., telephone call, letter, MyChart communication) and documented in the EHR. *For referrals >90 days old that have an appointment scheduled, confirm that the patient is followed using a patient list or spreadsheet every 90 days until the referral expires (12 months).*

F. The RN/MA/designee will verify through Care Everywhere or contact the patient/provider to confirm whether the appointment was attended.

G. Results found in Care Everywhere will be documented in the chart with the procedure date and results. If not available, records will be requested from the provider if the appointment is completed.

Referral Closure

H. Document referrals as “closed” in the EHR within 90 days and state the reason for closure.

References

Bureau of Primary Health Care. (n.d.). *FTCA deeming application tracking policies* [PDF]. Health Resources and Services Administration. https://bphc.hrsa.gov/sites/default/files/bphc/compliance/ftca-ta-resource-tracking-policies.pdf.

Appendix A

SA63 UC Health Provider/POS IDs

UNIVERSITY HOSPITAL - ALLERGY CLINIC	63000152
UNIVERSITY HOSPITAL - ANTICOAGULATION PHARMACY CLIN*	63000153
UNIVERSITY HOSPITAL - ARTHRITIS CLINIC	63000154
UNIVERSITY HOSPITAL - BREAST CONSULTATION	63000155
UNIVERSITY HOSPITAL - BURN CLINIC	63000156
UNIVERSITY HOSPITAL - CARDIAC CATH CV INTERVENTION *	63000158
UNIVERSITY HOSPITAL - CARDIAC CLINIC	63000157
UNIVERSITY HOSPITAL - CARDIAC SURGERY CLINIC	63000159
UNIVERSITY HOSPITAL - CONGESTIVE HEART FAILURE/TRAN*	63000160
UNIVERSITY HOSPITAL - DENTAL CENTER	63000161
UNIVERSITY HOSPITAL - DERMATOLOGY CLINIC	63000162
UNIVERSITY HOSPITAL - DIABETES CLINIC	63000163
UNIVERSITY HOSPITAL - ELECTROPHYSIOLOGY CLINIC	63000164
UNIVERSITY HOSPITAL - ENDOCRINE CLINIC	63000165
UNIVERSITY HOSPITAL - GASTROINTESTINAL CLINIC	63000166
UNIVERSITY HOSPITAL - GENERAL INTERNAL MEDICINE RES*	63000167
UNIVERSITY HOSPITAL - GREATER CINCINNATI NURSE MIDW*	63000177
UNIVERSITY HOSPITAL - GYNECOLOGY DYSPLASIA	63000168
UNIVERSITY HOSPITAL - GYNECOLOGY ONCOLOGY	63000169
UNIVERSITY HOSPITAL - HAND CENTER	63000170
UNIVERSITY HOSPITAL - HEMATOLOGY ONCOLOGY	63000171
UNIVERSITY HOSPITAL - INFECTIOUS DISEASE CENTER	63000172
UNIVERSITY HOSPITAL - INTERNAL MEDICINE CLINIC	63000173
UNIVERSITY HOSPITAL - KIDNEY TRANSPLANT CLINIC	63000174
UNIVERSITY HOSPITAL - LIVER CLINIC	63000175
UNIVERSITY HOSPITAL - LIVER TRANSPLANT CLINIC	63000176

UNIVERSITY HOSPITAL - NEUROLOGY CLINIC	63000178
UNIVERSITY HOSPITAL - NEUROSURGERY CLINIC	63000179
UNIVERSITY HOSPITAL - OBSTERTRICES AND GYNECOLOGY	63000180
UNIVERSITY HOSPITAL - OPHTHALMOLOGY	63000181
UNIVERSITY HOSPITAL - ORAL AND MAXILLOFACIAL SURGERY	63000182
UNIVERSITY HOSPITAL - ORTHOPAEDIC CLINIC	63000183
UNIVERSITY HOSPITAL - OTOLARYNGOLOGY CLINIC	63000184
UNIVERSITY HOSPITAL - PAIN CENTER	63000185
UNIVERSITY HOSPITAL - PANCREASE TRANSPLANT CLINIC	63000187
UNIVERSITY HOSPITAL - PANCREATIC DISEASE CLINIC	63000186
UNIVERSITY HOSPITAL - PERINATAL CENTER	63000188
UNIVERSITY HOSPITAL - PHYSICAL MEDICINE & REHABILIT*	63000189
UNIVERSITY HOSPITAL - PHYSICAL THERARPY	63000190
UNIVERSITY HOSPITAL - PLASTICS CLINIC	63000191
UNIVERSITY HOSPITAL - PODIATRY CLINIC	63000192
UNIVERSITY HOSPITAL - PSYCHIATRY	63000194
UNIVERSITY HOSPITAL - PULMONARY CLINIC	63000193
UNIVERSITY HOSPITAL - RADIATION ONCOLOGY	63000195
UNIVERSITY HOSPITAL - RENAL (HYPERTENSION) CLINIC	63000196
UNIVERSITY HOSPITAL - SPEECH THERAPY	63000197
UNIVERSITY HOSPITAL - SURGERY CLINIC	63000198
UNIVERSITY HOSPITAL - SURGICAL ONCOLOGY	63000199
UNIVERSITY HOSPITAL - THORACIC SURGERY	63000200
UNIVERSITY HOSPITAL - TRAUMA CLINIC	63000201
UNIVERSITY HOSPITAL - UROLOGY CLINIC	63000202
UNIVERSITY HOSPITAL - VASCULAR CLINIC	63000203
UNIVERSITY HOSPITAL - NEPHROLOGY	63000300
UNIVERSITY HOSPITAL - RHEUMATOLOGY	63000280
UNIVERSITY HOSPITAL ALL CLINIC REFERRAL	63000369
UNIVERSITY HOSPITAL DIAGNOSTICS SCHEDULING	63000370

Appendix B

CHILDREN'S HOSPITAL - ACRODIGESTIVE AND SLEEP CENTER	63000205
CHILDREN'S HOSPITAL - ADHD CENTER	63000301
CHILDREN'S HOSPITAL - ALLERGY CLINIC	63000206
CHILDREN'S HOSPITAL - AUDIOLOGY	63000207
CHILDREN'S HOSPITAL - BALANCE CENTER	63000208
CHILDREN'S HOSPITAL - BEHAVIORAL MEDICINE AND CLINIC*	63000209
CHILDREN'S HOSPITAL - BRACHIAL PLEXUS	63000302
CHILDREN'S HOSPITAL - BREAST FEEDING CLINIC	63000210
CHILDREN'S HOSPITAL - CARDIOLOGY	63000211
CHILDREN'S HOSPITAL - CENTER FOR BETTER HEALTH AND N*	63000212
CHILDREN'S HOSPITAL - CHOLESTEROL CLINIC	63000227
CHILDREN'S HOSPITAL - CHRONIC PAIN MANAGEMENT	63000303
CHILDREN'S HOSPITAL - DENTISTRY	63000213
CHILDREN'S HOSPITAL - DERMATOLOGY	63000214
CHILDREN'S HOSPITAL - DEVELOPMENTAL & BEHAVIORAL PED*	63000215
CHILDREN'S HOSPITAL - DIABETES CLINIC	63000216
CHILDREN'S HOSPITAL - DIAGNOSTIC CLINIC	63000217
CHILDREN'S HOSPITAL - ENDOCRINOLOGY	63000218
CHILDREN'S HOSPITAL - ENT OTOLARYNGOLOGY	63000219
CHILDREN'S HOSPITAL - FAMILY RESOURCE CENTER	63000220
CHILDREN'S HOSPITAL - FEEDING TEAM	63000304
CHILDREN'S HOSPITAL - GASTROENTEROLOGY	63000221
CHILDREN'S HOSPITAL - GYNECOLOGY, PEDS AND ADOLESCENT	63000222
CHILDREN'S HOSPITAL - HEMANGIOMA & VASCULAR MALFORMA*	63000305
CHILDREN'S HOSPITAL - HEMATOLOGY/ONCOLOGY	63000223
CHILDREN'S HOSPITAL - HOME HEALTH/SYNAGIS/HME	63000224
CHILDREN'S HOSPITAL - HUMAN GENETICS	63000225

CHILDREN'S HOSPITAL - HYPERTENSION CLINIC	63000226
CHILDREN'S HOSPITAL - INFECTIOUS DISEASE	63000228
CHILDREN'S HOSPITAL - INTEGRATIVE CARE CLINIC	63000229
CHILDREN'S HOSPITAL - INTERNATIONAL ADOPTION CENTER	63000230
CHILDREN'S HOSPITAL - LAB: GTT OR SWEAT CHLORIDE	63000231
CHILDREN'S HOSPITAL - MAYERSON CENTER	63000232
CHILDREN'S HOSPITAL - NEPHROLOGY	63000233
CHILDREN'S HOSPITAL - NEUROLOGY	63000234
CHILDREN'S HOSPITAL - NEUROSURGERY	63000235
CHILDREN'S HOSPITAL - NUTRITION	63000236
CHILDREN'S HOSPITAL - OCCUPATIONAL THERAPY	63000237
CHILDREN'S HOSPITAL - OPHTHALMOLOGY/EYE CLINIC	63000239
CHILDREN'S HOSPITAL - ORTHOPAEDICS	63000240
CHILDREN'S HOSPITAL - PERLMAN CENTER/UNITED CEREBRAL*	63000241
CHILDREN'S HOSPITAL - PHYSICAL MEDICINE AND REHAB	63000242
CHILDREN'S HOSPITAL - PHYSICAL THERAPY	63000238
CHILDREN'S HOSPITAL - PLASTIC SURGERY	63000243
CHILDREN'S HOSPITAL - PSYCHIATRY	63000244
CHILDREN'S HOSPITAL - PULMONARY MEDICINE	63000245
CHILDREN'S HOSPITAL - RADIOLOGY	63000246
CHILDREN'S HOSPITAL - RHEUMATOLOGY	63000247
CHILDREN'S HOSPITAL - SICKLE CELL	63000248
CHILDREN'S HOSPITAL - SLEEP CENTER	63000306
CHILDREN'S HOSPITAL - SPEECH THERAPY	63000249
CHILDREN'S HOSPITAL - SPORTS MEDICINE	63000250
CHILDREN'S HOSPITAL - SURGERY	63000251
CHILDREN'S HOSPITAL - SURGICAL WEIGHT LOSS CENTER	63000307
CHILDREN'S HOSPITAL - TEST REFERRAL	63000252
CHILDREN'S HOSPITAL - UROLOGY	63000253

Appendix C

REFERRAL STATUS

1. Pending: This status will be used for when the referral meets the following criteria:
    a. Prior authorization required
    b. An appointment is needed. Patients/parents will be instructed to call the health center once they schedule their appointment, and the referral status must be updated accordingly.
    c. Report not yet received
    d. Uninsured or underinsured patients needing financial assistance must complete the financial application process.
2. Authorized: This status will be used when the referral has been scheduled.
3. Closed: This status is used when the patient attended the appointment
    a. RN/MA/designee will use Care Everywhere or contact the patient to verify appointment status.

REFERRAL TYPE

A. Internal Referrals are ordered by the provider and sent electronically through the EHR to the following divisions:
    i. Dental—9144
    ii. Clinical Pharmacist--9155
    iii. Women, Infants, Children (WIC)--9103
    iv. Vision—9025 Optometry 9024; Ophthalmology 9067 Diabetic Retinal Exams
    v. Behavioral and Mental Health --9167
    vi. Nurse Navigator – 9091 Nurse Navigators (care coordination)
    vii. Medical - 9195 (care coordination)
    viii. Obstetrics – 9022
    ix. Gynecology –9013
    x. Pediatrics -9030

    *Once internal appointments for the above services have been completed, the referral's status is “closed.”

B. External Referrals are ordered by the provider and sent electronically or by fax to the outside specialist.
    I. University of Cincinnati Medical Center- send by fax (See appendix A for codes).
    II. Cincinnati Children’s Hospital- send electronically through EHR (See appendix B for codes)
    III. TriHealth- send by Fax
    IV. Mercy- send by Fax
    V. Christ- send by Fax
    VI. All other specialties- send by fax or contact the provider.

city of CINCINNATI
HEALTH DEPARTMENT

City of Cincinnati Primary Care (CCPC)

Patient Satisfaction Surveys

Effective Date: May XX, 2026

POLICY/ SYSTEM MANAGER

Title: Patient Satisfaction Surveys

Review: 07/2026

A biennial review is required by the Chief Executive Officer (CEO).

_____ _____

Board of Governors Chair CCPC Date

_____ _____

Chief Executive Officer, CCPC Date

_____ _____

Chief Medical Officer, CCPC Date

_____ _____

Chief Operations Officer, CCPC Date

_____ _____

Director of Clinical and Community Nursing Date

_____ _____

Health Commissioner Date

I. PURPOSE

To enhance patient satisfaction and strengthen the overall experience and health outcomes for City of Cincinnati Primary Care (CCPC) patients.

II. POLICY

CCPC health center staff will complete Patient Satisfaction Surveys (PSS) continuously throughout the year to determine the experience of patients during their visits.

III. PROCEDURE

A. Quantitative Surveys
   1. The PSS tool is provided by an outside vendor.
   2. The survey is conducted at all health centers by way of paper or QR code during or after any visit to the health center.
   3. Survey questions address access to appointment preference and experience, communication and care coordination.
   4. Each full-time provider is expected to have a minimum of 30 surveys per year.
   5. Multilingual surveys are available.
   6. The surveys are sent to the vendor once a year electronically to be analyzed by location, service, and provider.
   7. The vendor sends the results electronically to the designated survey coordinator.

B. Qualitative Surveys
   1. Patients will receive a four-question survey through text, MyChart or by phone
   2. Surveys will be sent to patients who were late or missed an appointment.
   3. The questions will focus on patient access to care, the patient's experience, and any barriers to care.

C. Survey Results
   1. The data of the PSS is consolidated and shared with CCPC Leadership, staff, stakeholders, and the CCPC board.

REFERENCES

Buse, K., Mays, N., Colombini, M., Fraser, A., Khan, M., & Walls, H. (2023). *Making Health Policy.* McGraw-Hill.

Campbell, N. (2022). *Effective policies and procedures: A step-by-step resource for clear communication*. Harper Collins Leadership.

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Seavey, J. W., Aytur, S. A., & McGrath, R. J. (2023). *Health policy and analysis: Framework and tools for success*. Springer Publishing Company.

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city of CINCINNATI
HEALTH DEPARTMENT

City of Cincinnati Primary Care (CCPC)
Standards of Medical Care

Effective Date: September 11, 2024

POLICY/ SYSTEM MANAGER

Title: Quality/Nursing Administration

Last Revised: 4/3/2026

Biennial review required by the Chief Executive Officer (CEO).

_____	_____
Board of Governors Chair CCPC	Date
_____	_____
Chief Executive Officer CCPC	Date
_____	_____
Medical Director CCPC	Date
_____	_____
Chief Operations Officer CCPC	Date
_____	_____
Director of Clinical and Community Nursing	Date
_____	_____
Health Commissioner	Date

I. PURPOSE

To standardize care based on national guidelines to enhance quality measures and improve patient outcomes.

II. POLICY

The City of Cincinnati Primary Care (CCPC) providers and health care teams will follow care guidelines based on National Standards.

III. PROCEDURE

1. Providers will have access to National Standards of Care guidelines at the point of care, through the evidence-based clinical resource UpToDate. When hired, providers will receive access to CCPC's subscription.

2. Annual comprehensive health assessments will be conducted for CCPC patients to evaluate their medical, social, and mental health status. These assessments will also address their communication needs, family and cultural characteristics, social determinants of health, and will include preventative health measures including immunizations and screenings. Providers may also utilize the most recent *Guide to Clinical Preventive Services* which includes U.S. Preventive Services Task Force (USPSTF) recommendations and the Centers for Disease Control and Prevention (CDC).

3. The providers and the health care team will implement the highest quality of care and treatment guidelines as appropriate for the patient. The health care team will conduct daily huddles as outlined in the patient care team's huddle policy.

References

The United States Preventative Services Task Force. Retrieved February 2, 2023, from https://www.uspreventiveservicestaskforce.org/uspstf/

city of CINCINNATI
HEALTH DEPARTMENT

City of Cincinnati Primary Care (CCPC)

Clinical Team Huddle Policy & Procedure

Effective Date:

POLICY / SYSTEMS MANAGER

Nursing Administration / Quality Improvement & Assurance

Review: 5/26. 6/26

A biennial review is required by the Chief Executive Officer (CEO).

Board of Governors Chair CCPC Date

_____ _____

Chief Executive Officer, CCPC Date

_____ _____

Chief Medical Officer, CCPC Date

_____ _____

Chief Operations Officer, CCPC Date

_____ _____

Director of Clinical and Community Nursing Date

_____ _____

Health Commissioner Date

I. PURPOSE

To establish a standardized process that supports efficient, high-quality care for all City of Cincinnati Primary Care (CCPC) patients through focused team-based communication, also known as a huddle.

II. POLICY

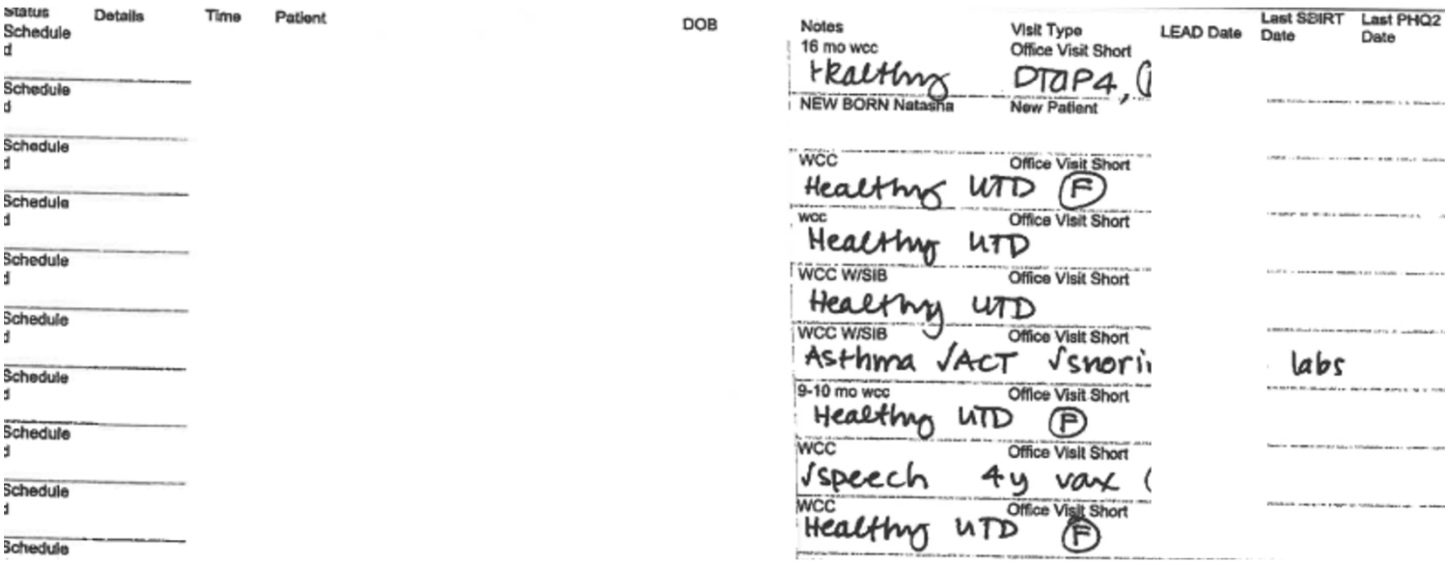
CCPC clinical personnel will huddle daily and as needed to discuss scheduled patients as a team.

III. PROCEDURE

1. Care team members may include the provider (MD, DO, APRN), a registered nurse (RN), a medical assistant (MA), the clinical pharmacist, dental and vision clinicians, or behavioral and mental health specialists.
2. CCPC clinical personnel will use a comprehensive worksheet also known as a pre-visit planning (PVP) worksheet to prepare and identify items to report during the huddles i.e. missing referrals, labs, imaging, diagnostics, immunizations, and screenings including social determinants of health (see appendix A).
3. Any potential issues that affect patient flow or could lead to adverse patient outcomes will be documented on the PVP worksheet and discussed during the huddle.
4. Designated CCPC clinical personnel will complete the PVP worksheet and distribute it to all care team members prior to the huddle.
5. The PVP worksheet is reviewed by all care team members in person and discussed simultaneously during the huddle. **The provider is responsible for leading the huddle**.
6. After the huddle, the PVP worksheet is signed by all huddle participants.
7. Signed PVP worksheets are to be submitted to the nursing supervisor or team leader for tracking. PVP worksheets are kept on file for at least one year.

APPENDIX A

Example of Huddle Employing the Use of the Department Appointments Report (DAR)



Status	Details	Time	Patient	DOB	Notes	Visit Type	LEAD Date	Last SBIRT Date	Last PHQ2 Date
Schedule d					16 mo wcc	Office Visit Short			
					tkalthy	DTaP4, (			
Schedule d					NEW BORN Natasha	New Patient			
Schedule d					WCC	Office Visit Short			
Schedule d					Healthy UTD (F)				
Schedule d					wcc	Office Visit Short			
Schedule d					Healthy UTD				
Schedule d					WCC W/SIB	Office Visit Short			
Schedule d					Healthy UTD				
Schedule d					WCC W/SIB	Office Visit Short			
Schedule d					Asthma √ACT √snori			labs	
Schedule d					9-10 mo wcc	Office Visit Short			
Schedule d					Healthy UTD (F)				
Schedule d					WCC	Office Visit Short			
Schedule d					√speech 4y vax (				
Schedule					WCC	Office Visit Short			
					Healthy UTD (F)				

city of CINCINNATI HEALTH DEPARTMENT

City of Cincinnati Primary Care (CCPC)

Termination of the Provider/Patient Relationship Policy and Procedure

Effective Date: April XX, 2026

POLICY/ SYSTEM MANAGER

Termination of the Provider/Patient Relationship Policy and Procedure

Review: 05/28

A biennial review is required by the Chief Executive Officer (CEO).

_____	_____
Board of Governors Chair CCPC	Date
_____	_____
Chief Executive Officer, CCPC	Date
_____	_____
Chief Medical Officer, CCPC	Date
_____	_____
Chief Operations Officer, CCPC	Date
_____	_____
Director of Clinical and Community Nursing	Date
_____	_____
Health Commissioner	Date

I. PURPOSE

To standardize a process for termination of the provider/patient relationship within the City of Cincinnati Primary Care health centers.

II. POLICY

A City of Cincinnati Primary Care (CCPC) provider has the right to terminate the provider–patient relationship with a CCPC patient if the provider determines that optimal medical care can no longer be delivered.

Care cannot be legally denied for any illegitimate reason, such as discriminating against a patient based on race, color, religion, national origin, or sexual orientation. Patients can exercise their right to file a grievance in response to pending patient termination proceedings.

III. PROCEDURE

A. Termination of Care for Patients Ineligible for Service

When a CCPC patient is being terminated from care because of ineligibility for service at the CCPC health centers, the care should be terminated according to the procedure outlined in the "Primary Care Patient Eligibility Policy"

B. Termination of care for Eligible Patients

Before terminating care of a CCPC patient, the provider is expected to make a reasonable effort at solving the concerns with the provider/patient relationship. Assistance in working through challenges can be obtained from: the Chief Medical Officer (CMO), the health center nursing supervisor, or CCPC administration/leadership. If the specific problems cannot be resolved, the provider has the right to terminate the provider/patient relationship, as long as the relationship is ended according to policy and the Ohio Administrative Code.

To terminate the provider/patient relationship with a CCPC patient, the provider is expected to:

1. Document in the Electronic Health Record (EHR) the concern and outline the efforts made to resolve the challenge/conflict.
2. Evaluate the patient's current condition and render any necessary care to stabilize the patient.
3. Notify the patient of the intent to withdraw care by a definite date, allowing at least 30 days for the patient to obtain alternative care. Inform the patient that urgent care and medications will be provided during the interim for up to 30 days. A letter of this notification, signed by the provider, is to be sent to the CMO office prior to sending it to the patient. The reason for termination is not mandatory but can be given.
4. Inform the patient that medical records will be made available to the new provider of their choosing upon receipt of the patient's written authorization.

5. If a patient is being terminated from all CCPC health centers, the letter must also be signed by the CMO.

REFERENCES

Ohio Administrative Code. (n.d.). *Rule 4731-27-02*. https://codes.ohio.gov/ohio-administrative-code/rule-4731-27-02

city of CINCINNATI
HEALTH DEPARTMENT

City of Cincinnati Primary Care (CCPC)

Primary Care Patient Eligibility

Effective Date: August xx, 2026

POLICY/ SYSTEM MANAGER

Name: Angela Mullins

Title: Quality/Nursing Administration

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Review: 5/05; rev. 11/09, 3/12, 3/23, 7/26

Biennial review required by the Chief Executive Officer (CEO).

_____	_____
Board of Governors Chair CCPC	Date
_____	_____
Chief Executive Officer CCPC	Date
_____	_____
Medical Director CCPC	Date
_____	_____
Chief Operations Officer CCPC	Date
_____	_____
Director of Clinical and Community Nursing	Date
_____	_____
Health Commissioner	Date

I. PURPOSE

To establish the eligibility criteria and requirements for patients receiving services through CCPC.

II. POLICY

The City of Cincinnati Primary Care (CCPC) is a Federally Qualified Health Center. CCPC was established to serve residents of its designated service area which has been extended to all areas within the city of Cincinnati and the greater Cincinnati area.

An individual will not be considered within the service area unless proof of residency is provided within (30 days). In addition, patients whose mail is returned to the health center may be required to show proof of address within the service area in order to be considered eligible for health center services.

No patient presenting to a CCPC health center will be denied medical, dental, or nursing, or behavioral health services due to inability to pay.

III. PROCEDURE

Procedure for Appointments for New Patients:

When an appointment is made for a new patient, the Customer Relations Representative (CRR), Medical Assistant (MA) or other designated staff must request that the individual bring proof of residency, proof of income, and an insurance card (if they have coverage) to the first visit. Examples of proof of residency include, but are not limited to, telephone, gas and electric bill, etc. Proof of income includes, but is not limited to, payroll stub (two most recent), income tax return form, W-2 form, social security and retirement plan benefit statements etc. Proofs of residency and income will be dated (including the year) and filed in the registration section of the Electronic Medical Record (EMR). If the patient is unable to produce any of the above documents, a notarized statement will be accepted as proof of residency and/or income.

Individuals will be advised to provide proof of income and address upon the date of service in order to qualify for the Sliding Fee Discount Program (SFDP). If the patient arrives for their first appointment without proof of income and address, they will be required to sign the Service Eligibility Form and given thirty days to submit required documentation. If proof is not provided within 30 days, the patient will be considered self-declared and not eligible for the SFDP. Patients will be advised that they are no longer eligible for the SFDP and will be charged the full amount for services received. CCPC will make every attempt to assist patients and will refer them to Outreach and Enrollment who can assist with insurance eligibility and proofs for SFDS.

Special Circumstances for Individuals Residing Outside the Service Area
CCPC may obtain contractual arrangements with Medicaid Health Maintenance Organizations (HMOs), and other private insurance companies to provide medical, dental, and other services to patients enrolled in these organizations.

Pregnancy: If an individual who lives outside of the service area calls and thinks she may be pregnant, she will be advised that she needs to seek care as soon as possible and referred to another source for OB/Gyn care. If such an individual walks into a CCPC center, she will be triaged by a nurse to address any urgent needs.

Previously Scheduled Appointments: If an individual who is outside the service area has been given an appointment and comes into CCPC for that appointment, the nurse will triage the patient to make sure that no urgent problem exists. If there is not an urgent problem, the patient will be offered all required immunizations and will be provided with information to make an appointment

with an alternative source of primary health care. If an urgent problem exists, the patient will be seen by the physician and appropriate medical care will be rendered. The patient will then be referred to an alternative source of health care if there is no exceptional need documented to continue care with CCPC.

Non-Service Area Walk-In: Refer to **"Previously Scheduled Appointments"**

Non-Service Area Resident Dental Emergencies: If an individual who is outside the service area calls for a dental emergency, they will be triaged, resulting in emergency treatment, or referred to an alternative source of dental care. If an individual who is outside the service area walks into CCPC with a dental emergency, the individual will be triaged by the dentist, resulting in either emergency treatment or referral to an alternative dental provider.

Special Programs: Non-service area residents may receive services from special programs including Women, Infants, and Children (WIC) and Immunization Action Program (IAP).

Current, Active Patients who are Non-Service Area Residents:
If an individual is a current patient of CCPC and moves outside the service area or is newly discovered to have an address outside the service area, the patient should be seen for any scheduled appointment. The individual will be informed that they may continue to receive care however they will be considered self-declared and not eligible for the SFDP. Additional resources may be provided to assist the patient with other healthcare options.

Registration Procedure:
Demographic information must be verified and up-dated each visit. Each visit, the patient must be asked for specific information regarding their address, telephone number, insurance, etc. Do not just ask the patient if all the information is the same. Ask specific questions at each visit and compare the information you receive with the information in the EMR, and up-date any changes.

Financial information must be verified and updated annually in the EMR. There will be verification of income and residency in the patient's medical record. Any requests to bring in verification at the next visit must be documented on the Service Eligibility Form. Patients will be told that failure to provide documentation of income may lead to loss of discount at the next visit. If verification is not provided within (30 days), discounting will be discontinued. Parents of Children's Health Insurance Program (CHIP) eligible patients (under the age of 19) and pregnant women who are considered minimum pay will be strongly encouraged to apply for CHIP.

Miscellaneous Situations:

Returned Mail
When mail is returned to CCPC (e.g., returned appointment letter) this will be noted in the EMR. The CRR, MA or designee is responsible for asking each individual with returned mail to confirm their address. The CRR, MA or designee will update the EMR with the updated information.

Non-U.S. Citizens
Immigrants referred to CCPC who require immunizations will be immunized appropriately. Non-U.S. citizens will not be asked or expected to show a green card to be eligible for services.

Patients Whose Bills Exceed $500.00:
Patients with an unpaid balance which exceeds $500.00 will be set up for a payment plan. The payment plan will require that the patient pay at least $10.00 per month on their balance and more if possible, to reduce their unpaid balance. Payment plans can be set up onsite at the health center, or via MyChart. Patients are asked to pay the current balance for services incurred and the payment plan amount during the time of each visit. Waiver of fees or payment plans may be made available to qualified patients due to hardship. Hardship examples may include but are not limited to the following: deceased patient, destruction of home due to fire, flood or natural disaster and military deployment of both parents in the family. Refer to the CCPC Waiver Reduction policy for additional instructions.

Patient Balances: Patients will receive a billing statement in the mail on any outstanding balance(s). Patients will have the option to mail in their payment (check, money order, or credit card), pay via MyChart using a credit card or the patient may make a payment onsite at the health center. Cashiers will request that the patient pay the balance of their bill for services received at this visit.

city of CINCINNATI
HEALTH DEPARTMENT

City of Cincinnati Primary Care (CCPC)
Sliding Fee Discount

Effective Date: August xx, 2026

POLICY/ SYSTEM MANAGER

Name: Angela Mullins

Title: Quality/Nursing Administration

Contact: (513) 357-7332, angela.mullins@cincinnati-oh.gov

Last Reviewed: 07/27/2026

Biennial review required by the Chief Executive Officer (CEO).

Board of Governors Chair CCPC	Date
Chief Executive Officer CCPC	Date
Medical Director CCPC	Date
Chief Operations Officer CCPC	Date
Director of Clinical and Community Nursing	Date
Health Commissioner	Date

I. PURPOSE

Every service within the City of Cincinnati Primary Care (CCPC) approved scope of project for which CCPC has established a charge, regardless of the services type or mode of service delivery, must be made available to all health center patients regardless of ability to pay. To facilitate patient access and utilization, CCPC must ensure that: a) patients are made aware of the Siding Fee Discount (SFD); and b) eligibility for discounts is based on income and family size and no other factors (such as insurance status or population type). Specifically, CCPC should establish multiple methods for informing patients of the sliding fee discount program (e.g., signage, registration process). In addition, information about the sliding fee discount program must be available in appropriate languages and literacy levels for the health center's target population.

II. POLICY

The City of Cincinnati Primary Care (CCPC) Board directs that no patient will be denied health care services due to an individual's inability to pay for such services; and directs that any fees or payments required by the center for such services will be reduced or waived to enable the center to fulfill the assurance. The CCPC Board further requires health center management to prepare a schedule of fees or payments for the provision of its services consistent with locally prevailing rates or charges and designed to cover its reasonable costs of operation. The CCPC Board also requires health center management to make every reasonable effort to secure from patients' payment for services in accordance with such schedules; and to collect reimbursement for health services provided to persons [covered by public or private insurance].

Neither the fees themselves nor the supporting operating procedures for assessing patient eligibility and collecting payments should create barriers to care.

III. PROCEDURE

1. All patients are notified of CCPC's Sliding Fee Discount System (SFDS) by appropriate signage and by registration personnel upon initial contact with patients when scheduling an appointment, walk-in, or other contact opportunities.
2. Patients or Guarantors who elect to participate in the SFDS will be required to complete a SFD application, which asks for annual household income and the number of persons living in the household. Patients or Guarantors may elect to participate in the SFDS regardless of insurance status. Patients or Guarantors are asked to provide copies of documents as proof of income.
3. For purposes of the SFDS, the number of persons living in the household will be defined as persons who cohabit, mutually contribute to household expenses and assert that they are a household unit. It is recognized that other persons may reside at the common residence and not be considered as part of the household unit.
4. Annual household income is defined as income for all members of the household including gross wages, net earnings from self-employment or business, tips, social security, disability payments, pension, annuities, veteran's benefits, alimony, child support, military, unemployment, public aid and any other source of income providing payments to members of the household, excluding non-cash benefits such as the value of USDA Food Stamps received. Documentation is required to substantiate annual household income and may include tax returns, Form(s) W-2, payroll stubs (two most recent), social security benefits statements, retirement plan benefit statements and attestations by persons making payments to household members or other documents.
5. Data collected from the SFD application is entered into the EHR. The system will assign a SFD level and expiration date twelve (12) months from the date the application for discount was completed.
6. The patient or Guarantor is informed of the SFDS level and what the nominal charge for services will be, if applicable, or the applicable discounted fee category. ["*Nominal fee" denotes the charge a person at or below 100% of the Federal Poverty Guideline (FPG) would pay. Fees will be evaluated to ensure that they are "nominal" from a patient's perspective. All others whose income does not exceed 200% of the FG are charged a discounted fee. Those patients*

above 200% poverty are not eligible for the SFDS program will not receive a discount.] The nominal feel is not based on the cost of services.

7. Patients or Guarantors who elect to participate in the SFDS who do not have required documentation available at the time of the service may complete a Service Eligibility Form providing annual household income and the number of persons living in the household. This Self Declaration is accepted only one time per patient and will be used to determine the SFDS level; which will be entered into the EHR system and the discount applied to charges for services rendered for the current visit. The patient or guarantor will have thirty (30) days to provide CCPC with required documentation to receive the SFDS level on subsequent visits.
8. Out-of-pocket fees for insured patients who qualify for sliding fees based on income and family size will be lesser of their copayment or the sliding fee charge unless prohibited by contract between CCPC and the insurance carrier. Patients who are eligible for sliding fee discounts who have third-party coverage are charged no more for any out-of-pocket costs than they would have paid under the applicable SFDS discount pay class.

Special Instructions:

1. The Board will review the SFDS at least once every three years (i.e., once per Health Resources Services Administration - HRSA project period) to evaluate its effectiveness at reducing barriers to care. The Board will approve documentation required to establish annual household income and the number of persons living in the household for SFDS eligibility. The Board will make the determination of the required documentation to establish household income and the number of persons living in the household based on knowledge of the community, patient surveys and other available data. Patient feedback will be obtained to indicate whether the nominal fee is considered nominal from the patient's perspective.
2. CCPC will ensure SFDS patients receiving care through service contracts/agreements are provided in a manner that meets all Health Center Program Requirements. CCPC will ensure that outside providers who receive referrals for required, or in-scope services have a provision for reduced fees based on income and family size that mirrors or exceeds the level of discount offered by CCPC. If CCPC cannot successfully negotiate such discounted fee arrangements, CCPC will budget funds to pay for the required service to meet the (HRSA) requirement that the service be offered.
3. The SFDS will be based on the most current HHS FPG by family size. The SFDS will consist of five (5) levels (A-E).

Level A	Income level at or below 100%
Level B	Income level 101-150% FPG
Level C	Income level 151-175% FPG
Level D	Income level 176-200% FPG
Level E	Income level above 200% FPG

city of CINCINNATI
HEALTH DEPARTMENT

City of Cincinnati Primary Care (CCPC)
Patient Collections

Effective Date: July 23, 2026

POLICY/ SYSTEM MANAGER

Name: Angela Mullins

Title: Quality/Nursing Administration

Contact: (513) 357-7332, angela.mullins@cincinnati-oh.gov

Last Revised: 7/23/2026

Biennial review required by the Chief Executive Officer (CEO).

_____	_____
Board of Governors Chair CCPC	Date
_____	_____
Chief Executive Officer CCPC	Date
_____	_____
Medical Director CCPC	Date
_____	_____
Chief Operations Officer CCPC	Date
_____	_____
Director of Clinical and Community Nursing	Date
_____	_____
Health Commissioner	Date

I. PURPOSE

To ensure that the City of Cincinnati Primary Care (CCPC) patient account management process meets federal, and local requirements.

II. POLICY

The City of Cincinnati Primary Care (CCPC) will process, manage, adjust and write off patient accounts by following a standardized process, that has been approved by the CCPC Board of Governors.

III. PROCEDURE

1) CCPC will use a third-party billing company to send invoices to patients with delinquent account balances. CCPC will not send patient accounts to private collections.
2) Patients will not be required to enroll in public or private insurance but, all patients will be educated on the options that are available to them, based on their eligibility for insurance, and the Sliding Fee Discount Schedule (SFDS).
3) The SFDS is reviewed and amended annually to comply with updates in the federal standards.
4) Insurance eligibility, benefits and/or eligibility for the SFDS will be checked prior to an appointment or service with few exceptions. Patients with third party coverage may also be eligible for the SFDS. The SFDS applies to services.
5) Supplies will be discounted separately as listed on the Fee Schedule. In all cases, prior to the provision of service, patients will be informed of the following should there be an out-of-pocket cost for supplies or equipment:
    - When a supply or service will be an extra charge
    - What the total amount will be
    - What and if any payment plans are available

    * Dental prosthetics, eye wear, and pharmacy Durable Medical Equipment (DME) are considered a supply and are included in the supply fee schedule.

6) Charges are entered into the system and billed to the insurance, or if the patient does not have insurance, or is assigned a portion (due to co-pay, co-insurance, deductible etc.) of their charges by their insurance company then a statement is generated. Reasonable efforts will be made to collect payment from a patient in an efficient, respectful, confidential, and culturally competent manner.

7) Patients will receive a written monthly statement of account from a third-party billing company unless the account meets the definition of "refusal to pay" below. Accounts will be managed by the third-party billing company as follows:

    a) If no payment or response has been received from the patient within 30 days from the date of service, and at least 1 statement has been issued, an initial collection letter (COLLECTION LETTER #1) will be sent and the account will be deferred for 30 days.

    b) If no payment or response has been received from the patient within 60 days from the first letter a second collection (COLLECTION LETTER #2) will be sent and the account will be deferred for **30** days.

c) If no payment or response has been received from the patient within 90 days from the second letter a third and final collection letter (COLLECTION LETTER #3) will be sent and the account will be deferred for **30** days.

d) If **120** days has passed since the final collection letter, and there is still no payment, payment arrangement or response, then all balances will be adjusted off to bad debt using adjustment code 1864 UNCOLLECTIBLE SELF PAY. In addition, the following will occur:

i. Accounts will be flagged with a "Bad Debt" account status.
ii. A patient message will be added to the patient's account asking for payment in full at the time of the next visit.

8) Patients may at times refuse to pay their portion of their service and supplies. For the purpose of this policy "refusal to pay" is defined as no receipt of payment or contact regarding the account from a patient after three monthly statements have been sent. The billing specialist will be responsible for tracking delinquent patient accounts. Patients will be contacted to discuss any individual circumstances affecting payment of their account. Patients will be offered grace periods and payment plans (See CCPC Payment Plan policy) as appropriate to the individual's circumstances.

9) CCPC authorizes all non-contested insurance adjustments that are required per contract, out-of-network fee acceptance waivers, bankruptcies, contractual obligations, and CCPC errors to be eliminated from patient accounts without prior approval. Additionally, required fee discounts or waiver of balance billing based on a contractual agreement i.e., grant programs, may also be adjusted from patient accounts. Patient records will reflect the reason for all adjustments.

10) CCPC authorizes the reduction of patient fees for the uninsured based on income thresholds Established by the annual Federal Poverty Guidelines (FPG).

11) If a patient makes a request to pay for service(s) versus having a claim filed with the insurer, full payment is expected at the time of service. A Waiver of Health Insurance Claim and Election to Self-Pay form must be signed.

12) Clients eligible for Reproductive Health and Wellness Services, regardless of age, are asked income status and will be billed according to grant guidelines and the Title X sliding fee scale updated by the U.S. Department for Health & Human Services annually. However, income verification is not required to establish the fees to be charged; client self-certification of income is adequate. The fees paid by unemancipated minors who wish to receive Reproductive health and Wellness Services, on a confidential basis, must be the same as other clients, based on income status and the Title X schedule of discounts. These minors should be charged based on their own income, which is income that is available for the minor to spend, such as allowance or income from a parti-time job. This does not include imputed income, such as the cost of room and board, scholarships, or other support that is not actually available for the minor to spend.

13) Clients eligible for the Vaccines for Children (VFC) program will receive immunizations with publicly supplied vaccines at no charge to the patient for the vaccine. CCPC will not charge a vaccine administration fee to non-Medicaid federal vaccine eligible children that exceeds the

administration fee cap of $21.25 per vaccine dose. Additionally, only one bill will be sent for vaccine administration fees, and it will be sent within 90 days of the vaccine administration date. For Medicaid children, CCPC will accept the reimbursement for immunization administration set by the state Medicaid agency or the contracted Medicaid health plans. CCPC will not deny administration of a publicly purchased vaccine to an established patient because the child's parent/guardian/individual of record is unable to pay the administration fee.

Medicaid
Upon submission and adjudication of the claim, the patient's account will be adjusted, and no statement will be sent to the patient. However, if the patient is responsible for part of the claim, the patient will be billed in accordance with this policy. If Medicaid denies payment, the patient will be billed using the Sliding Fee Discount Program (SFDP) scale.

Commercial Insurance
All co-pays will be collected at the time of service. Claims shall be submitted to the commercial insurance company. When a claim is satisfactorily adjudicated, the patient's account will be adjusted, and no statement will be sent to the patient if there is no balance on the account. If the patient is responsible for part of the claim, the patient's balance will be invoiced in accordance with this policy. It is the patient's responsibility to understand their commercial insurance coverage. If a patient requests a service that may not be covered by insurance, the patient will be billed according to the SFDS.

Medicare
All co-pays will be collected at the time of service (if required). Upon submission and adjudication of the claim, the patient's account will be adjusted, and no statement will be sent to the patient. However, if the patient is responsible for part of the claim, the patient will be billed in accordance with this policy. An Advance Beneficiary Notice (ABN) form is generated by the Electronic Health Record (EHR) for applicable services and must be completed by the patient at the time of service. If Medicare denies payment, the patient will be billed using the Sliding Fee Discount Program (SFDP) scale.

city of CINCINNATI
HEALTH DEPARTMENT

City of Cincinnati Primary Care (CCPC)
Waiver Reduction-Patient Fees Policy

Effective Date: July 23, 2026

POLICY/ SYSTEM MANAGER

Name: Angela Mullins

Title: Quality/Nursing Administration

Contact: (513) 357-7332, angela.mullins@cincinnati-oh.gov

Last Revised: 4/2020, 3/24/2023, 7/23/26

A biennial review is required by the Chief Executive Officer (CEO).

Board of Governors Chair CCPC	Date
Joyce Tate	7/23/2026
Chief Executive Officer CCPC	Date
Medical Director/CMO CCPC	Date
Geneva Goode	7/23/2026
Chief Operations Officer CCPC	Date
Michelle Daniels	7/23/2026
Director of Clinical and Community Nursing	Date
	7/23/2026
Health Commissioner	Date

I. PURPOSE

Provide options to patients to prevent barriers to care based on financial hardship or inability to pay, regardless of patient income level.

II. POLICY

CCPC does not limit or deny services due to a patient's inability to pay due to financial circumstances or hardship. CCPC seeks to identify patients eligible for the sliding fee discount (see CCPC FQHC Sliding Fee Policy), offers payment plans/terms (see CCPC Patient Collections Policy), and other options to prevent barriers to care.

III. PROCEDURE

1) Waiver of fees or payment plans may be made available to qualified patients due to hardship. Hardship examples may include but are not limited to the following:
   a) Deceased patient,
   b) Destruction of home due to fire,
   c) Flood or natural disaster,
   d) Military deployment of both parents in the family.
2) The charges will be adjusted to a level commensurate with the individuals' ability to pay including an adjustment to zero.
3) A hardship waiver application may be submitted in writing to any CCPC employee. Requests for a hardship waiver will be reviewed by the Chief Executive Officer (CEO) or their designee, who will determine eligibility based on supporting documentation provided and the criteria outlined in the attached Hardship Waiver Application. (See attached.)

city of CINCINNATI PRIMARY CARE

Financial Hardship Waiver Request

Patient's Full Name: _____

Guarantor's Full Name (if applicable): _____

Patient's Address: _____

Patient's Phone Number: _____

Current Discount (FPL%): _____ **Total Balance Due: $**_____

Length of time needing extra help (limit one year) _____

Please select the hardship that applies to you and provide supporting documents if requested.

- ☐ **Terminal illness (noted in the patient's chart)**
- ☐ **Catastrophic events affecting the home (such as a fire, flood, natural disaster, or other major loss)**
- ☐ **Unexpected increases in necessary living expenses resulting from the death, disability, or serious illness of a family member, or from assuming responsibility for the care of an ill, aging, or dependent family member.**
- ☐ **Other situations where paying medical bills would make it difficult for the patient to pay for basic living expenses or other necessary medical care.**

Please describe your situation below, including how long it has affected you and the amount of financial assistance needed to help address the hardship.

_____

_____

_____

_____ _____

Parent/Guardian Signature **Date**

_____ _____

Staff Member's Signature **Date**

Approved: Yes / No

Approved by: _____ **Date:** _____

city of CINCINNATI
HEALTH DEPARTMENT

City of Cincinnati Primary Care (CCPC) & Community Nursing

Clinical Safety Event Reporting

Effective Date: August 12th, 2026

POLICY/ SYSTEM MANAGER

Review: 8/12; rev. 5/19, 7/21, 3/23, 4/26,7/26

Biennial review required by the Chief Executive Officer (CEO).

_____	_____
Board of Governors Chair CCPC	Date
_____	_____
Chief Executive Officer CCPC	Date
_____	_____
Medical Director CCPC	Date
_____	_____
Chief Operations Officer CCPC	Date
_____	_____
Director of Clinical and Community Nursing	Date
_____	_____
Health Commissioner	Date

Glossary

Clinical Safety Event – an occurrence in the clinical setting that deviates from the normal course of care delivery, service, or generally accepted practice

Near Miss - an event or situation that could have resulted in an undesired outcome, accident, injury or illness but did not

Health Insurance Portability and Accountability Act (HIPAA) Breach - an impermissible use or disclosure under the Privacy Rule that compromises the security or privacy of the protected health information.

I. PURPOSE

To provide a uniform method by which clinical safety events are documented, investigated, and analyzed to identify root causes and prevent future occurrences.

II. POLICY

Clinical safety events including HIPAA breaches and near misses will be reported to the worksite supervisor or manager immediately upon occurrence or discovery and documented by the next workday to ensure prompt investigation and follow up.

III. PROCEDURE

Reporting

1. Report clinical safety events, HIPAA breaches and near misses to the worksite supervisor or manager immediately upon occurrence or discovery and complete an Electronic Clinical Safety Event form no later than the next workday after the event.
   Note: For clinical safety events that involve an employee injury, an electronic employee safety report form (link here) must be completed as well.
2. Record all known details of the event in an objective and legible manner. **Do not** record assumptions or opinions.
3. If the event involves a patient, **do not** file or reference the clinical safety event report in the patient's health record or use the report in lieu of charting.
4. Neither the safety events, nor the circumstances surrounding it, are to be discussed with, or in the presence of, patients or outside agencies.

Investigation

1. The worksite supervisor or manager will investigate the safety event as soon as possible and complete the electronic summary of investigation within 3 business days of receiving the clinical safety event report.
   a. Gather data and evidence from all parties involved in a non-punitive manner.
      Note: For HIPAA related events, provide evidence of what was breached (i.e. copy of after visit summary)
   b. Analyze the facts of the event from a learning perspective (what, how, why) with a focus on what can be done to prevent future events.
   c. Develop and initiate corrective and preventative actions to remediate the event
2. The worksite supervisor or manager will initiate and document the corrective and preventative actions taken along with any recommendations

Event Closure

1. Leadership will analyze the safety events quarterly or sooner if required to determine future and current risk probability and impact to the organization.
2. Leadership will initiate additional corrective actions, improvement processes, or policy changes when appropriate.
3. The clinical risk manager will provide feedback to staff and disseminate learnings via clinical quality improvement meetings

Resource

U.S. Department of Health & Human Services. (n.d.). Breach notification rule. https://www.hhs.gov/hipaa/for-professionals/breach-notification/index.html

city of CINCINNATI
HEALTH DEPARTMENT

City of Cincinnati Primary Care (CCPC)

Patient Complaints and Grievances

Effective Date: August 12, 2026

POLICY/ SYSTEM MANAGER

Review: 7/2026

Biennial review required by the Chief Executive Officer (CEO).

_____ _____

Board of Governors Chair CCPC Date

_____ _____

Chief Executive Officer CCPC Date

_____ _____

Medical Director CCPC Date

_____ _____

Chief Operations Officer CCPC Date

_____ _____

Director of Clinical and Community Nursing Date

_____ _____

Health Commissioner Date

I. PURPOSE

To provide a uniform method by which complaints and grievances are received, documented, investigated, and analyzed to identify any root causes and provide resolutions or prevent future occurrences.

II. POLICY

Patient complaints and grievances may be submitted verbally or in writing for review and investigation. The CCPC Board of Governors assigns the duty to approve and oversee the grievance process to the Chief Executive Officer (CEO), Chief Operations Officer (COO), Chief Medical Officer (CMO), Direct of Nursing (DON), Dental Director Pharmacy Director and Clinical Risk Manager.

Definitions:

Complaint- A patient issue that can be resolved promptly by the staff present at the time of the complaint (either immediately or within 24 hours), and in an informal manner by the staff members(s) present at the time of the complaint. Complaints typically do not require investigation or peer review process.

Grievance – a patient issue that cannot be resolved immediately by the staff present at the time of the complaint. The complaint is then escalated to leadership.

III. PROCEDURE

1. A verbal or written grievance received by a CCPC staff member initiates the grievance process.

   <u>Verbal Complaints and Grievances</u>
   Staff receiving a verbal grievance/complaint will notify the site supervisor immediately and a complaint form will be completed by staff or patient. Ensuring the site supervisor receives the complaint form by the next workday.

   <u>Written Complaints and Grievances</u>
   Staff receiving a written grievance form will notify the site supervisor immediately. Submit the form to the site supervisor by the next workday.

   <u>Grievance From Legal Counsel</u>
   Staff receiving a grievance from a patient's legal counsel will notify the site supervisor immediately and submit the form to the site supervisor by the next workday. The site supervisor will inform the CEO upon receipt of the grievance.

2. Upon receipt of the complaint or grievance, the supervisor will:

    a. Begin the investigation
    b. Notify the CEO
    c. Notify the Health Insurance Portability and Accountability Act (HIPAA) privacy officer if a patient believes their privacy has been violated. A separate privacy complaint form will be completed.
3. The worksite supervisor or manager will make three contact attempts to reach the complainant to resolve the matter and provide an update to the CEO or designee. The privacy officer will follow up in writing with the complainant within 60 days.
4. Grievances are closed when the investigation is completed by leadership.
5. Grievances are reviewed quarterly during clinical risk management safety event meetings.

city of CINCINNATI
HEALTH DEPARTMENT

City of Cincinnati Primary Care (CCPC)
Provider Peer Review

Effective Date: August 12, 2026

POLICY/ SYSTEM MANAGER

Last Revised: 7/30/26

Biennial review required by the Chief Executive Officer (CEO).

_____	_____
Board of Governors Chair CCPC	Date
_____	_____
Chief Executive Officer CCPC	Date
_____	_____
Medical Director CCPC	Date
_____	_____
Chief Operations Officer CCPC	Date
_____	_____
Director of Clinical and Community Nursing	Date
_____	_____
Health Commissioner	Date

I. PURPOSE

To ensure the safe delivery of quality care by CCPC providers

II. POLICY

Individual provider performance is evaluated through:

1. **Monthly quality measure reports** shared with providers.
2. **Annual performance reviews** conducted by the Medical Director.
3. **Chart-based peer reviews** when requested by the Medical Director.

Peer performance will be shared with the provider, CCPC leadership and the CCPC board. Any corrective actions will be reported to the individuals involved and the CCPC Board.

III. PROCEDURE

Performance Review

A. Providers receive monthly reports on quality performance measures.
B. The Medical Director reviews each provider's productivity and quality outcomes annually.

Special Peer Reviews

The Medical Director may request a chart review when concerns arise from:

A. Staff requests regarding patient care
B. Patient or staff complaints
C. Findings from quality improvement audits

Chart Review Process

A. At least 5-10 charts per provider will be reviewed.
B. Reviews are conducted by a provider in the same specialty whenever possible.
C. Patient charts are selected randomly by the appropriate clinical leader or designee.
D. Results are discussed at relevant provider and specialty meetings.

Reviewer Assignment

Specialty	Reviewer
Adult Medicine	Medical Director or another Adult Medicine physician if reviewing the Medical Director
Pediatrics	Randomly selected Pediatrician not involved in the patient's care
Obstetrics & Gynecology	Randomly selected OB/GYN physician
Dental	Dental Director or designee

School Health	School Health Medical Director or designee

Review and Follow-Up

A. Reviewers evaluate the appropriateness and quality of care and submit findings in writing.
B. Findings are reviewed by clinical and administrative leadership.
C. Corrective actions, when needed, are developed and implemented according to Human Resources policies.
D. Providers are informed of results and any required actions.

Provider Rights

Providers may review, appeal, or challenge peer review findings and corrective actions in accordance with City of Cincinnati and CCPC policies.

city of CINCINNATI
HEALTH DEPARTMENT

City of Cincinnati Primary Care (CCPC)

Clinical Risk Management Plan

Effective Date: August 12, 2026

POLICY/ SYSTEM MANAGER

Review: 7/2026

Biennial review required by the Chief Executive Officer (CEO).

_____	_____
Board of Governors Chair CCPC	Date
_____	_____
Chief Executive Officer CCPC	Date
_____	_____
Medical Director CCPC	Date
_____	_____
Chief Operations Officer CCPC	Date
_____	_____
Director of Clinical and Community Nursing	Date
_____	_____
Health Commissioner	Date

I. PURPOSE

To establish a framework for managing risks and implementing activities designed to prevent or mitigate threats to safety across the health centers.

II. POLICY

Through a standardized risk management approach, CCPC will proactively identify and minimize risks that may compromise safety within its health centers.

III. GUIDING PRINCIPLES

A safety culture with open communication and data sharing is implemented to proactively identify and manage risks. Evidence-based clinical practices, continuous improvement, and constructive feedback create a strong foundation for learning and development.

IV. GOALS AND OBJECTIVES

The goals and objectives of the Risk Management Program are to:

- Promote patient safety by preventing errors, adverse events, and system breakdowns that may cause harm to patients, staff, or visitors. This is achieved through proactive patient safety and risk management initiatives.
- Minimize adverse outcomes when errors, events, or system failures occur.
- Minimize losses to the organization by proactively identifying, analyzing, preventing, and controlling potential clinical and operational risks.
- Support adherence to regulatory, legal, and accrediting body requirements.
- Safeguard personnel, organizational resources, and assets.

V. RISK MANAGEMENT LEADERSHIP

The ultimate authority for the patient safety and risk management activities of CCPC rests with the CCPC Board of Governors (Board). The Board approves the Clinical Risk Management Plan biennially and receives reports on clinical risk management activities at least annually and as needed. The leadership team includes the CCPC Chief Executive Officer (CEO), Chief Medical Officer (CMO), Chief Operations Officer (COO), the Director of Nursing (DON), and the Clinical Risk Manager. The Clinical Risk Manager (CRM) will lead day-to-day risk management activities of CCPC and chair the Clinical Risk Management Committee. (See Administration and Committee Structure)

VI. MECHANISMS FOR COORDINATION

Clinical Risk Manager (CRM)

CRM is the overall coordinator and supervisor of CCPC's clinical risk management and patient safety activities. The CRM is supervised by the organization's Director of Nursing (DON) and supervises the staff of the Quality Management Team. The Chief Medical Officer (CMO) and the Director of Nursing (DON) also share the responsibility for clinical risk management and patient safety. CRM Duties include the following activities:

- Engage with administration and staff across operational lines to implement, monitor, and achieve the goals of the program.
- Provide day-to-day oversight of clinical risk management and patient safety activities and supports the investigation, reporting, and resolution of adverse events, near misses, unsafe conditions, and patient complaints.
- Analyze trends in risk management and patient safety event reports.

- Ensures the development and implementation of risk-reduction activities through policy and procedure updates
- Provide regular updates on clinical risk management and patient safety activities to leadership and staff and report annually to the Board of Governors.

VII. CLINICAL RISK MANAGEMENT COMMITTEE

A multi-disciplinary group of leaders from dental, pharmacy, nursing, administration, Women Infants and Children (WIC) and the medical provider's office meet quarterly to review, evaluate and manage findings from risk assessments, reported claims, and clinical safety events. The CRM serves as the chair of the committee.

VIII. CLINICAL RISK MANAGEMENT AND PATIENT SAFETY EDUCATION

All CCPC providers and staff are required to complete annual training through the organization's web-based learning management system and, when appropriate, through additional external training programs. Courses are selected based on regulatory requirements, staff learning needs, and areas of high clinical risk.

IX. FUNCTIONAL INTERFACES

Clinical risk management interfaces with all staff, providers, leaders, legal, CHD safety and committees (pharmacy and therapeutics, CCPC board clinical and quality assurance committee and CCPC clinical quality improvement committee) involved in patient care and organizational operations.

X. CLINICAL RISK MANAGEMENT PROGRAM FUNCTIONS

- Develop systems to report adverse events, near misses, and potentially unsafe conditions. Reporting responsibilities include internal reporting and external reporting to regulatory agencies.
- Develop and implement event reporting policies and procedures.
- Collect and analyze data to monitor the performance of processes which involve risk or that may result in adverse events.
- Oversee the organization's clinical risk management information flow, reporting and Clinical Risk Management Information System (CRMIS)
- Review, analyze, and disseminate data on adverse events, near misses, and potentially unsafe conditions to inform corrective actions and prevent the recurrence of similar events.
- Ensure compliance with data collection and reporting requirements
- Facilitate the implementation of patient safety initiatives and a culture of safety that supports an atmosphere of trust in which all staff can freely discuss safety problems and potential solutions without fear of retribution.
- Advise CCPC management on strategies to reduce unsafe conditions and improve overall safety for patients, staff, and visitors at the health center.
- Reduce the occurrence of events that may result in losses to the organization's facilities or equipment.

XI. CLINICAL RISK MANAGEMENT REPORT

The annual clinical risk management report details event report summaries, risk assessment activities, claims reports, relevant provider and staff education and other efforts made to identify and reduce risks. The Risk Manager presents the report to the CCPC Board of Governors annually.

XII. CONFIDENTIALITY

All documents and records that are part of the Risk Management and Patient Safety Program are privileged and confidential to the extent provided by state and federal law. Identifying information for patients, providers and staff is removed from event reports and patient complaints prior to discussion by the Risk Management Committee.

DEFINITIONS:

- **Adverse Event** - an occurrence that resulted in harm to a patient/person
- **Claims management:** Activities to exert control over potential or filed claims against the organization and/or its providers.
- **Clinical Safety Event** – an occurrence or near miss in the clinical setting that deviates from the normal course of care delivery, service, or generally accepted practice
- **Near Miss** - an event or situation that could have resulted in an undesired outcome, accident, injury or illness but did not either by chance or through timely intervention. (ECRI Institute, n.d.)
- **Failure mode and effects analysis:** A proactive method for evaluating a process to identify where and how it might fail and for assessing the relative impact of different failures in order to identify the parts of the process that are most in need of improvement.
- **Patient Safety Goals:** National Patient Safety Goals (NPSGs) for ambulatory care, established by the Joint Commission. The purpose of NPSGs is to improve patient safety by focusing on problems in healthcare safety and how to solve them.
- **Risk analysis:** Determination of the causes, potential probability, and potential harm of an identified risk and alternatives for dealing with the risk. Examples of risk analysis techniques include failure mode and effects analysis, systems analysis, root-cause analysis, and tracking and trending of adverse events and near misses, among others.
- **Risk assessment:** Activities undertaken in order to identify potential risks and unsafe conditions inherent in the organization or within targeted systems or processes.
- **Risk avoidance:** Avoidance of engaging in practices or of hazards that expose the organization to liability.
- **Risk control:** Treatment of risk using methods aimed at eliminating or lowering the probability of an adverse event (i.e., loss prevention) and eliminating, reducing, or minimizing harm to individuals and the financial severity of losses when they occur (i.e., loss reduction).
- **Root-cause analysis:** A process for identifying the basic or causal factor(s) that underlie the occurrence or possible occurrence of an adverse event.
- **Risk management information system (RMIS):** A computerized system used for data collection and processing, information analysis, and generation of statistical trend reports for the identification and monitoring of events.
- **Sentinel event:** Defined by the Joint Commission as an unexpected occurrence involving death or serious physical or psychological injury, or the risk thereof. Serious injury specifically includes loss of limb or function. The phrase “or the risk thereof” includes any process variation for which a recurrence would carry a significant chance of a serious adverse event.
- **Unsafe and/or hazardous condition:** Any set of circumstances (exclusive of a patient’s own disease process or condition) that significantly increases the likelihood of a serious adverse outcome for a patient or of a loss due to an accident or injury to a visitor, employee, volunteer, or other individual.

Reference

ECRI Institute. (n.d.). Adverse event analysis: A staff training exercise. Retrieved March 12, 2025, from https://www.ecri.org/EmailResources/HRC/VirtualConf/Adverse%20Event%20Analysis%20A%20Staff%20Training%20Exercise.pdf

Office of Inspector General, U.S. Department of Health and Human Services. (n.d.). Adverse events. Retrieved March 12, 2025, from https://oig.hhs.gov/reports/featured/adverse-events/

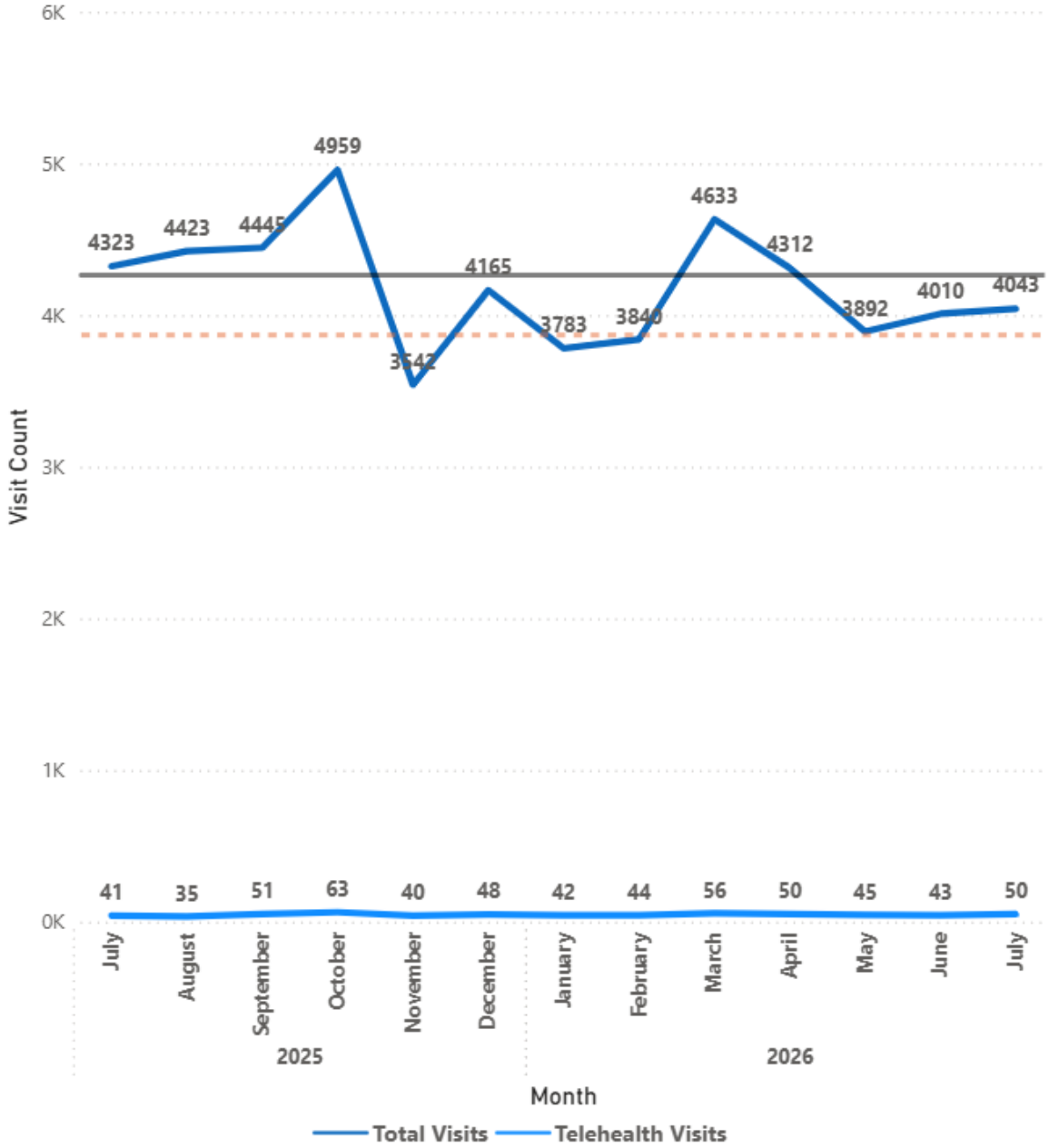
The Joint Commission. (n.d.). *National Patient Safety Goals* [PDF]. https://digitalassets.jointcommission.org/api/public/content/ae7098d32da04319a0b76ed26dc39701

CCPC Board Meeting – Efficiency Update

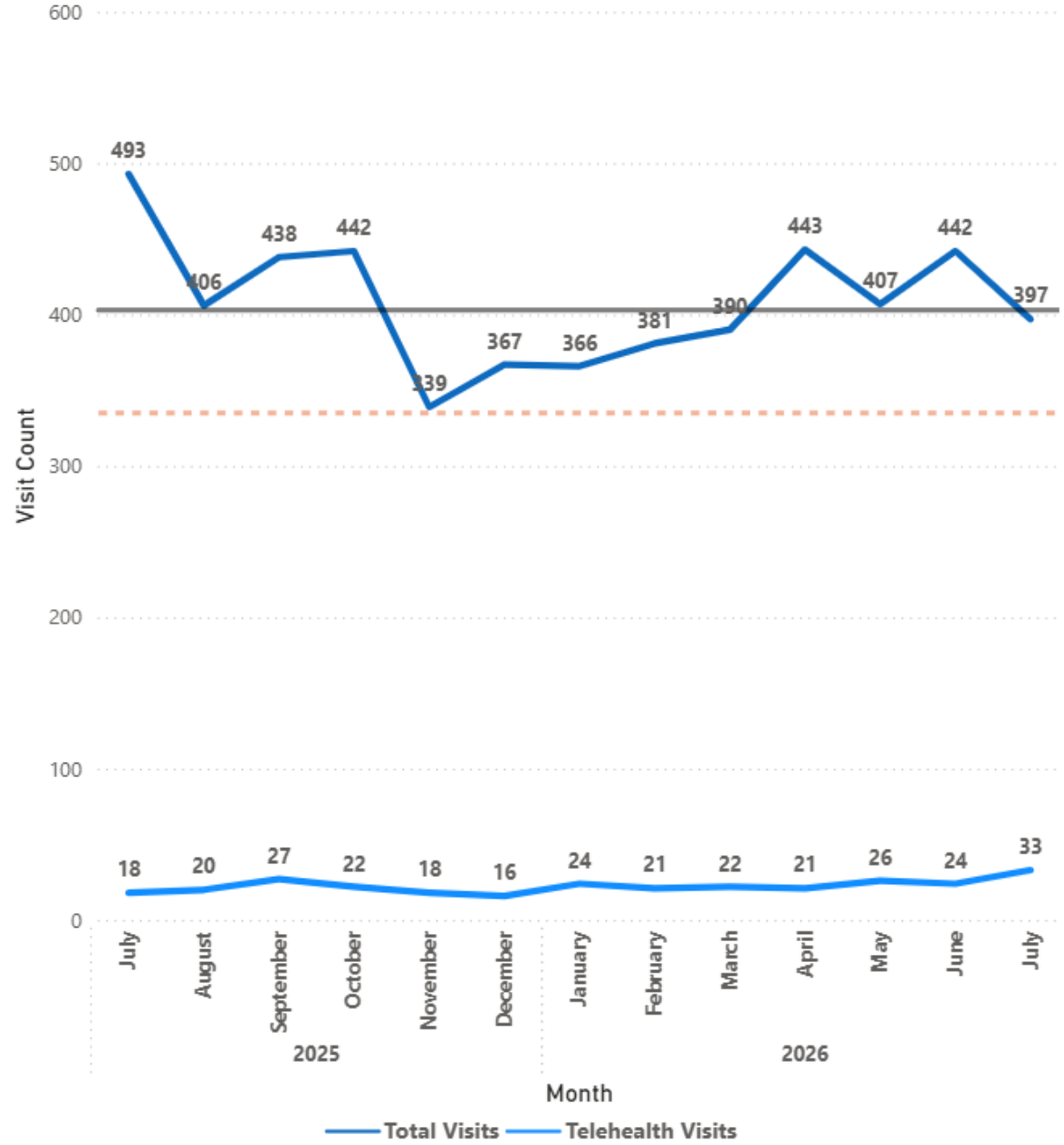
August 2026

Medical/Behavioral Health

Total Visits - All Locations



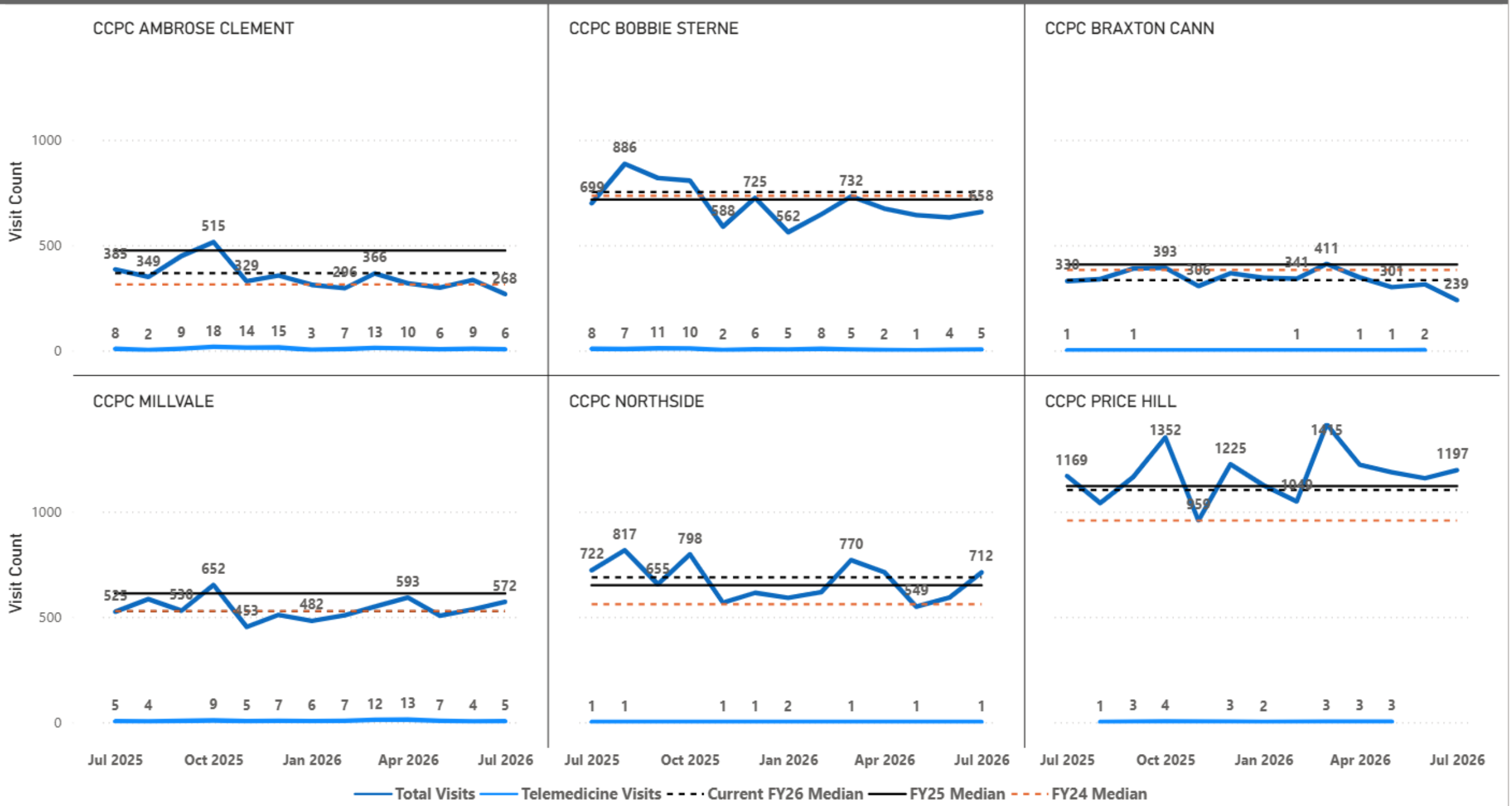
Total Visits - All Behavioral Health



Filters

Current FY26 Median
FY25 Median
FY24 Median

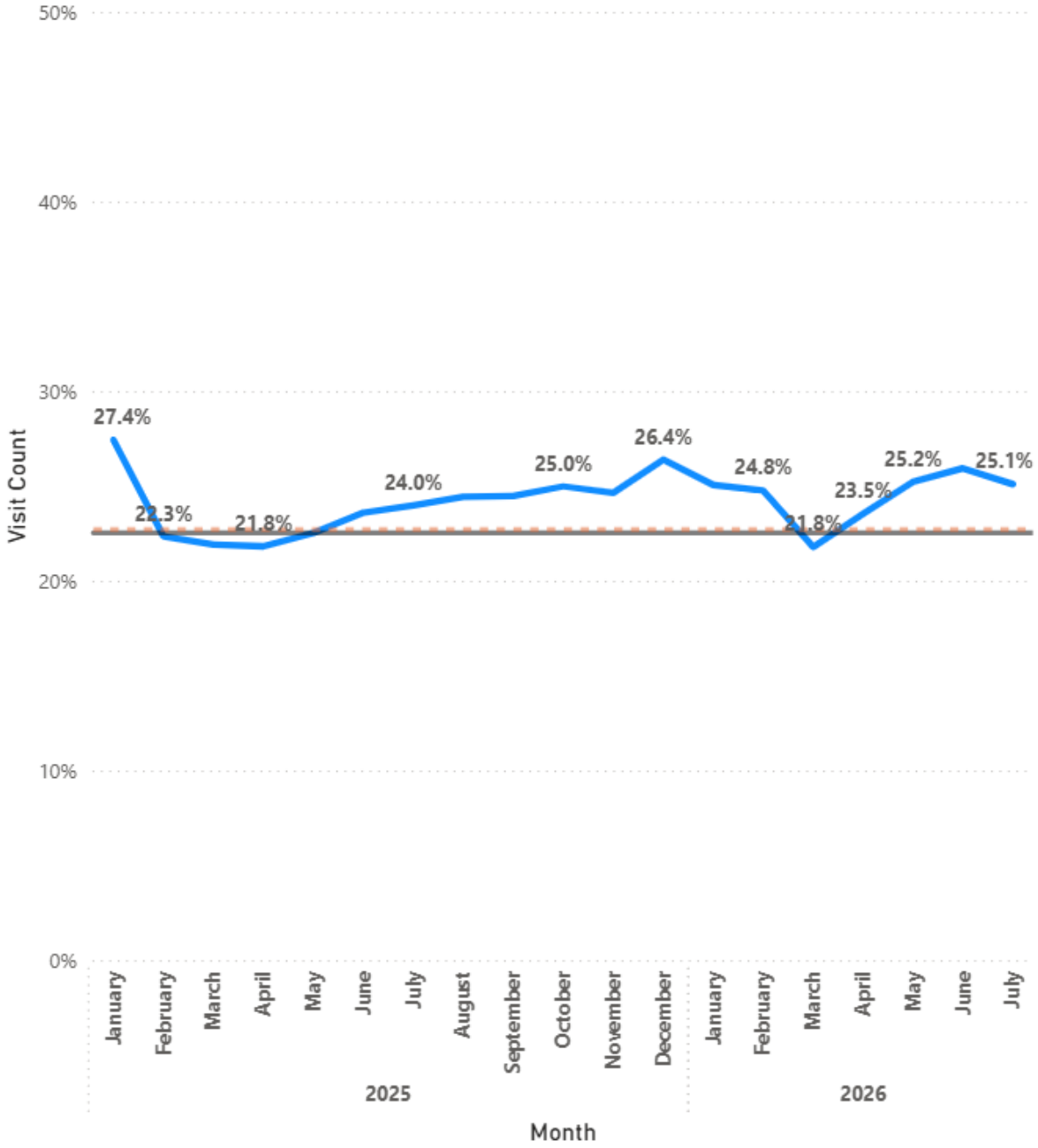
Visits by Department



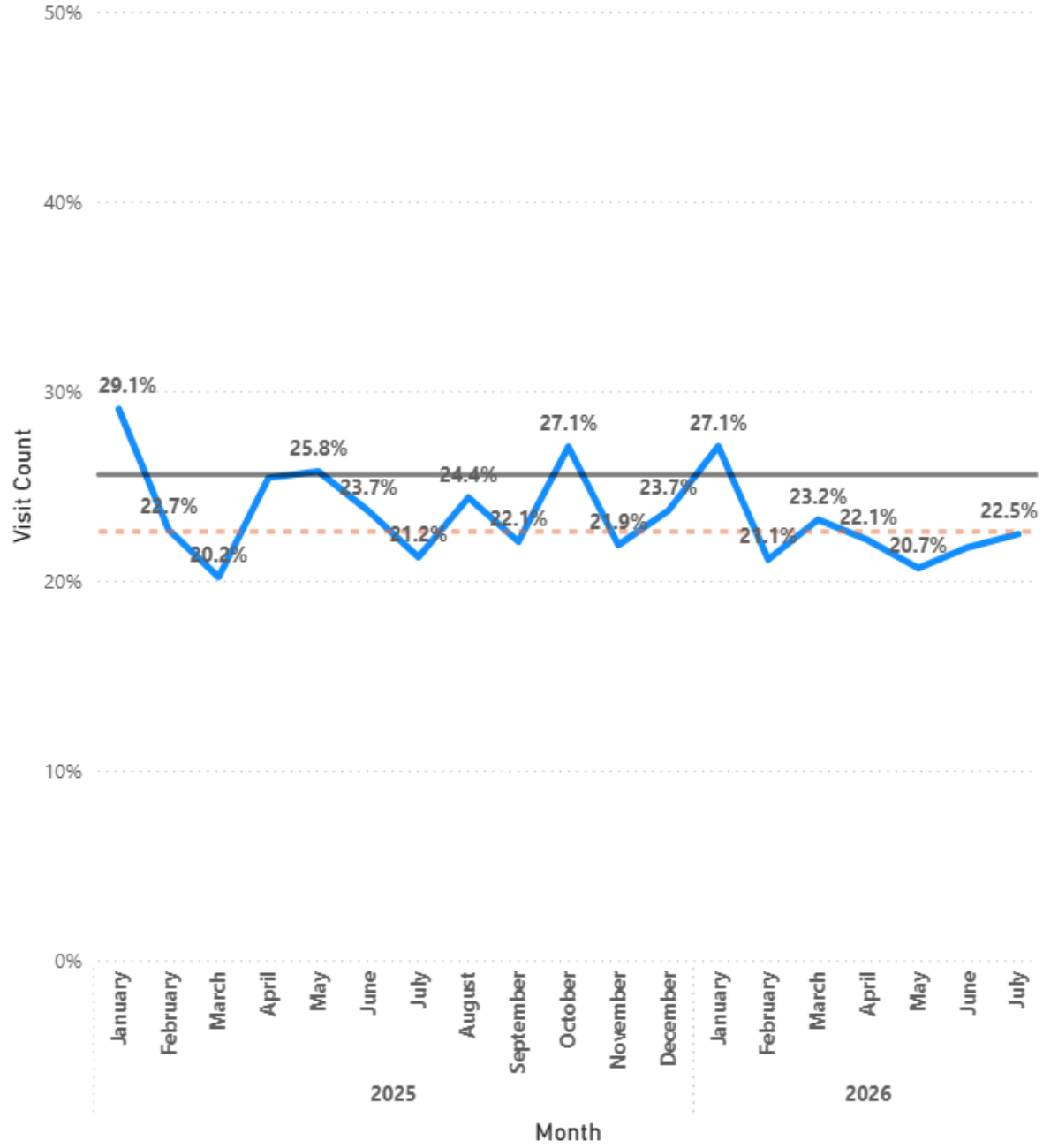
Filters

CCPC Board Mee... , Visits by Depart...

No Show % - All Locations

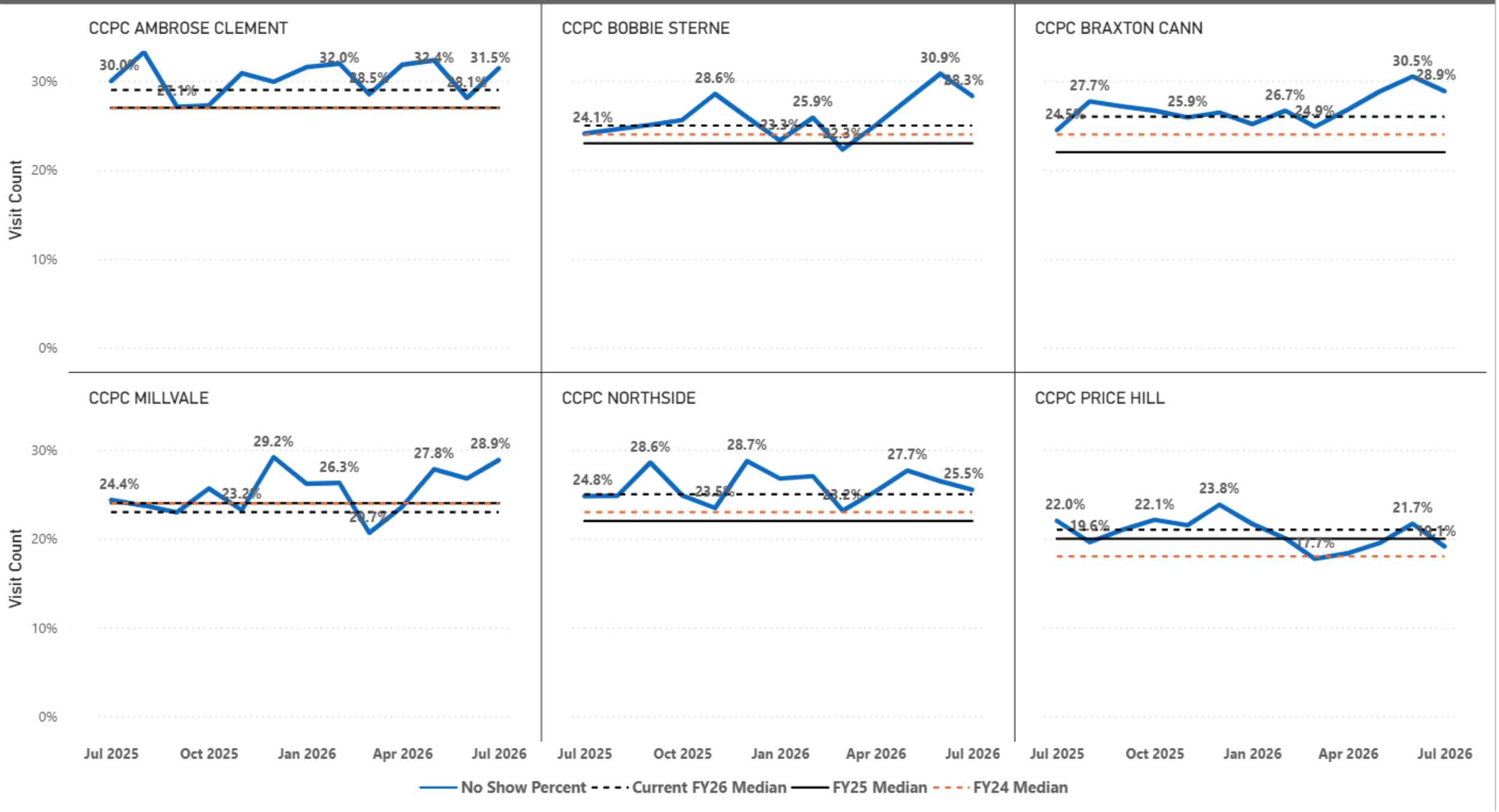


No Show % - All Behavioral Health



Current FY26 Median — FY25 Median - - - FY24 Median

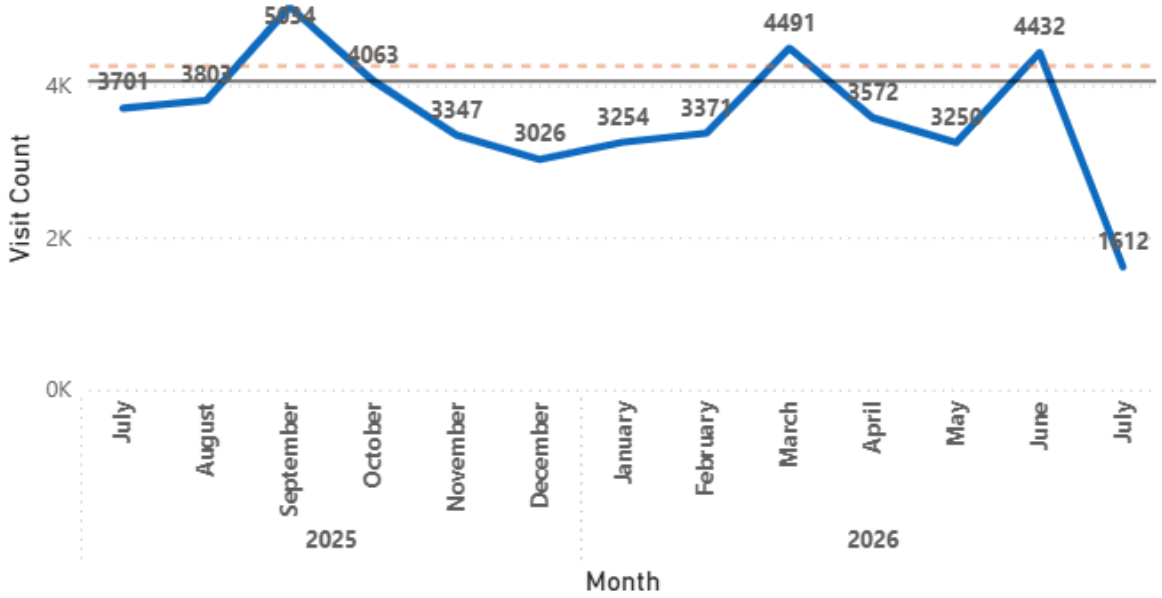
No Show % by Department



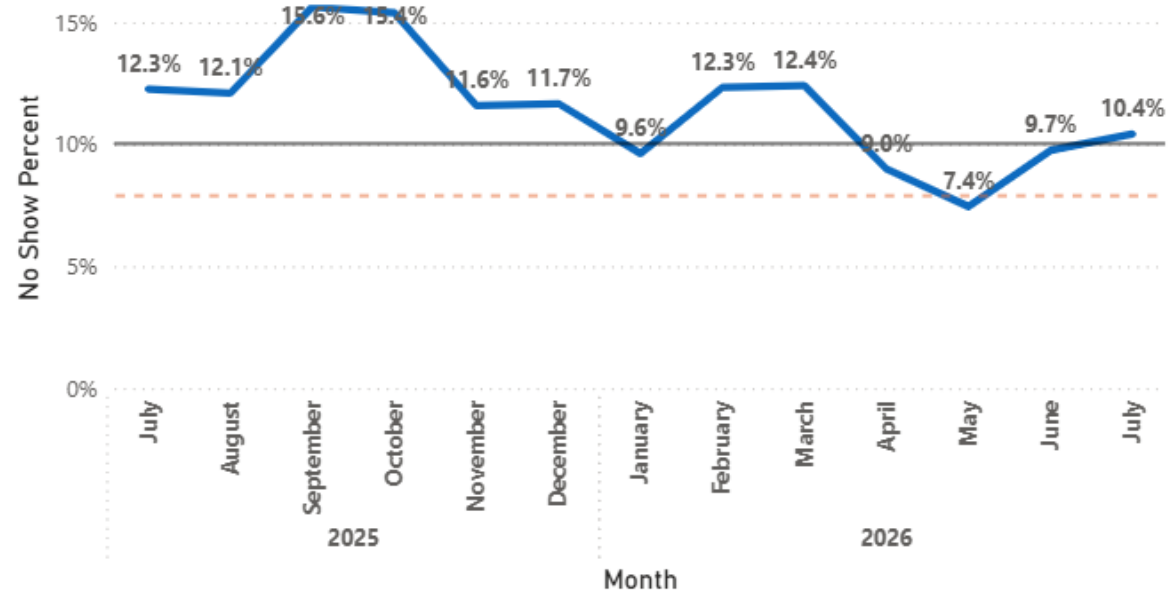
Filters

Dental

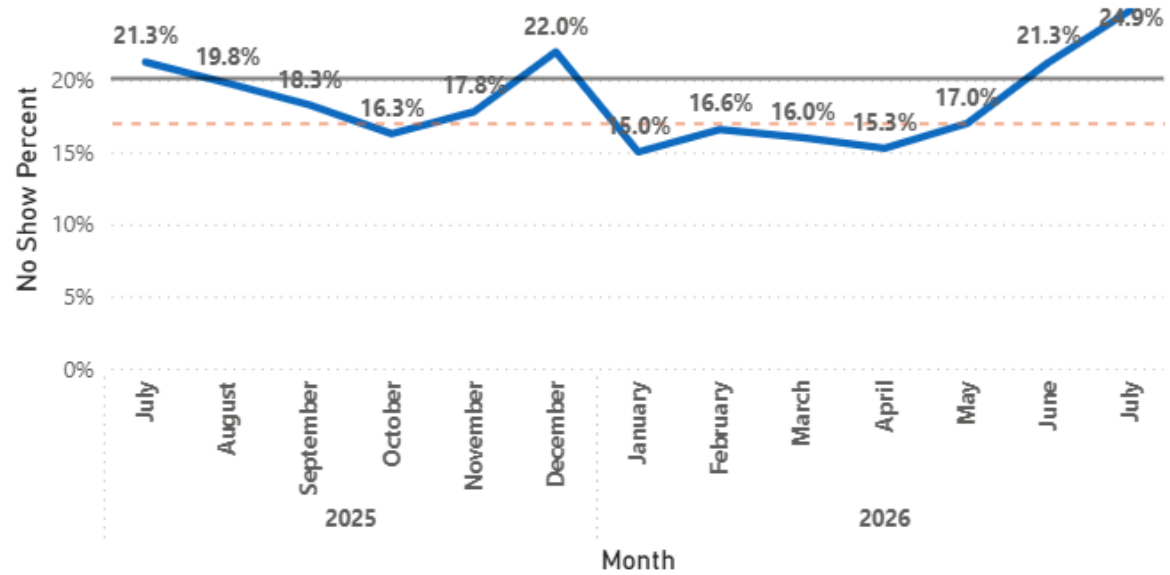
Total Visits - All Dental Locations



New Patient % - All Dental Locations



Broken Appt % - All Dental Locations

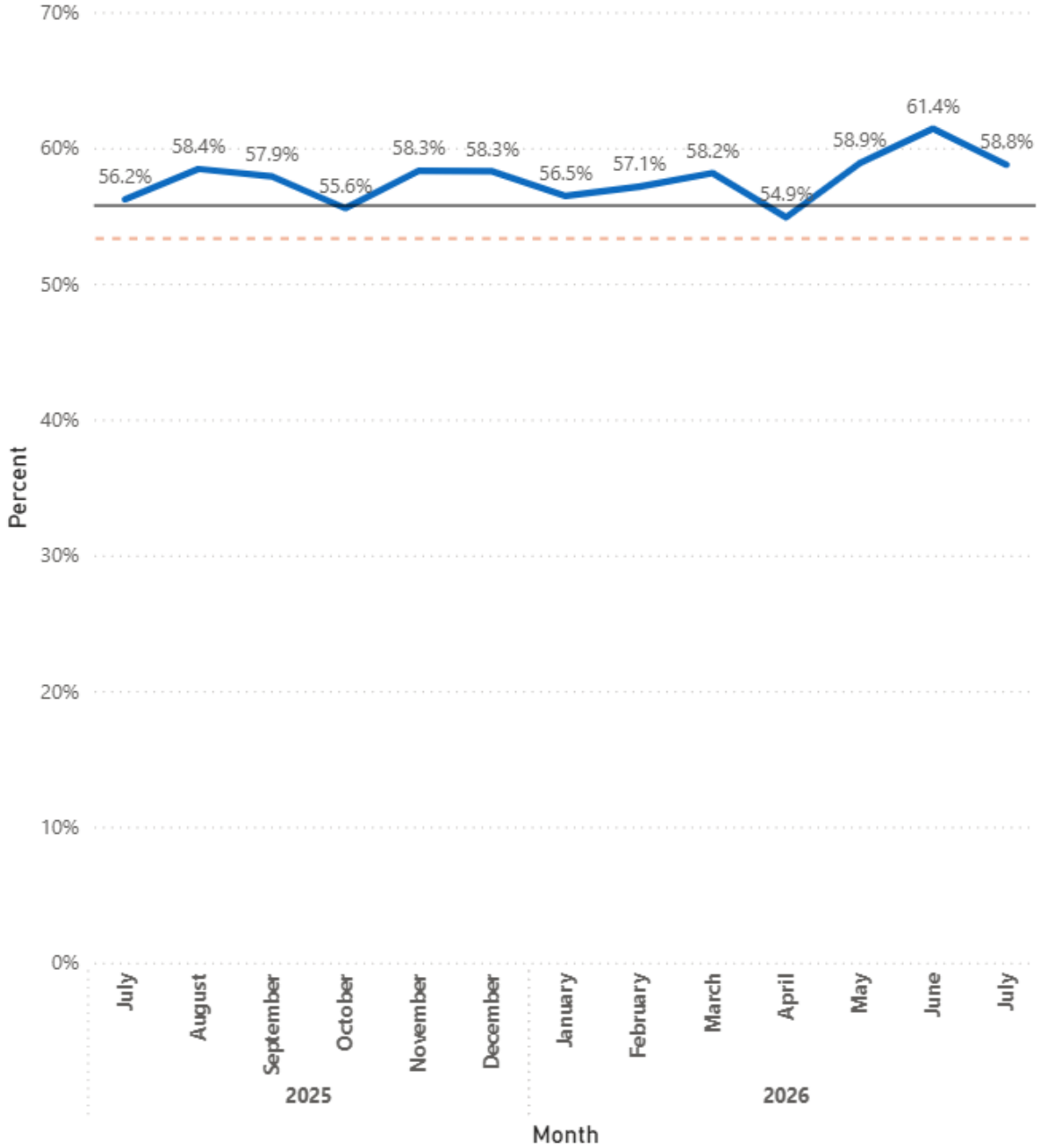


Current FY26 Median — FY25 Median - - - FY24 Median

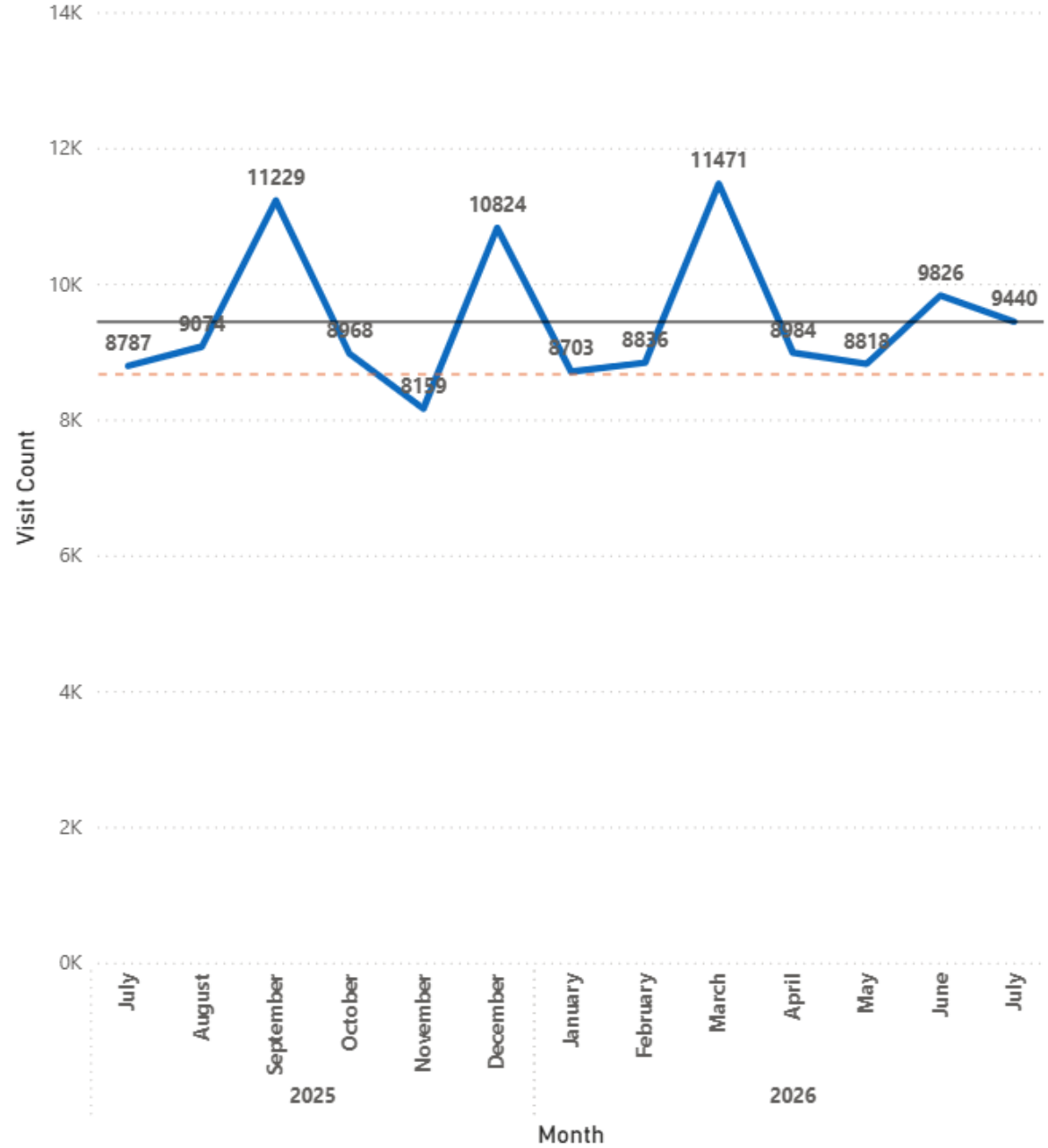
« Filters

Pharmacy

Pharmacy Escribe % - All Locations



Total Fills - All Locations

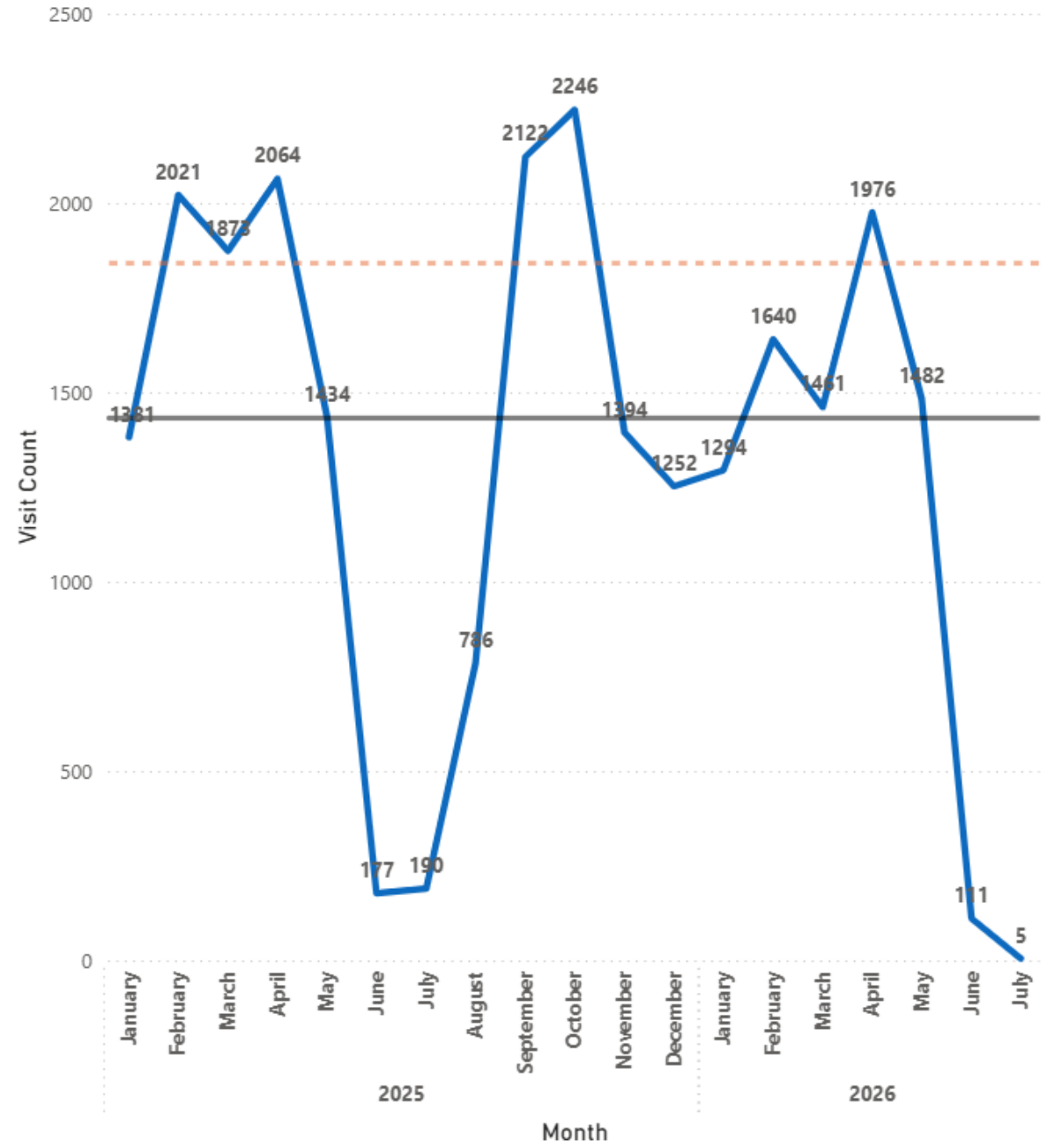


Filters

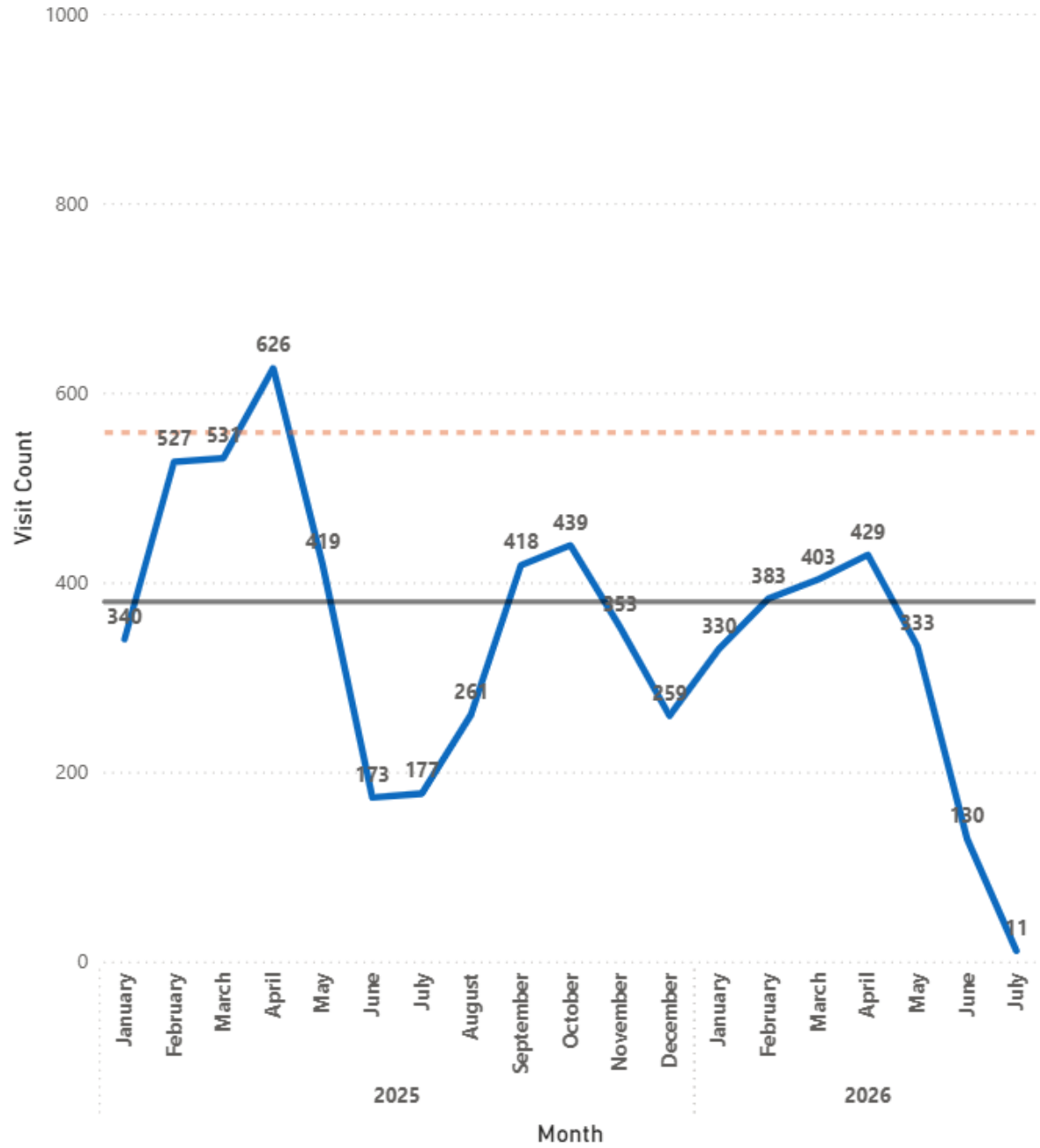
Current FY26 Median — FY25 Median - - - FY24 Median

School Based Health Centers

SBHC Visits - All Locations



Vision Visits - All Locations



Current FY26 Median — FY25 Median - - - FY24 Median

« Filters