



REDWOOD COAST MEDICAL SERVICES, INC
BOARD OF DIRECTORS - MEETING AGENDA
In person: Elaine Jacob Center | Online: Zoom
February 28, 2024 5:00 PM – 7:00 PM

Order of Business	Business Item	Person	Vote(s) Required	Page #
5:00 pm	AGENDA <ul style="list-style-type: none"> Review and vote on acceptance of Meeting Agenda 	Leslie Bates	Vote	Page 1
5:01 pm	MINUTES <ul style="list-style-type: none"> Vote on acceptance of the Minutes of January 31, 2024 	Leslie Bates	Vote	Page 2-4
5:05 pm	HUMAN RESOURCES COMMITTEE REPORT <ul style="list-style-type: none"> Update 	Renee Kaucnik		
5:15 pm	MEDICAL TEAM REPORT <ul style="list-style-type: none"> Update on clinic operations 	Barbara Brittell		
5:30 pm	DEVELOPMENT, GRANTS, OUTREACH & RISK/COMPLIANCE REPORT <ul style="list-style-type: none"> Updates Report on policies, procedures, and credentialing for review/approval Vote on acceptance of policies, procedures, and credentialing Board Training: HRSA Uniform Data System (UDS) 	Dawn McQuarrie	Votes	Page 5-32
5:40 pm	PERFORMANCE IMPROVEMENT COMMITTEE Update	Susan Hamlin		
5:55 pm	CEO REPORT Operations/Staffing Update	Ara Chakrabarti		
6:10 pm	FINANCE COMMITTEE REPORT <ul style="list-style-type: none"> Report on January Financials Vote on acceptance of the January Financials 	Drew McCalley	Vote	Page 33-43
6:25 pm	INFORMATION TECHNOLOGY COMMITTEE REPORT <ul style="list-style-type: none"> Update 	Drew McCalley		
6:35 pm	MENDONOMA HEALTH ALLIANCE REPORT <ul style="list-style-type: none"> Update 	Janis Dolphin		
6:45 pm	EMERGENCY PREPAREDNESS <ul style="list-style-type: none"> Update 	Leslie Bates		
6:50 pm	EXECUTIVE COMMITTEE REPORT <ul style="list-style-type: none"> Update 	Leslie Bates		
6:55 pm	PUBLIC COMMENT/SHOUT OUTS	Leslie Bates		

The mission of Redwood Coast Medical Services (RCMS) is to provide high quality, family-oriented, community based medical care, dental care and behavioral health services, including a broad range of preventive health services to residents and visitors within the coastal areas of Southern Mendocino and Northern Sonoma Counties. Services are designed to meet identified needs of the communities served, are integrated with other existing health care services and systems and are evaluated on a regular basis to assure that community health needs are being met. As a non-profit corporation receiving public funds, RCMS provides services to qualifying individuals on a sliding fee scale as well as to patients with MediCal and MediCare coverage, private insurance or self pay status. RCMS plays a special role as the sole provider of medical care in the community and in responding to public health emergencies.



Redwood Coast Medical Services, Inc.
Board of Directors Meeting – Zoom Online Meeting
Meeting Minutes of January 31, 2024

BOARD MEMBER	P	A/E	BOARD MEMBER	P	A/E
Leslie Bates	X		Drew McCalley	X	
Janis Dolphin	X		Jim Nybakken	X	
Susan Hamlin	X		Andrea Polk	X	
Hall Kelley	X		Janet Sanchez	X	
Kimberley Lakes	X		Laurie Voss		X
Patricia Lynch	X		Harriet Wright	X	

STAFF PRESENT	
Ara Chakrabarti	
Barbara Brittell	
Renee Kaucnik	
Christie MacVitie	
Karen Wilder	

Public Attendees: 1 **Guests:** Chris Behrens, David Crowl

CALL TO ORDER: Leslie Bates called the meeting to order at 5:00 pm.

APPROVAL OF AGENDA: After review, Susan Hamlin moved to accept the agenda. Unanimously accepted.

APPROVAL OF MINUTES: After review and corrections, Janis Dolphin moved to accept the minutes of December 20, 2023. Seconded: Kelley.

WELCOME GUESTS: Leslie Bates, Board Chair

- Welcome Chris Behrens, Safety Coordinator at RCMS
 - Safety for patients and staff.
 - Emergency Preparedness – meeting and coordinating with all community organizations.
 - Originally from Southern California.
 - Will be conducting risk assessments, and has already been implanting plans to update cameras and signage at the clinics.
- Welcome David Crowl, District Administrator, Coast Life Support District (CLSD)
 - Provided an annual review of statistics and highlights at CLSD.
 - Discussed community partnerships and plans to create a community wide response.

HUMAN RESOURCES REPORT: Renee Kaucnik, HR/Operations Manager

- New Health Technician that was recently hired quickly advanced to a Medical Assistant.
- Signed a contract with Inline group to recruit a full-time doctor.
- Anniversaries in January: Lon Transue 1 year, Laura Metzinger 2 years, Alexander Ramirez 2 years.
- Currently looking to fill a full-time front desk position and full-time MD or DO position.
- Continuing to develop comprehensive training for all in house positions.
- Staff leadership training attended – looking at ways to implement some of the information and activities learned at this training.

MEDICAL TEAM REPORT: Barbara Brittell, Deputy Medical Director

- Thank you to our new safety coordinator and CLSD.
- COVID, flu, and RSV are still going around – please get vaccinated if you can.
- Discussed the difference between Primary Care and Secondary Care (Urgent Care, Emergency Care).
- Medical care teams are making preventative screenings a priority.
- Appointment and annual exam reminders are something that the providers are working towards.
- Dr. Afsoon has collaborated with a Breast Surgeon to provide a free breast care presentation on Feb. 8



- Medicare Wellness visits are back on board thanks to full provider staffing.
- Dental – working with the team to focus on pediatric care.

CEO REPORT: Ara Chakrabarti, CEO

- National Statistics on Federally Qualified Health Centers (FQHCs):
 - RCMS is one of only 1,500 FQHCs across the nation.
 - 1/10 of the population of the U.S. get their healthcare at an FQHC like RCMS.
 - About 10% are children .
 - 25 million out of 32 million get Medicaid, MediCare, or uninsured.
 - 10 million of that 32 million are rural.
 - Out of 32 million, 90% of them are at or below the federal poverty line.
- Operations Update:
 - Still working on getting hospital support to move forward with the palliative care initiative.
 - New health care insurance for staff started this month, cost went up significantly, but are now able to provide insurance for dependents.
 - 403b retirement plan employer contribution went up \$2,000 starting this year.
 - Planning to have another leadership meeting offsite in the next month and will report back on team initiatives that come out of that meeting.
 - Patient portal is live for a small subset of patients at this time – more to added in the coming months.
 - RCMS lab is designated as a Moderately Complex Lab – just successfully completed the lab audit.
- Facility Update:
 - Installation of new flooring in the Gualala clinic is delayed due to supply shortage.
 - Currently replacing and upgrading the flooring in the Gualala main clinic to hospital standards.
 - Met with Gualala Municipal Advisory Council (GMAC) and plans were well received.
 - Capital Campaign Committee has been assembled: Ara Chakrabarti, Dawn McQuarrie, Leslie Bates, Kimberly Lakes, Hall Kelley, Drew McCalley, and Jim Nybakken will Chair that committee, Kristina Jetton of Sea Ranch Lodge will also be joining the committee.
 - Met with Mendocino County planning staff.
 - Discussed the resubmittal process of the Use Permit to the County.
 - Permission of RCMS Board required to authorize the building addition.

On behalf of the Capital Campaign Committee, Jim Nybakken made a motion that the Board adopt the following Trustee/Authorization statement as presented:

On behalf of the RCMS Board of Directors Ara Chakrabarti, CEO, is hereby authorized to propose the clinic building addition to Mendocino County Planning and Building Services. He, along with Board Member Jim Nybakken, are also authorized to take whatever subsequent actions are necessary to obtain the permits and entitlements to carry out the project. Moved by Leslie Bates, seconded by Hall Kelley, and unanimously adopted.

FINANCE COMMITTEE REPORT: Drew McCalley, Board Treasurer

- Reviewed the Executive Summary for the month of December 2023.
- Financial position is still strong and are able to start the capital campaign project with RCMS resources.
- \$109k positive for December – budget anticipated having a negative balance at this time.
- Key ratios are all on track.
- Patient visits exceeded the budget goals (first time in a long time – due in large part to full provider staffing)
- Net Patient Revenue was positive – higher visits and higher rate of pay per visit.
- Reviewed highlights of the detailed financial statements.
- Grants and Other Revenue – negative variance for the month due to 340B transition to new onsite pharmacy, it should catch up later in the fiscal year.



- Fundraising is expected to continue to go up as donations from the annual appeal keep rolling in
- Salaries were over budget for the month – increased staffing has also led to increased visits and less need for contracted services so it is positively impacting the budget overall.

On behalf of the Finance Committee, Drew McCalley made the recommendation for the Board to accept the December 2023 financials as presented. Moved/Seconded: Kelley/Bates. Vote: Unanimously accepted.

- Quarterly Investment Report: Reviewed the unrealized gains received. Also showed that the recent move of \$1 million from West America Bank into money market fund has already earned over \$5k in the first 3 weeks
- Annual review of the Sliding Fee Discount Program – change in accordance with new Federal Poverty Level rates. Discussed that HRSA no longer requires Board final review and approval, now only need to review by the Finance Committee.

On behalf of the Finance Committee, Drew McCalley made the recommendation for the Board to accept the updated Sliding Fee Discount Program Policy contingent on updating wording according to HRSA requirements. Moved/Seconded: Kelley/Bates. Vote: Unanimously accepted.

INFORMATION TECHNOLOGY COMMITTEE REPORT: Drew McCalley, Committee Chair

- Thank you, Devin Delgrego, for leading all the efforts to roll out the patient portal launch
- Intellichart patient portal implementation is going well – beginning roll out to groups of patients in the coming weeks. Further functionalities will be gradually rolled out.
- Labdaq software will be ready for implementation in February.

MENDONOMA HEALTH ALLIANCE REPORT: Janis Dolphin, MHA Board Member

- Enhanced Care Management Program (CalAIM) program continues to roll out and they are getting the hang of the billing – goal is to have 50 billable encounters per month, making good progress.
- Executive Director of Partnership Health Plan of California recruited MHA to train other providers on how to implement the CalAIM program.
- Community Health Worker making connections in Kashia.
- Mobil Dental Clinic in Fort Ross has a launch date of Feb. 20.
- MHA will Increase screenings as part of the CalAIM program.
- Fentanyl overdose prevention grant getting ready to roll out.

EXECUTIVE COMMITTEE REPORT: Leslie Bates, Board Chair

- RCMS will be sponsoring another t-ball team for spring

PUBLIC COMMENT/SHOUT OUTS:

- Ara Chakrabarti: Thank you Madeline Perket for everything you are doing to improve the Primary Care operations.
- Drew McCalley: Thank you Devin Delgrago for your outstanding help with the patient portal development.

Meeting adjourned at 6:35 PM.

Karen Wilder, for Janis Dolphin, Board Secretary for the RCMS Board of Directors

Grants, Development, Outreach, and Risk/Compliance Report

February 2024 Activities

Grants/Funding

- HRSA COVID-19 survey submitted February 5
- UDS submitted February 8
- PATH CITED Round 3 application submitted February 14
- March 20, 2024 – fundraising event at The Sea Ranch Lodge
- Looking at potential grants
- Attended meetings for all grants

Marketing

- We are leveraging print media, social media, flyers, radio, TV monitors, and The Pulse
- We respond to all messages received via Facebook and website

Outreach and Enrollment

- Javier Chavez continues to assist our community members
- Community education is an ongoing activity

Surveys

Urgent Care surveys are sent weekly and compiled quarterly

Q1 CY24:	in process
Q4 CY23:	in process
Q3 CY23:	965 given – 103 surveys returned – 10.67% return rate
Q2 CY23:	1,075 were sent – 171 surveys returned – 15.91% return rate
Q1 CY23:	1,064 were sent – 112 surveys returned – 10.53% return rate

Primary Care surveys are sent quarterly and compiled quarterly

Q4 CY23:	
Gualala:	in process
Point Arena:	in process
Q3 CY23:	
Gualala:	1,164 were sent – 118 surveys returned – 10.14% return rate
Point Arena:	357 were sent – 33 surveys returned – 9.24% return rate
Q2 CY23:	
Gualala:	1,163 were sent – 123 surveys returned – 10.58% return rate
Point Arena:	327 were sent – 44 surveys returned – 13.46% return rate
Q1 CY23:	
Gualala:	1,076 were sent – 98 surveys returned – 9.11% return rate
Point Arena:	317 were sent – 47 surveys returned – 14.83% return rate

Risk/Compliance

- Continuing to update and streamline PnPs
- Attending meeting and trainings

Other/Policies and Procedures

- Data Validation
- Emergency Codes
- Empanelment
- Uses and Disclosures of Protected Health Information
- QI-PI Work Plan 2024

Credentialing

- Chris Eichele, MA
- Ivan Gustafson, MA
- Holly Hamm, FNP
- Michelle Kilday, MA

Board Training

Uniform Data Systems (UDS)

Health Center Program awardees and look-alikes report on a core set of operational and performance measures each calendar year as defined in the Uniform Data System (UDS).

What is the UDS?

The UDS is a standardized data set and annual program requirement that is defined in Section 330 of the Public Health Service Act.

Health centers are expected to have a system in place to collect and organize data related to the HRSA-approved scope of project, as required to meet Health and Human Services (HHS) reporting requirements, including those data elements for UDS reporting; and that they submit timely, accurate, and complete UDS reports in accordance with HRSA instructions.

How are the UDS data used?

Through the UDS, health centers report annually on patient characteristics, services provided, clinical processes and health outcomes, staffing, patients' use of services, and costs and revenues.

These data help inform efforts to further expand access to care, address health disparities, improve quality of care, and reduce health care costs. UDS data are also used to document program effectiveness; identify administrative, clinical, and financial trends over time; and compare clinical quality measures (CQMs) with national benchmarks.

Table	Data Reported
Service Area	
Zip Code Table	Patients by Zip Code
Patient Profile	
Table 3A	Patients by Age and by Sex Assigned at Birth
Table 3B	Demographic Characteristics
Table 4	Selected Patient Characteristics
Staffing and	
Table 5	Staffing and Utilization
Clinical	
Table 6A	Selected Diagnoses and Services Rendered
Table 6B	Quality of Care Measures
Table 7	Health Outcomes and Disparities
Financial	
Table 8A	Financial Costs
Table 9D	Patient Related Revenue
Table 9E	Other Revenue
Other Form	
HIT Form	Health Information Technology (HIT) Capabilities and Quality Recognition
Other Form	Other Data Elements (telehealth, medications of opioid use disorder (MOUD) and outreach and enrollment assists)

Data Validation Policy and Procedure

Department	Clinic	First Approval Date	
Scope	Entire Clinic	Revision Date(s)	
BoD Adoption Date		Committee Approval Date	February 8, 2024 - PIC
Next Review Date	2026	Date(s) Announced to Staff	

Purpose / Policy	<p>Policy: It is the policy of RCMS to ensure the accuracy of quality metrics before reporting.</p> <p>Purpose: This policy describes the process for data validation for the PHMI Core Set metrics.</p>
Mandated by	PHMI
Definitions	<p>Data Validation: The act of reviewing and confirming that the CHC data used to calculate the measures are of a minimum acceptable level of quality and accuracy.</p> <p>Inter-rater reliability: the consistency with which multiple individuals determine the same findings.</p> <p>Primary source verification: A process of tracing the data points in a given rate (e.g., a patient in the numerator, or in the denominator) back to the primary source of data (e.g., the medical record) to determine if the information is consistent with the finding in the rate (e.g., the medical record includes information that demonstrates the patient is compliant with the numerator criteria).</p>
Attachments / References	

PROCEDURE

A. Process for Validation

1. Validations are conducted by quality and clinical staff trained in the measures, criteria for compliance, and data sources.
2. Validation includes Primary Source Verification (PSV) of 5-10 records of each denominator and numerator, depending on the size.
3. Other sources of knowledge, such as UDS reports, population health custom reports, QIP eReports, HEDIS lists received directly from the payer, attribution lists (segmented by age, gender) are utilized to verify alignment.
4. Measure variations of more than 5% from the previous quarter report are investigated.

B. Timeline for Validation

1. Ongoing validations throughout the year are performed according to the following cadence: Quarterly, when rates for the given time reporting period are generated, rates will be validated prior to submission.

C. Validation Criteria

- For the total population and for specific measures, the following validation criteria are applied:

Validation Area	Validation Criteria	Y/N	Notes
Total Population Database/File Validation Steps			
Total Records	Number of records/patients in the reporting database/file matches the number extracted from the EHR/primary source		
Total Eligible Population	Criteria used to identify the population applied with fidelity to PHMI/HEDIS specifications		
	Population size appears reasonable and in alignment with other sources/knowledge		
	Number of MCP-attributed patients align with the sum of patients on individual MCP-provided member attribution lists		
	Sub-populations are not greater than the parent population		
	Sub-populations (e.g., number of children, number of diabetics, race, and ethnicity) are in alignment with other sources/knowledge		
Race/Ethnicity	Categorization of race and ethnicity applied with fidelity to PHMI specifications		
	Numbers/percentages of patients by race and ethnicity appear reasonable and in alignment with other sources/ knowledge		
	Number of unknown or unassigned patients reasonable appear reasonable and in alignment with other sources/ knowledge		
	Sum of patients delineated by race and ethnicity equals the total population		
Site-specific	Sum of patients delineated by clinic site equals the total population		
Measure-Specific Validation Steps			
Hemoglobin A1c Control in Patients with Diabetes (Poor Control >9%)	Numerator appears reasonable and in alignment with other sources/ knowledge		
	Denominator appears reasonable and in alignment with other sources/ knowledge		
	Numerator is not greater than the denominator (note: the numerator can be equal to the denominator but not greater than it)		
	Segmented populations (e.g., race/ethnicity) align with expectations and are reasonable given the segmented population breakdown across health center		

Validation Area	Validation Criteria	Y/N	Notes
Controlling High Blood Pressure	Numerator appears reasonable and in alignment with other sources/ knowledge		
	Denominator appears reasonable and in alignment with other sources/ knowledge		
	Numerator is not greater than the denominator <i>(note: the numerator can be equal to the denominator but not greater than it)</i>		
	Segmented populations (e.g., race/ethnicity) align with expectations and are reasonable given the segmented population breakdown across health center		
Prenatal and Postpartum Care (Postpartum)	Numerator appears reasonable and in alignment with other sources/ knowledge		
	Denominator appears reasonable and in alignment with other sources/ knowledge		
	Numerator is not greater than the denominator <i>(note: the numerator can be equal to the denominator but not greater than it)</i>		
	Segmented populations (e.g., race/ethnicity) align with expectations and are reasonable given the segmented population breakdown across health center		
Colorectal Cancer Screening	Numerator appears reasonable and in alignment with other sources/ knowledge		
	Denominator appears reasonable and in alignment with other sources/ knowledge		
	Numerator is not greater than the denominator <i>(note: the numerator can be equal to the denominator but not greater than it)</i>		
	Segmented populations (e.g., race/ethnicity) align with expectations and are reasonable given the segmented population breakdown across health center		
Well Child Visits in the First 30 Months of Life (First 15 Months)	Numerator appears reasonable and in alignment with other sources/ knowledge		
	Denominator appears reasonable and in alignment with other sources/ knowledge		
	Numerator is not greater than the denominator <i>(note: the numerator can be equal to the denominator but not greater than it)</i>		
	Segmented populations (e.g., race/ethnicity) align with expectations and are reasonable given the segmented population breakdown across health center		

Validation Area	Validation Criteria	Y/N	Notes
Child Immunization Status (Combo 10)	Numerator appears reasonable and in alignment with other sources/ knowledge		
	Denominator appears reasonable and in alignment with other sources/ knowledge		
	Numerator is not greater than the denominator <i>(note: the numerator can be equal to the denominator but not greater than it)</i>		
	Segmented populations (e.g., race/ethnicity) align with expectations and are reasonable given the segmented population breakdown across health center		
Depression Screening and Follow-Up for Adolescents and Adults	Numerator 1 (patients screened) appears reasonable and in alignment with other sources/ knowledge		
	Denominator 1 (patients 12+ years of age) appears reasonable and in alignment with other sources/ knowledge		
	Numerator 2 (patients followed up) appears reasonable and in alignment with other sources/ knowledge		
	Denominator 2 (patients screened positive) appears reasonable and in alignment with other sources/ knowledge		
	Numerators are not greater than the denominators <i>(note: the numerator can be equal to the denominator but not greater than it)</i>		
	Segmented populations (e.g., race/ethnicity) align with expectations and are reasonable given the segmented population breakdown across health center		

D. Validation Findings

1. Validation findings are used to identify errors or inconsistencies in the quality measures.
2. When errors are found, they are corrected in the rate.
3. When patterns of errors are found, an action plan to address the systematic issue are developed. Action plans are tracked until the issue is resolved and subsequent data indicates no more issues found.

Emergency Codes Policy and Procedure

Department	Clinic	First Approval Date	July 1, 2001
Scope	Entire Clinic	Revision Date(s)	December 2023 August 2019 May 2015 November 2003
BoD Adoption Date		Committee Approval Date	February 8, 2024 - PIC
Next Review Date	December 2025	Date(s) Announced to Staff	

Purpose / Policy	"Calling codes" is the standard procedure used by the staff of medical Facilities to call for both medical and non-medical assistance in certain situations. Each Code describes the specific response needed for each internal problem.
Mandated by	HRSA, FTCA
Definitions	<ol style="list-style-type: none"> 1. CODE BLUE-MEDICAL EMERGENCIES: An internal event requiring medical assistance. A medical emergency signifies a cardio-pulmonary arrest or other medical condition which requires immediate attention. 2. CODE RED-FIRE: An internal event (fire) in which evacuation of the building is required. Only a few employees will respond to the scene (i.e., Administration). All other employees are responsible to help evacuate patients, visitors and themselves from the building. After making a CODE RED announcement, the operator also will alert the local fire department to the situation. 3. CODE GREY-VIOLENCE: An internal event with a patient, visitor or family member who is exhibiting abusive or violent behavior, presence of alcohol and/or drugs. 4. CODE SILVER-WEAPON: An internal event of criminal activity. i.e., robbery, overt sexual behavior, any attempted crime, person/s brandishing a weapon or who have taken hostages. 5. CODE GREEN-BOMB THREAT: An internal threat (bomb threat) in which evacuation of the building is required. All employees are responsible to help evacuate patients and visitors from the building. Suspicious objects or packages will not be touched, but once outside the building, supervisors will be informed of any suspicious objects or suspicious packages seen.

	<p>6. CODE PINK-INFANT-CHILD ABDUCTION: An internal event where infants and children are removed or attempted to be removed by an unauthorized person/s.</p> <p>7. CODE YELLOW-HAZARDOUS SPILL: An internal event that identifies unsafe exposure condition due to hazardous materials spill or bioterrorism. The hazardous spill response code is to designed to expedite the proper clean-up of any and all hazardous chemical spills that may occur at the Gualala Health Center, Point Arena Health Center, and Point Arena Dental Center.</p> <p>8. CODE SHELTER IN PLACE: Finding a save location indoors and staying there until you are given an ALL CLEAR or told to evacuate.</p>
Attachments / References	<p><u>References</u></p> <ul style="list-style-type: none"> – California Primary Care Association Emergency Preparedness for Community Clinics/Centers – Redwood Coast Medical Services Emergency Operations Plan – Board Approved: April 4, 2011 <p><u>Attachments</u></p> <ul style="list-style-type: none"> – Emergency Response Poster for RCMS Health and Dental Centers – Emergency Response for Code Blue (Specifics) and Critical and Surge Support – Incident Report Form

PROCEDURES:

How to call an emergency Response Code over the RCMS Phone System:

- Lift the receiver
- Press the pound (#) key
- Then press 0
- Announce the location only
- Repeat three (3) times (five (5) times if infant/child abduction)

This will broadcast to all phone extensions in all RCMS buildings

1. CODE BLUE: MEDICAL EMERGENCIES

- Any patient /visitor/employee or anyone on the RCMS property is experiencing a medical emergency; **CODE BLUE** is announced following the above Emergency Response Code procedure. If in Point Arena Health Center or Point Arena Dental Center, **CODE BLUE** is called, then **CALL 911**.
- All available clinical personnel respond to location indicated in the intercom announcement.
- Initiate Cardiopulmonary Resuscitation (CPR), if necessary or appropriate.
- Maintain airway.
- Designate a person to obtain a crash cart.

- Emergency IV drug therapy for cardiac arrhythmia will only be administered by Advanced Cardiac Life Support (ACLS) and/or Pediatric Advanced Life Support (PALS) trained personnel.
- Emergency electrical cardioversion defibrillation can be administered by trained clinical staff.
- Provider will facilitate transfer of patient to higher level of medical treatment.
- Staff not directly involved with the emergency therapy will provide crowd control and direct an ambulance or helicopter personnel to the site of the code.
- One of the health care professionals responding to the code will be designated to record the events as they occur on the appropriate forms.
- An accident report will be completed.

A. **CODE BLUE (Specifics):** (Code Blue in progress in Urgent Care or Primary Care)

The following RCMS staff members will present to urgent care or primary care:

- All providers in clinic
- Lab representative
- Lead primary care Medical Assistant (MA)
- Front Desk Representative
- X-Ray Tech
- Other available staff- who may be asked to stay or leave, depending on needed skill set.

B. **CRITICAL SUPPORT URGENT CARE** (Critical patient in urgent care, assistance needed)

The following staff members to present in urgent care:

- Lab Representative
- Lead Primary Care MA
- Front Desk Representative
- X-Ray Tech

C. **SURGE SUPPORT URGENT CARE** (Overflow of patients in urgent care, assistance needed)

- These staff will respond to urgent care:
- The designated Surge MA will report to urgent care
- Providers to help triage patients
- Staff will monitor door sign outside of Urgent Care:
 - Green Sign (No assistance needed)
 - Yellow Sign (Urgent Care Overloaded) Primary care providers assist by taking non-critical patients from urgent care waiting list, if possible
 - Red Sign (Critical patient in progress) Primary care providers assist by taking non-critical patients from Urgent Care waiting list.

2. **CODE RED: FIRE**

Institute the acronym **R.A.C.E.:**

R = RESCUE anyone in immediate danger from the fire, if it does not endanger your life.

- If a patient's or staff's clothes are on fire-Instruct them to **STOP, DROP & ROLL**
- If you or anyone is caught in smoke, instruct them to drop to hands and knees and crawl.
- If you, or anyone, are trapped in a room, place cloth and material under the door to prevent smoke from entering.

A = ALARM/ACTIVATE the RCMS emergency Code System (or instruct a staff

- Member to do so, (if you cannot): Lift receiver, press (#) key, then press 0 and Announce **CODE RED**, the location of the fire and repeat three (3) times. Call or instruct someone to call the Fire Department. Give the Fire Department your location, nature of fire and name.

C = CONFINE the fire by closing all doors and windows, if safe to do so.

E = EXTINGUISH/EVACUATE

EXTINGUISH the fire with a fire extinguisher. **EVACUATE** the area, if possible. Learn at least two escape routes and emergency exits from your area.

If a fire extinguisher is used, remember the acronym **P.A.S.S.**

P = PULL the pin on the fire extinguisher

A = AIM the extinguisher at the base of the fire

S = SQUEEZE or press the handle

S = SWEEP from side to side until the fire appears to be out

Notify Administrative staff as soon as it is safe to do so.

3. CODE GREY: VIOLENCE

- Evaluate each situation for potential violence when you enter a room or begin to relate to a patient or visitor.
- **STAY CALM** – Have a staff person activate **CODE GREY: CALL 911**, if needed, do not hesitate if the person is exhibiting violent or aggressive behavior.
- Identify the staff person who is in charge of the de-escalation communication. Only one person will communicate with the person, the provider or staff who knows the person best.
- Look around the room, be aware, and take all items that may be used as a weapon, if safe to do so.
- Do not isolate yourself with a potentially violent person. As many staff as possible will be present. Do not invade the person's personal space. All staff will stay arm's length away.
- Always keep an open path for exiting. Do not let the potential violent person stand between you and the door.
- Report any violent incidents using the Incident Report Form.

4. CODE SILVER: WEAPON

- A. If you witness a criminal act or notice someone acting suspiciously and feel threatened, immediately activate **CODE SILVER** and **CALL 911**.
- B. In the event of a robbery, assault, overt sexual crime or attempted crime or if someone has a gun or other weapon:
- Follow the instruction of the perpetrator
 - Observe the person(s) carefully for:
 - Physical description (height, weight, hair, clothes, etc.)
 - Type of weapon displayed
 - Number of perpetrators
 - Behavior (nervous, calm, etc.)
 - Upon departure of the perpetrators:
 - Notify Law Enforcement
 - Notify Administration staff
 - Note the exact time of departure and the direction of travel, if possible
 - Write a description of each person
 - Write the year, make, and model of vehicle
 - Write the description of the property involved
 - Safeguard the robbery or other scene for physical evidence by locking the door
 - Prevent persons from entering – remove people from the vicinity as soon as possible
 - Assist the police when they arrive by supplying them with any information they request
 - Ask others to do the same

C. ACTIVE SHOOTER

When an Active Shooter is in your vicinity, you must be prepared both mentally and physically to deal with the situation.

1. RUN

- Have an escape route in mind
- Leave your belongings behind
- Evacuate regardless whether others agree to follow
- Help others escape, if possible
- Do not attempt to move the wounded
- Prevent others from entering an area where the active shooter may be
- Keep your hands visible
- **CALL 911** when you are safe

2. HIDE

- Hide in an area out of the shooters view
- Lock door or block entry to your building place
- Silence your cell phone (including vibrate mode) and remain quiet

3. FIGHT

- Fight as a last resort and only when your life is in imminent danger
- Attempt to incapacitate the shooter
- Act with as much physical aggression as possible
- Improvise weapons or throw items at the active shooter
- Commit to your actions. . . your life depends on it

5. CODE GREEN: BOMB THREAT

Upon receiving a telephone bomb threat: **BE CALM, BE COURTEOUS, LISTEN, and DO NOT INTERRUPT** the caller. Keep the caller on line.

- Immediately:
 - Upon receiving a threat by telephone or mail, notify Administrative staff immediately.
 - Upon receiving a telephone bomb threat or other threat, remain calm. Much can depend on information from the caller. Be calm, courteous and listen. Do not interrupt the caller. Try to notify another person. This person should **CALL 911** immediately.
- Note the following facts such as:
 - Is the caller male or female?
 - Is the caller's voice calm? Angry? Do you hear a stutter? An accent?
 - What do the background noises sound like?
 - The person receiving the call should try to record the following:

Time of Call: _____

Caller is male _____ Female _____

Are there background noises? _____

Language Use? Excellent _____ Good _____ Fair _____ Poor _____

Accent: _____

Manner: Calm _____ Angry _____ Laughing _____ Righteous _____ Other _____
- Other Information (Bomb Threat)
 - Try to find the location of the bomb, size of bomb, time to explode.
 - Try to engage in conversation and keep the caller on the line for as long as possible.
 - Obtain and document any other pertinent or relevant information.
- When the caller hangs up, the person receiving the threat will immediately notify the Floor Supervisor, Deputy Medical Director/Chief Physician and/or Chief Executive Officer (or his/her designee), or any Administrative staff. Pass all the information that was received in reference to the threat.
- Confirm that Law Enforcement has been notified, if not the Administrative staff will call.
- Administrative staff only will give the authorization to begin **CODE GREEN** announcement over the paging system. The caller will make the announcement three (3) times as follows: **"To all staff, please begin CODE GREEN"**.
- Staff will begin the evacuation process for their specific areas. Never touch suspicious objects. Once outside the building at the meeting area in the North East parking lot (of the Gualala Health Center), alert supervisors of any suspicious objects seen.
- Staff will not discuss the matter with any media, patients or visitors. The Sheriff's Department or other Law Enforcement will conduct the search. Staff will stand by until given further instructions From Administrative staff.

6. CODE PINK: INFANT/CHILD ABDUCTION

- A. Any staff who has been made aware of a lost or missing child in the health center will immediately notify their Supervisor and Administrative staff. **CODE PINK** will be announced five (5) times utilizing the security paging system.
- B. Upon hearing the **CODE PINK** announcement, all staff will be placed at each entry/exit door to prevent anyone from leaving or entering the facility until the child has been located or authorities have been contacted. Identify the physical descriptions and actions of someone attempting to kidnap an infant or child from the healthcare center.
- Monitor each entrance and stairway
 - Watch for unusual behavior by an individual
 - Stop all individuals carrying an infant or child
 - Stop all individuals carrying a large package, (e.g., gym bag) particularly if the person is “cradling” or “talking” to it
 - Staff should respond “We are in a security situation, please stay in this area until the event is over
 - Do not attempt to physically restrain the individual
 - Note physical characteristics, vehicle descriptions and license and exit route. Identify the physical descriptions and actions of someone attempting to kidnap an infant or child from the healthcare center
 - Administrative staff will escort the person who has reported the lost child through the facility to look for the child
 - Ask for a photo of the child if available
 - If, after, the facility and grounds have been searched, 911 will be called.

7. CODE YELLOW: HAZARDOUS MATERIAL SPILL/BIOTERRORISM

- A. In the event of a chemical exposure or a chemical spill, activate the RCMS Emergency Code Response System over the intercom and announce **CODE YELLOW**. Once responders are on the scene, give the following information:
- The identification of the spilled material (Chemical name)
 - The quantity spilled
 - Location of spill (i.e., Room #)
 - Your name and call back number
 - **REMEMBER!** Injuries needing medical assistance are the priority
- B. Administration will coordinate clean up. Until the clean-up crew arrives to properly clean and contain the spill, while awaiting the arrival of the emergency responders, close all doors to the area, evacuate anyone in the immediate area of the spill, do not allow anyone to enter the room until the clean-up crew arrives. At that time, they will provide instruction.
- C. Chemical Exposure: Blister Agents (Mustard gas, Lewisite) or Nerve Agents (Sarin, Soman, VS)

Chemical splash to skin or eyes- In the event of a chemical exposure or chemical splash to yourself, or someone in your lab, it is important to use the emergency eyewashes. Each contaminated person will remove all contaminated clothing, jewelry and glasses, flush the area for at least 15 minutes, and seek medical attention. Use soap, if available.

- D. Radiological Exposure – Dirty Bombs or Radiological Dispersal Devices – are Conventional bombs designed to scatter radioactive dust. Tune into local radio or media stations for instructions. If a radiation emergency, you may be advised to **SHELTER IN PLACE** which means to stay in the clinic, or you may be advised to move to another location. If advised to evacuate, follow the directions of local officials. If possible, take a flashlight, portable radio, batteries, first aid kit, supply of food and water, essential medications, cash and credit cards.

8. CODE SHELTER IN PLACE:

Shelter in place means finding a safe location indoors and staying there until you are given an “All Clear” or told to evacuate. You may be asked to shelter in place because of an active shooter; tornado; or chemical, radiological, or other hazard. The RCMS code for shelter in place is **SHELTER IN PLACE**. Follow the instructions on the Emergency Response poster and repeat three (3) times.

- Close the clinics.
- Shut and lock the door(s)
- If there are patients in the building, provide for their safety by asking them to stay – not leave.
- When authorities provide directions to shelter-in-place, they want everyone to stay where they are and not drive or walk outdoors. Unless there is an imminent threat, ask patients and visitors to call their emergency contact to let them know where they are and that they are safe.
- Close and lock all windows, exterior doors, and any other openings to the outside.
- Close the window shades, blinds, or curtains, if appropriate.
- Have employees familiar with your building’s mechanical system turn off all fans, heating and air conditioning systems.
- It is ideal to have a land line phone. Call emergency contacts and have the phone available.
- Cellular telephone equipment may be overwhelmed or damaged during an emergency.
- Keep listening to the radio or television until you are told all is safe or you are told to evacuate. Local officials may call for evacuation in specific areas at greatest risk in your community.

Empanelment Policy and Procedure

Department	Clinic	First Approval Date	
Scope	Entire Clinic	Revision Date(s)	
BoD Adoption Date		Committee Approval Date	February 8, 2024 - PIC
Next Review Date		Date(s) Announced to Staff	

Purpose / Policy	<p>Policy Designated primary care providers (PCP) at RCMS will hold a panel of patients for which the PCP is responsible. When scheduling an empaneled patient for a primary care visit, every attempt will be made to schedule with the patient's PCP. Patients may request to change their PCP at any time using the PCP change process. Provider panels will be monitored quarterly for size and composition using access, productivity, and continuity as indirect measures of panel fullness. RCMS will record in the EHR if the patient has another PCP.</p> <p>Purpose Designating groups of patients to be cared for by individual PCPs and their care teams is a cornerstone for high-performing primary care and population health management.</p>
Mandated by	PHMI, PCMH
Definitions	<p>Primary Care Provider (PCP) – the provider who oversees the delivery of care of a patient. Ideally the PCP will be working with the patient during the majority of the scheduled appointments.</p> <p>Provider Team – a defined group of PCPs working together to care for several panels collaboratively.</p> <p>Care Teams – Support staff who are consistently assigned to a particular provider.</p> <p>Empanelment – a method of facilitating long term healing relationships between providers (and care teams) and patients through continuity of care. It promotes the health and wellbeing of the RCMS community by proactively creating working/healing relationships between patients and providers with patient outcomes, continuity, and advancing quality of care as the centralized focus between patients, their PCP and care team.</p> <p>Panel – the patients of a specific provider. This population may consist of established, assigned, and potential patients. Although panels are always changing, they should have all the patients that a PCP is responsible for,</p>

	<p>including new patients as they enter the care of the provider or change providers.</p> <p>Patient-Perspective Continuity – Percent of patients’ appointments (all or specific type) that occurred with the PCP to whom they are empaneled</p> <ul style="list-style-type: none"> • Numerator: Number of visits for which the visit provider was the empaneled provider for the time period • Denominator: Total number of primary care visits patients of the empaneled provider had in the time period <p>Provider-Perspective Continuity – Percent of providers’ appointments that are with patients that are on their panel</p> <ul style="list-style-type: none"> • Numerator: Number of visits for which the visit provider was the empaneled provider for the time period • Denominator: Total number of visits provider completed for the time period <p>Empanelment Committee – a group of RCMS employees who understand the importance of empanelment and make decisions about empanelment at RCMS for the empanelment manager to operationalize. The committee may decide to pursue a certain intervention to improve continuity, analyze PCP changes, open/close panels, as well as assess how well empanelment is functioning overall. The committee will meet biannually or as needed. A quarterly report will be reviewed and recommendations derived from the data will be shared with the providers. The empanelment committee will review each provider’s panel quarterly and consider the following:</p> <ul style="list-style-type: none"> • Panel size is not dependent on the number or FTE of the provider and may be greater or less than other providers • Composition will be reviewed for Acuity and Utilization • Provider panels with high utilization and/or high acuity will tend to have lower empanelment numbers • Patients who have been seen by a provider other than their assigned PCP or provider team for three or more consecutive appointments will be reviewed by the Empanelment Committee to determine the next best steps for ensuring they are established with a PCP and provider team that meets their needs
Attachments / References	PCP Change Request Form

PROCEDURE

Empaneling New Patients and Assigned Patients Seen for the First Time

- PCPs each have a defined set of “New” appointments on their schedules, to be used for the following instances:
 - A new patient’s first visit to their new PCP

- A second visit of an assigned member when their first visit was done through a follow up or urgent care appointment and they could not have the provider be their PCP because the provider's panel was full (or any other reason), or they did not want the provider to be their PCP
 - When a dis-empaneled patient is returning to care and their former PCP's panel is full
 - When a patient has requested a change in PCP
- PCPs with full panels will not have any "New" appointments on their schedules, unless the PCP specifically requests to add a new patient to their panel with a new appointment slot.
- When a new patient, including an assigned member being seen for the first time, calls RCMS, the person will be offered a "New" appointment with any PCP with an open "New" slot. Patients will be empaneled to that PCP at the time of booking the appointment. Schedulers will assist patients in making a choice of their PCP. If the patient prefers a specific PCP, that patient can be empaneled to the PCP, if PCP's panel is open.
 - When empaneling patients to a new provider, consideration will be given to the complexity of the patient or their specific condition(s) and providers who are best positioned to have complex patients on their panels.
- If an assigned member being seen for the first time needs an appointment sooner than a "New" appointment slot is available, then schedulers may use a follow up or urgent care slot of any available provider. Schedulers will first use a follow up or urgent care slot of a provider that does not have a full panel and will empanel the patient to that PCP at the time of making the appointment if the patient agrees. If the PCP's panel is full, or if the patient does not agree to the PCP, then a "New" appointment slot will be sought for the patient with a PCP of their choice. If the patient's visit was with a full provider and the patient does not desire a return appointment to establish care with a PCP with capacity, then the patient will remain non-empaneled.
- Unless a provider's panel is closed, empanelment will be based on patients' choice.
- Staff will document in the patient's EHR if the patient has another PCP at a different clinic.
- After the initial visit with an RCMS PCP all patients should have a PCP in the PCP field per above steps, except those patients choosing to remain non-empaneled. Empanelment manager will periodically identify patients with visits without an empaneled PCP.

Dis-empaneling and Re-empaneling Patients

- If a patient has not had a visit within three years, the value in the PCP field will be removed and will appear as blank. If patient requests an appointment after three years, they will be treated as a "New" patient again.
- Patients may be dis-empaneled sooner than three years if any of the following apply:
 - Patient is assigned elsewhere by their health plan
 - Patient moved beyond the service area of RCMS
 - Patient died
 - Patient directly requests dis-empanelment

Promoting Continuity

- Established patients will be scheduled to see their PCP as much as possible
 - If the appointment offered with the patient's empaneled PCP does not meet the patient's needs, the patient will be offered an appointment with a different PCP

Changing Provider per Patient Request

- If an established patient indicates that they wish to change PCPs, the MA of the new PCP will make that change in the Electronic Health Record (EHR) after the initial visit with the new PCP
 - Patients wishing to change PCPs must fill out a PCP change request form and indicate the reason for requesting the change.
 - A subsequent visit should be made with the new PCP to establish care
 - The Empanelment Manager will bring a report to the he Empanelment Committee identifying the number of changes made per PCP
- If the patient is requesting to change PCP to a provider with a closed panel the patient will be told that the provider will have to be consulted prior to making the change
 - Staff should direct those requests to a supervisor to follow up on
 - The supervisor or designee will follow up with the provider and the patient until resolution

Changing Provider per Practice

- Providers who are no longer employed at RCMS will have their panels distributed to a suitable PCP
- As patients call in for appointments and/or contacted for needed appointments, they will be scheduled into “New” patient appointment types with their new empaneled PCP, if new empaneled PCP is agreeable to patient.
 - The determination of this distribution can be influenced by the Empanelment Committee and Providers alike, but the patients will need to have a visit to establish care with a new PCP

Specialists, non-general, and per-diem providers

- Providers with specialty services such as contracted specialists, services to chronic care patients for their specific condition only, and some per-diem providers will not have assigned paneled patients.

Quality Improvement (QI) – Performance Improvement (PI) Work Plan 2024

Department	Clinic	First Approval Date	December 2014
Scope	Entire Clinic	Revision Date(s)	2022, 2021, 2020, 2019, 2018, 2017, 2016, 2015, 2014
BoD Adoption Date		Committee Approval Date	
Next Review Date	2025	Date(s) Announced to Staff	

Purpose / Policy	Quality Improvement Committee (QI) and Performance Improvement Committee (PIC) provide a process to continuously improve quality and appropriateness of services and make recommendations to the Chief Executive Officer (CEO) and Board of Directors (BOD). This work plan is reviewed and updated yearly.
Mandated by	FTCA, HRSA
Definitions	
Attachments / References	

QUALITY IMPROVEMENT – PERFORMANCE IMPROVEMENT OVERVIEW

QI and PIC consist of:

1. QI and PIC set forth the overview of mechanisms and oversight to assure the delivery of safe, continuous quality services and care to patients through an integrated program of quality improvement strategies, studies, audits, and education.
2. QI-PI Work Plan is a blueprint for QI and PIC goals and activities for a particular year. The QI-PI Work Plan consists of those yearly QI and PIC activities which are regularly conducted every year or every other year (e.g. credentialing) as well as special projects.
3. The BOD receives QI and PIC updates no less than six times a year at their monthly Board meetings to monitor the QI-PI activities throughout the year.

Level One Activities: Level One Activities are the responsibility of the BOD, CEO, and PIC.

Activity	Rationale	Timeline	Evaluation	Person Responsible
Approval of annual QI-PI Work Plan	Federal Tort Claims Act (FTCA) recommendations and compliance with federal regulations	Ongoing	PIC Chair QI Manager	PIC Chair Deputy Medical Director (DMD), Chief Physician (CP), or Provider Designee (PD) BOD Chair
Update annual QI-PI Work Plan	FTCA recommendations and compliance with federal regulations	Annually	CEO DMD, CP, or PD QI Manager Risk/Compliance Director	PIC QI Manager Risk/Compliance Director
Adhere to Credentialing Policy	Regulatory compliance with FTCA recommendations and 330 funding	Ongoing	CEO DMD, CP, or PD	PIC HR QI Manager
Policy and Procedure updates	Regulatory compliance with 330 grant standards	Ongoing	CEO DMD, CP, or PD QI Manager Risk/Compliance Director	Department Heads Supervisors Office Managers QI Manager Risk/Compliance Director
Review reports from QI	FTCA recommendations and compliance with federal regulations	Ongoing	BOD	PIC
Review and implement necessary actions	FTCA recommendations and compliance with federal regulations	Ongoing	BOD	QI

Level One: Performance Improvement Committee

PIC is a BOD-appointed committee which provides leadership to the QI Program, including QI special projects. PIC meets every other month and applies the Continuous Quality Improvement CQI process. The members of PIC are listed below.

Members:

- PIC Chair(s)
- Representatives from the Board of Directors
- Board Approved Community Members-At-Large
- Chief Executive Officer
- Deputy Medical Director, Chief Physician, or Provider Designee
- Quality Improvement Manager
- Risk/Compliance Director

Level Two Activities: Level Two Activities are the internal quality improvement activities, which involves general staff meetings and communications of department leads.

Activity	Rationale	Timeline	Evaluation	Person Responsible
Department Staff Meetings	Documentation of discussions, action items, decisions and/or recommendations. QI committee activities to be reported at each meeting	For each meeting, minutes are forwarded to appropriate QI committee members, as applicable	QI Manager	Supervisors Office Managers Team Leads

Level Two: Quality Improvement Committee

QI is appointed by the CEO. QI meets every other month, with additional communication as needed or required. QI represents a cross section of RCMS staff. The members of QI are listed below.

Members:

- Quality Improvement Chair - DMD
- Electronic Health Record (EHR) Coordinator
- Chief Executive Officer
- Quality Improvement Manager
- Risk/Compliance Director
- Point Arena Clinic Office Lead
- Dental Office Manager
- Urgent Care Team Lead or designee
- Primary Care Team Lead
- Front Desk Team Lead
- Information Technology Representative (as needed)
- Home Health (as needed)

Level Three Activities: Level Three Annual Activities are determined by QI.

What	How	When	Who
Performance/Clinical Measures – Unified Data System (UDS)	UDS Module EHR Chart Review Electronic Practice Management	Annually – February 15	CEO QI Manager EHR Coordinator Grant Director
Clinical Protocol <ul style="list-style-type: none"> • Diagnosis Specific • Scope of Practice 	Annual Review and Update	Annually	DMD, CP, or PD
Provider Performance <ul style="list-style-type: none"> a. Credentialing b. Evaluation c. Peer Review 	Record Review Reports Files Chart Review	<ul style="list-style-type: none"> a. Every two years b. Annually c. Quarterly 	HR DMD, CP, or PD
Staff Performance Evaluation	Documentation	Annually	CEO HR Supervisors Office Managers Team Leads
Patient Satisfaction <ul style="list-style-type: none"> • Patient Care Surveys • Incident Reports • Patient Complaints and Compliments 	Survey Reports Incident Reports Patient Complaints and Compliments	<ul style="list-style-type: none"> Quarterly As needed 	QI Manager Office Managers Team Leads PIC

Level Four Activities: Level Four Activities (special projects) are conducted by Quality Improvement Teams as determined by QI.

Due December 31, 2024

What	How	Who
Cervical Cancer Screening Percentage of women 52–74 years of age who had a mammogram to screen for breast cancer Goal: 45% Prior Goal: 55%	Cervical Screening reminders Morning Huddles i2i NextGen	QI Clinical Staff Providers
Colorectal Cancer Screening Percentage of patients 46-75 years of age who had appropriate screening Goal: 30% Prior Goal: 30%	i2i reminders Morning Huddles NextGen American Cancer Society Best Practices	QI Clinical Staff Providers
Controlled Hypertension Percentage of patients 18-85 years of age who had a diagnosis of hypertension and whose most recent blood pressure was less than 140/90 mm Hg Goal: 55% Prior Goal: 55%	Peer review Train staff Morning Huddles i2i NextGen	QI Clinical Staff Providers
Diabetes Good Control Percentage of patients 18-75 years of age with diabetes who had HgbA1c less than 9% Goal: 80% Prior Goal: 80%	Peer review Train staff Morning Huddles i2i NextGen	QI Clinical Staff Providers
Depression Screening Percentage of patients 12 years of age and older who were (1) screened for depression with a standardized tool and, if screening was positive, (2) had a follow-up plan documented Goal: 45% Prior Goal: 45%	Peer review Train staff Morning Huddles i2i NextGen Initial visit and annually	QI Clinical Staff Providers
Breast Cancer Screening Percentage of women 52–74 years of age who had a mammogram to screen for breast cancer Goal: 45% Prior Goal: 60%	Peer review Train staff Morning Huddles i2i NextGen	QI Clinical Staff Providers
Fluoride Varnish Percentage of patients 6 months-5 years of age who had fluoride varnish Goal: 30% Prior Goal: 30%	Peer review Train staff Morning Huddles i2i NextGen	QI Clinical Staff Dental Staff All Providers

What	How	Who
NEW Pediatric Dental Sealant Percentage of dental patients 6-9 years of age, at moderate to high risk of caries who received a dental sealant on a first permanent molar Goal: 45%	Peer review Train staff Morning Huddles i2i NextGen	QI Dental Staff Dental Providers

Frequency is Quarterly

Staff Training <ul style="list-style-type: none"> Front desk, health techs, MAs, RNs, LVNs, referrals, medical records, lab, X-ray techs, and other staff as needed 	Managers/Supervisors/Team Leads to determine training as needed Competencies and training	Providers Supervisors Team Leads
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ORGANIZATIONAL CHART

Board of Directors

The BOD will:

- Adopt annual QI-PI Work Plan
- Adopt requested actions by PIC
- Receive a PIC report every other month

Performance Improvement Committee

PIC will:

- Review/Approve Annual QI-PI Work Plan for recommendation to BOD
- Approve Credentialing and Privileging
- Approve Policies and Procedures
- Establish priorities for QI
- Review resource allocations to meet priorities and makes recommendations to BOD
- Assist in establishing priorities of care with QI

Quality Improvement Committee

QI will:

- Implement the QI-PI Work Plan
- Provide reports to the PIC for review and submission to BOD
- Provide annual quality reports, as needed
- Appoint special work groups to investigate issues brought to QI
- QI trainings and other projects, as needed

Uses and Disclosures of Protected Health Information Policy and Procedure

Department	Clinic	First Approval Date	February 6, 2013
Scope	Entire Clinic	Revision Date(s)	February 2013
BoD Adoption Date		Committee Approval Date	February 8, 2024 - PIC
Next Review Date	2026	Date(s) Announced to Staff	

Purpose / Policy	<p>To ensure that disclosure of protected health information (PHI) is made consistent with applicable laws, regulations, and health information standards, and to ensure that any disclosures of a patient's PHI to a patients' family members or other relatives, friends, or other persons designated by the patient as appropriate.</p> <p>Disclosure of PHI will only be allowed with a properly completed and signed authorization except:</p> <ul style="list-style-type: none"> • When required or allowed by law • As defined in the Notice of Privacy Practices: <ul style="list-style-type: none"> – For continuing care (treatment) – To obtain payment for services (payment) – For the day-to-day operations of RCMS and the care given to the patients (health care operations) <p>Disclosure of PHI will be carried out in accordance with all applicable legal requirements and in accordance with RCMS policy.</p>
Mandated by	HRSA
Definitions	PHI – protected health information
Attachments / References	<p>HIPAA Privacy Rule-A Guide for Law Enforcement</p> <p>Release of Information-PHI from RCMS</p> <p>Release of Information-PHI to RCMS</p> <p>Support Role</p>

PROCEDURE

A. Receiving a request for medical records:

Requests for Medical Records shall be managed by the Medical Records department

- Other staff members will not release PHI without approval from the RCMS provider
- Only emergency release of information will be done after hours or on weekends

- After hours and on weekends, release of information for continuing care (i.e., transfer to a hospital or emergency clinic) is allowed
- B. Responding to specific types of disclosures:
- Media: No PHI shall be released to the news media or commercial organizations without the authorization of the patient or their personal representative
 - Telephone Requests: Staff members receiving requests for PHI via the telephone will make reasonable efforts to identify and verify that the requesting party is entitled to receive such information
- C. Disclosures to persons involved in a patient's care:
- RCMS may disclose to a family member, other relative, friend, or any other person identified by the patient:
 - That is directly relevant to that person's involvement with the patient's care
 - To notify such person of the patient's location, general condition
 - Conditions if the patient is Present. If the patient is present for, or otherwise available, prior to a permitted disclosure, then RCMS may use or disclose the PHI only if RCMS:
 - Obtains the patient's agreement
 - Provides the patient with an opportunity to object to the disclosure, and the patient does not express an objection (this opportunity to object and the patient's response may be done orally)
 - or
 - May reasonably infer from the circumstances, based on the exercise of professional judgement, that the patient does not object to the disclosure
 - Conditions if the patient is Not Present or is Incapacitated. RCMS may, in the exercise of professional judgement, determine whether the disclosure is in the best interest of the patient, and, if so, disclosure only that PHI which is directly relevant to the person's involvement with the patient's care if:
 - The patient is not present
 - The opportunity to agree/object to the use or disclosure cannot practicably be provided because of the patient's incapacity
 - or
 - In an emergency
 - Confirming Identity. RCMS shall take reasonable steps to confirm the identity of a patient's family member. RCMS is permitted to rely on the circumstances as confirmation of involvement in care.

REDWOOD COAST MEDICAL SERVICES, INC.

EXECUTIVE SUMMARY-PRELIMINARY

January 2024

STATEMENT OF FINANCIAL POSITION

ASSETS	Jan-24	Jan-23	Change	Dec-23	Change
Current Assets	4,470,406	4,011,423	11.44%	4,376,664	2.14%
Long-Term Assets	2,654,616	2,526,354	5.08%	2,645,384	0.35%
TOTAL ASSETS	7,125,022	6,537,777	8.98%	7,022,048	1.47%
LIABILITIES AND NET ASSETS					
Current Liabilities	928,840	554,368	67.55%	814,562	14.03%
Estimated Medi-Cal Liabilities	574,193	409,835	40.10%	574,193	0.00%
Total Liabilities	1,503,033	964,203	55.88%	1,388,755	8.23%
Net Assets	5,621,990	5,573,574	0.87%	5,633,293	-0.20%
TOTAL LIABILITIES AND NET ASSETS	7,125,022	6,537,777	8.98%	7,022,048	1.47%

STATEMENT OF ACTIVITIES - YTD

REVENUES	Actual	Budget	Variance	Prior Year	Variance
Patient Service Revenue	2,461,611	2,342,868	5.07%	1,940,075	26.88%
Grant & Other Revenue	2,163,304	2,247,014	-3.73%	2,587,017	-16.38%
NET REVENUE	4,624,915	4,589,882	0.76%	4,527,093	2.16%
OPERATING EXPENSES					
Salaries and Benefits	3,552,401	3,733,828	-4.86%	3,167,417	12.15%
Contracted Services	21,522	76,648	-71.92%	119,419	-81.98%
Facility Costs	160,350	186,382	-13.97%	162,560	-1.36%
Supplies	346,581	333,594	3.89%	338,879	2.27%
Depreciation & Amortization	46,858	55,356	-15.35%	44,232	5.94%
Other Operating Expenses	845,611	892,977	-5.30%	977,307	-13.48%
TOTAL OPERATING EXPENSES	4,973,323	5,278,785	-5.79%	4,809,815	3.40%
OPERATING EXCESS/(DEFICIENCY)	(348,408)	(688,903)	-49.43%	(282,723)	23.23%
Net Capital Income/(Expenses)	446,775	568,625	-21.43%	482,197	-7.35%
TOTAL EXCESS/(DEFICIENCY)	98,367	(120,278)		199,474	-50.69%

REDWOOD COAST MEDICAL SERVICES, INC.

EXECUTIVE SUMMARY-PRELIMINARY

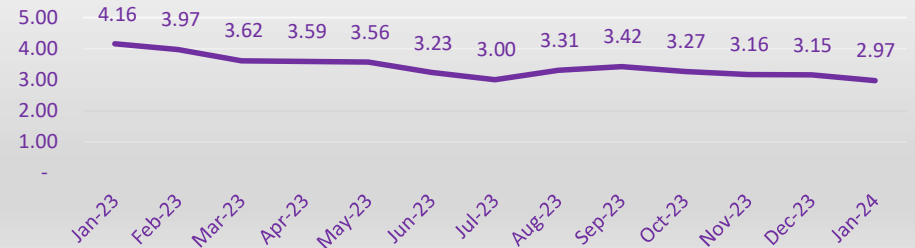
January 2024

Cash on Hand

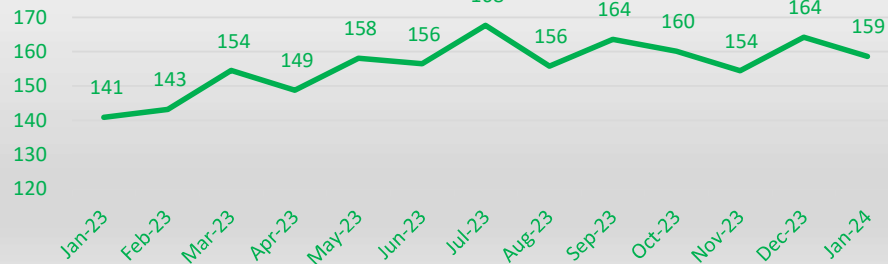


Current Ratio

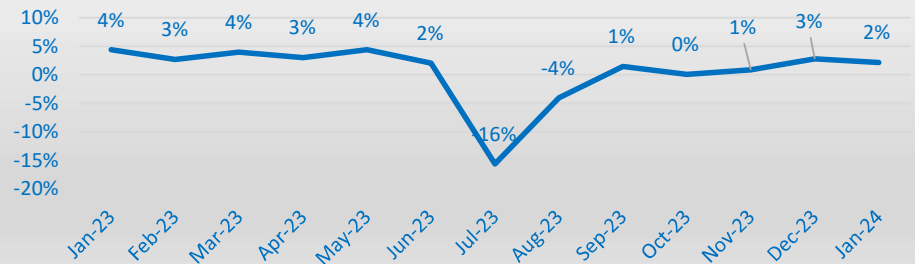
Healthy = > 1.0, higher is better
(Current Asset divided by Current Liabilities)



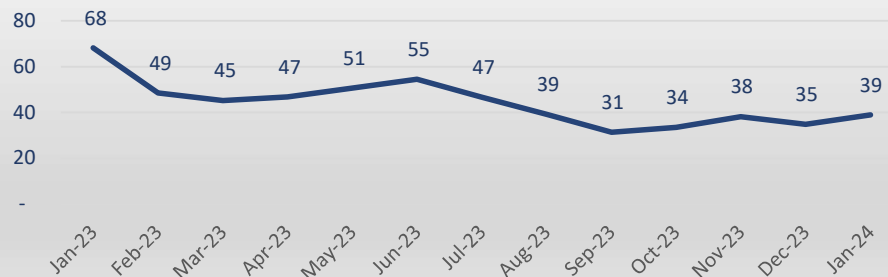
Days Unrestricted Cash on Hand Recommend > 60 days; higher is better



Net Margin Goal = 0%; higher is better



Days Net AR Outstanding Recommend < 45 days, lower is better

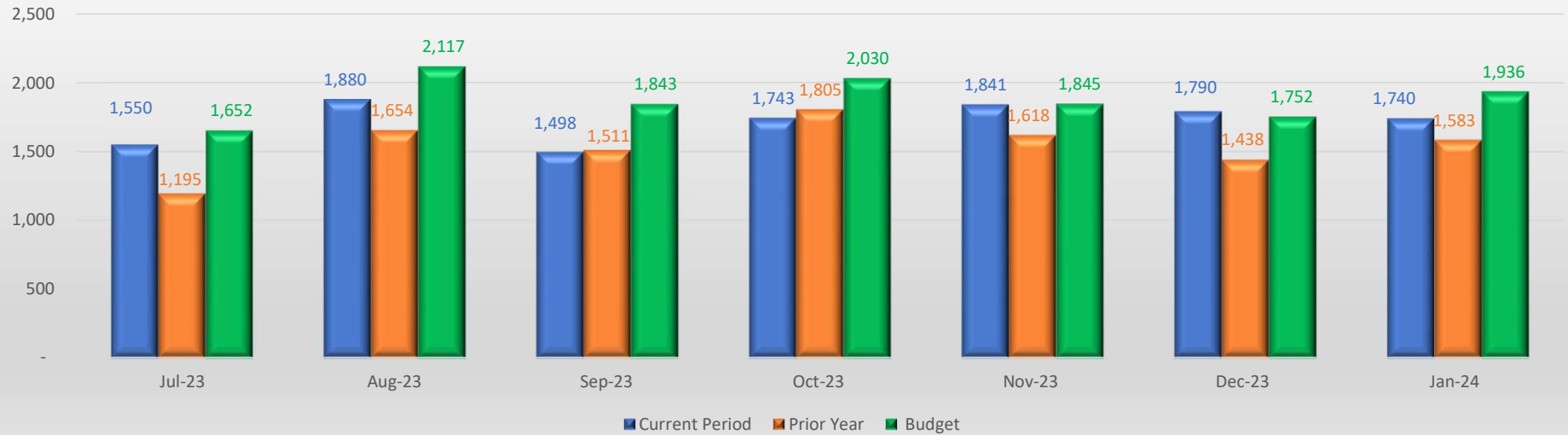


Patient AR Balance



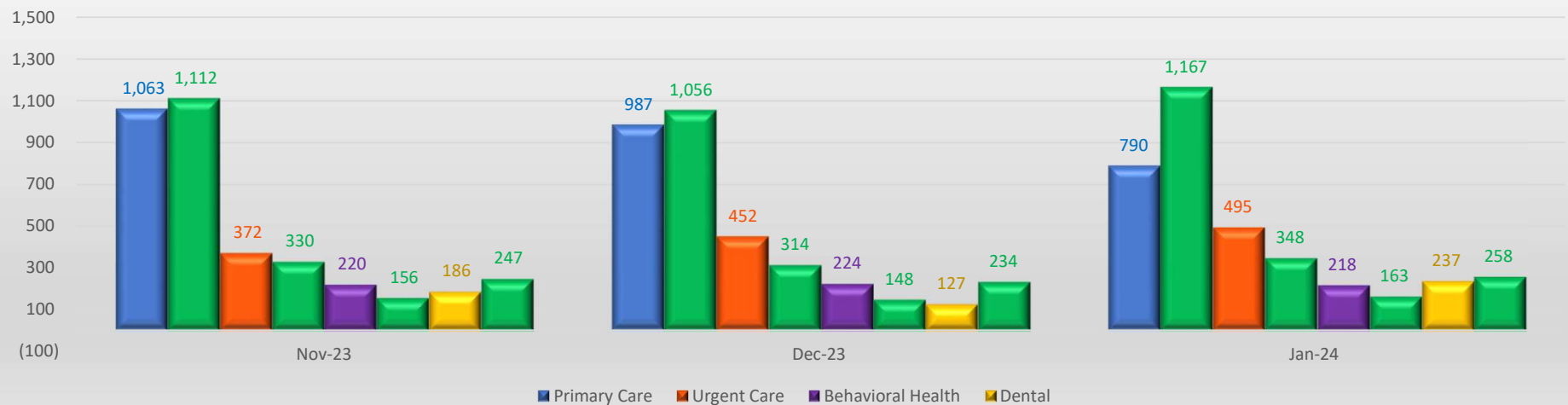
REDWOOD COAST MEDICAL SERVICES, INC.
EXECUTIVE SUMMARY-PRELIMINARY
January 2024

Monthly Visits



Monthly Visits by Department

Budgeted visits depicted in green



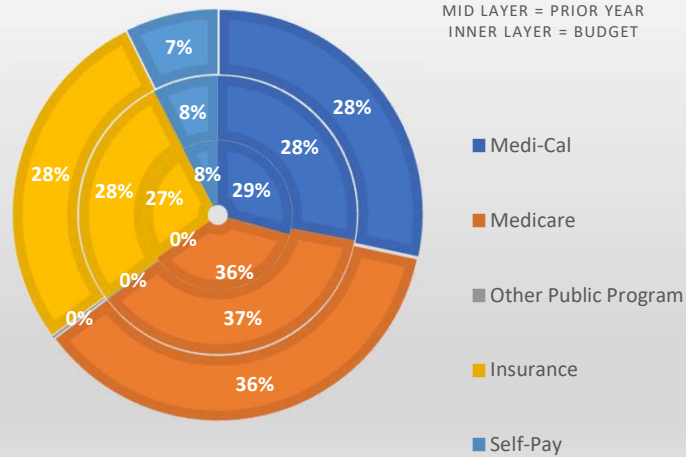
REDWOOD COAST MEDICAL SERVICES, INC.

EXECUTIVE SUMMARY-PRELIMINARY

January 2024

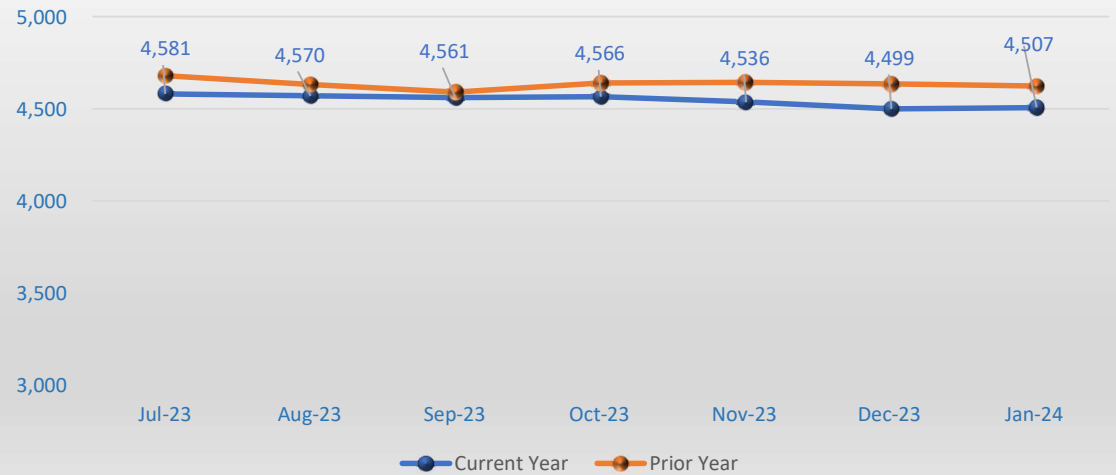
YTD PAYOR MIX

OUTER LAYER = CURRENT YEAR
MID LAYER = PRIOR YEAR
INNER LAYER = BUDGET

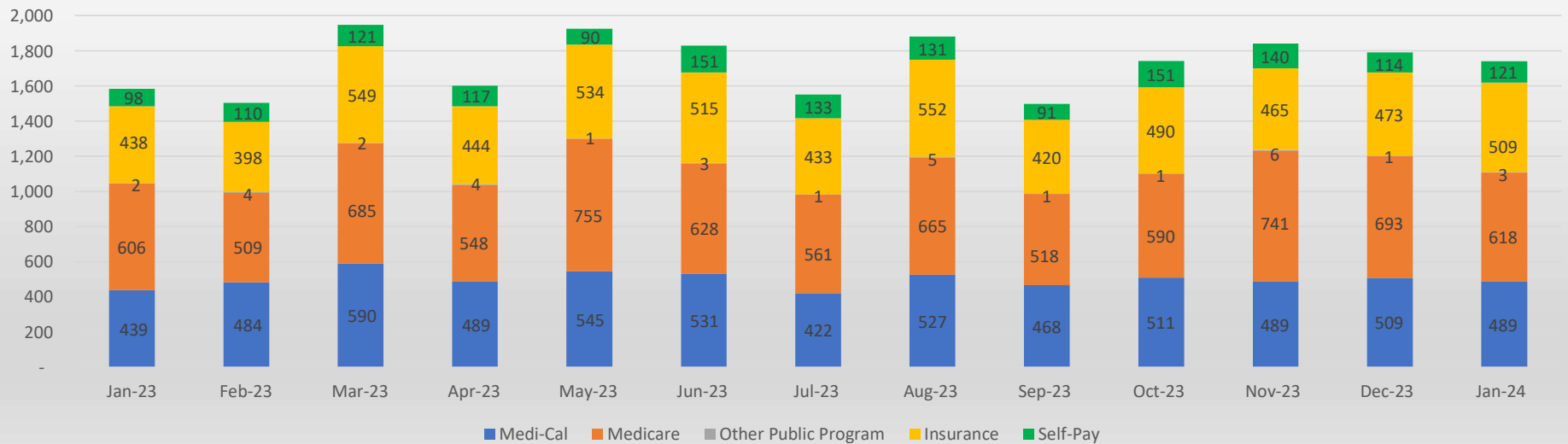


Unduplicated Patients

SAC = 5,000



Monthly Visits by Financial Class



REDWOOD COAST MEDICAL SERVICES, INC.

FINANCIAL NARRATIVE – PRELIMINARY

January 2024

Prepared by Christie MacVitie, contract CFO

Operating financial results:

The month of January was \$42,438 better than the budgeted loss of \$53,742, with a bottom-line loss of \$11,304. The year-to-date bottom-line result was \$218,645 favorable to the budgeted loss of \$120,278, as we ended January with a year-to-date profit of \$98,367. Net Patient Revenue (NPR) of \$413,665 was \$69,079 over budget.

NPR Variance	69,078.50
Due to higher/(lower) visits	(34,885.77)
Due to higher/(lower) rate per visit	103,964.27

- January visits of 1,740 were 196 less than the 1,936 visits budgeted.
- The average rate per visit of \$237.74 was \$59.75 higher than the budgeted average rate per visit of \$177.99.
- Operating Expenses of \$838,990 were \$59,321 over budget.
 - Total Compensation was \$17,353 over budget, due to salary adjustments, a one-time bonus, and higher payroll tax expenses during the first part of each calendar year.
 - Janitorial expenses were \$3,445 under budget.
 - Board Expenses were \$2,521 over budget due to the receipt of an invoice for prior period services.
 - Continuing Education was \$2,547 under budget.
 - Recruiting Expense was \$6,839 below budget.
 - Office Supplies were \$13,359 over budget due to \$10,000 for the Annual Ask mailing and \$4,700 for the quarterly survey letter for Gualala and Point Arena primary care.

- Clinical Supplies were \$26,142 over budget due to the receipt of invoices for prior period purchases and the purchase of hypertension supplies which are grant funded.
- Vaccine Supplies were \$21,914 over budget due to the receipt of prior and current period purchases of seasonal vaccines.
- Transcription Services were \$3,498 under budget.

Changes in Financial position:

- Cash and Investments were \$3,635,603 as of the end of January, which is \$513,466 more than the balance as of the end of January 2023.
 - Cash and Investments decreased by \$19,186 during the month.

Visits:

- January visits of 1,740 were 196 lower than the budgeted visits of 1,936.
 - Primary Care – 377 fewer than budgeted (790 vs. 1,167)
 - Urgent Care – 147 more than budgeted (495 vs. 348)
 - Behavioral Health – 55 more than budgeted (218 vs. 163)
 - Dental – 21 fewer than budgeted (237 vs. 258)

REDWOOD COAST MEDICAL SERVICES, INC.

Statement of Financial Position-Preliminary

As of 1/31/2024

	Current Year	Prior Year	Variance
Current Assets			
Cash & Investments			
Cash on Hand	2,031,743.94	1,909,282.09	122,461.85
Investments	1,603,858.83	1,212,854.43	391,004.40
Total Cash & Investments	3,635,602.77	3,122,136.52	513,466.25
Patient Accounts Receivable			
Accounts Receivable	647,628.88	856,379.86	(208,750.98)
Allowance for Doubtful Accounts	(201,478.00)	(240,803.00)	39,325.00
Total Patient Accounts Receivable	446,150.88	615,576.86	(169,425.98)
Other Current Assets			
Grants Receivable	36,971.48	40,618.48	(3,647.00)
Medi-Cal Receivable - Current Year	73,942.00	0.00	73,942.00
QIP Receivable	146,369.00	36,455.00	109,914.00
340B Receivable	0.00	29,007.00	(29,007.00)
Other Accounts Receivable	2,137.66	66,666.66	(64,529.00)
Prepaid Expenses	123,232.18	94,962.67	28,269.51
Other Assets	6,000.00	6,000.00	0.00
Total Other Current Assets	388,652.32	273,709.81	114,942.51
Total Current Assets	4,470,405.97	4,011,423.19	458,982.78
Property & Equipment			
Property & Equipment	5,146,712.89	4,920,140.33	226,572.56
Accumulated Depreciation	(2,492,096.47)	(2,393,786.54)	(98,309.93)
Total Property & Equipment	2,654,616.42	2,526,353.79	128,262.63
Total Assets	7,125,022.39	6,537,776.98	587,245.41
Current Liabilities			
Accounts Payable	137,407.72	64,209.46	73,198.26
Patient Refunds Due	7,890.52	0.00	7,890.52
Accrued Compensation and Related Liabilities	575,070.58	443,612.96	131,457.62
Medi-Cal Payable - Current Year	0.00	143,202.00	(143,202.00)
Medi-Cal Payable - Prior Year	574,193.30	266,632.93	307,560.37
Other Liabilities	2,800.00	2,800.00	0.00
Other Accounts Payable	18,419.77	24,412.00	(5,992.23)
Current Portion of Long Term Debt	0.00	19,333.75	(19,333.75)
Deferred Revenue	187,251.00	0.00	187,251.00
Total Current Liabilities	1,503,032.89	964,203.10	538,829.79
Total Liabilities	1,503,032.89	964,203.10	538,829.79
Net Assets			
Unrestricted Net Assets	5,523,622.55	5,374,099.98	149,522.57
Current Year Net Excess/Deficit	98,366.95	199,473.90	(101,106.95)
Total Net Assets	5,621,989.50	5,573,573.88	48,415.62
Total Liabilities & Net Assets	7,125,022.39	6,537,776.98	587,245.41

REDWOOD COAST MEDICAL SERVICES, INC.

Statement of Activities From 1/1/2024 Through 1/31/2024

	<u>MTD Actual</u>	<u>MTD Budget</u>	<u>Variance</u>	<u>YTD Actual</u>	<u>YTD Budget</u>	<u>Variance</u>
Patient Revenue						
Medi-Cal	120,888.14	123,264.00	(2,375.86)	858,420.45	838,796.00	19,624.45
Medicare	153,244.63	125,357.00	27,887.63	1,055,935.27	854,059.00	201,876.27
Family Pact	1,940.00	1,365.00	575.00	4,640.03	8,463.00	(3,822.97)
Insurance	74,959.18	72,628.00	2,331.18	435,394.01	494,335.00	(58,940.99)
Self Pay & Other	46,074.81	40,443.00	5,631.81	215,502.70	272,134.00	(56,631.30)
Sliding Scale & Other Write-Offs	(24,177.00)	(19,667.00)	(4,510.00)	(144,929.50)	(133,291.00)	(11,638.50)
Cost Report & Other Settlements	41,153.00	1,613.00	39,540.00	41,153.00	11,291.00	29,862.00
Patient Refunds	(418.26)	(417.00)	(1.26)	(4,504.54)	(2,919.00)	(1,585.54)
Total Patient Revenue	<u>413,664.50</u>	<u>344,586.00</u>	<u>69,078.50</u>	<u>2,461,611.42</u>	<u>2,342,868.00</u>	<u>118,743.42</u>
Operating Expenses						
Operating Expenses	<u>838,989.54</u>	<u>779,669.00</u>	<u>(59,320.54)</u>	<u>4,973,323.45</u>	<u>5,278,785.00</u>	<u>305,461.55</u>
Total Operating Expenses	<u>838,989.54</u>	<u>779,669.00</u>	<u>(59,320.54)</u>	<u>4,973,323.45</u>	<u>5,278,785.00</u>	<u>305,461.55</u>
Net Before Other Revenue	<u>(425,325.04)</u>	<u>(435,083.00)</u>	<u>9,757.96</u>	<u>(2,511,712.03)</u>	<u>(2,935,917.00)</u>	<u>424,204.97</u>
Grants & Other Revenue						
Grant Revenue-Federal 330	162,409.00	154,628.00	7,781.00	1,181,659.00	1,082,396.00	99,263.00
Grant Revenue-CADRE	0.00	0.00	0.00	9,439.00	0.00	9,439.00
Grant Revenue-Fed Hypertension	10,053.00	2,577.00	7,476.00	73,889.00	18,039.00	55,850.00
Grant Revenue-ECV	0.00	9,800.00	(9,800.00)	0.00	68,600.00	(68,600.00)
Grant Revenue-Federal UDS	0.00	1,292.00	(1,292.00)	0.00	9,044.00	(9,044.00)
Grant Revenue-Other	5,242.00	19,906.00	(14,664.00)	92,903.34	139,342.00	(46,438.66)
340B Revenue	49,200.80	44,748.00	4,452.80	135,115.71	313,236.00	(178,120.29)
Contract Revenue-CLSD	66,666.66	66,667.00	(0.34)	466,666.62	466,669.00	(2.38)
QIP Revenue	17,185.00	17,499.00	(314.00)	139,703.50	122,493.00	17,210.50
Rental Income	3,077.00	1,385.00	1,692.00	21,089.00	9,695.00	11,394.00
Other Income	3,382.60	0.00	3,382.60	3,382.60	0.00	3,382.60
Interest & Dividends Earned	<u>3,496.42</u>	<u>2,500.00</u>	<u>996.42</u>	<u>39,456.09</u>	<u>17,500.00</u>	<u>21,956.09</u>
Total Grants & Other Revenue	<u>320,712.48</u>	<u>321,002.00</u>	<u>(289.52)</u>	<u>2,163,303.86</u>	<u>2,247,014.00</u>	<u>(83,710.14)</u>
Net Operating Income/(Loss)	<u>(104,612.56)</u>	<u>(114,081.00)</u>	<u>9,468.44</u>	<u>(348,408.17)</u>	<u>(688,903.00)</u>	<u>340,494.83</u>
Fundraising & Capital Activity						
Capital Grant Revenue	8,730.00	41,667.00	(32,937.00)	46,187.00	291,669.00	(245,482.00)
Fundraising Income	76,367.80	17,000.00	59,367.80	345,474.99	265,000.00	80,474.99
Fundraising Expense	(1,805.07)	(878.00)	(927.07)	(8,493.07)	(5,894.00)	(2,599.07)
Donations	0.00	1,550.00	(1,550.00)	5,673.32	10,850.00	(5,176.68)
Realized/Unrealized Gains/(Losses)	<u>10,015.97</u>	<u>1,000.00</u>	<u>9,015.97</u>	<u>57,932.88</u>	<u>7,000.00</u>	<u>50,932.88</u>
Total Fundraising & Capital Activity	<u>93,308.70</u>	<u>60,339.00</u>	<u>32,969.70</u>	<u>446,775.12</u>	<u>568,625.00</u>	<u>(121,849.88)</u>
Net Excess of Revenue over Expenses	<u>(11,303.86)</u>	<u>(53,742.00)</u>	<u>42,438.14</u>	<u>98,366.95</u>	<u>(120,278.00)</u>	<u>218,644.95</u>

REDWOOD COAST MEDICAL SERVICES, INC.

Schedule of Expenses

From 1/1/2024 Through 1/31/2024

	Actual	Budget	Variance	YTD Actual	YTD Budget	Variance
Salaries & Wages						
Salaries & Wages	480,760.30	465,876.00	(14,884.30)	3,015,392.57	3,099,098.00	83,705.43
Total Salaries & Wages	480,760.30	465,876.00	(14,884.30)	3,015,392.57	3,099,098.00	83,705.43
Benefits						
Payroll Taxes	49,914.19	34,884.00	(15,030.19)	219,438.76	232,080.00	12,641.24
Health Insurance	43,739.96	52,249.00	8,509.04	270,616.89	347,596.00	76,979.11
Workmans Compensation	4,948.00	6,550.00	1,602.00	32,519.00	43,573.00	11,054.00
Retirement	8,171.11	0.00	(8,171.11)	10,933.57	0.00	(10,933.57)
Other Benefits	500.00	1,725.00	1,225.00	3,500.00	11,481.00	7,981.00
Total Benefits	107,273.26	95,408.00	(11,865.26)	537,008.22	634,730.00	97,721.78
Contracted Services						
Contracted Physician	0.00	3,817.00	3,817.00	9,540.00	25,391.00	15,851.00
Contracted Physicians Assistant	0.00	5,308.00	5,308.00	0.00	35,308.00	35,308.00
Contracted Dentist Svcs	1,625.00	1,831.00	206.00	8,437.50	12,182.00	3,744.50
Contracted Pharmacist	500.00	566.00	66.00	3,544.86	3,767.00	222.14
Total Contracted Services	2,125.00	11,522.00	9,397.00	21,522.36	76,648.00	55,125.64
Total Compensation	590,158.56	572,806.00	(17,352.56)	3,573,923.15	3,810,476.00	236,552.85
Facility Expenses						
Depreciation-Facility	4,972.68	6,022.00	1,049.32	33,960.66	42,154.00	8,193.34
Janitorial	2,130.69	5,576.00	3,445.31	17,126.83	39,032.00	21,905.17
Rent	10,773.00	10,398.00	(375.00)	73,311.00	72,786.00	(525.00)
Repairs & Maint-Facility	954.15	1,773.00	818.85	8,654.57	12,411.00	3,756.43
Utilities	7,876.85	6,946.00	(930.85)	50,028.71	48,622.00	(1,406.71)
Real Estate Taxes	1,312.77	1,933.00	620.23	11,229.22	13,531.00	2,301.78
Total Facility Expenses	28,020.14	32,648.00	4,627.86	194,310.99	228,536.00	34,225.01
Other Expenses						
Advice Line	1,820.00	1,771.00	(49.00)	12,740.00	12,397.00	(343.00)
Audit Fees	0.00	0.00	0.00	0.00	20,000.00	20,000.00
Bad Debt	0.00	0.00	0.00	1,655.00	0.00	(1,655.00)
Bank Charges	1,513.67	683.00	(830.67)	7,260.01	4,781.00	(2,479.01)
Board Expense	3,744.00	1,223.00	(2,521.00)	14,905.44	8,561.00	(6,344.44)
Billing Services	2,443.26	1,557.00	(886.26)	13,150.16	10,899.00	(2,251.16)
Computer Supplies & Support	37,837.87	36,239.00	(1,598.87)	272,622.77	253,673.00	(18,949.77)
Consulting Fees	3,997.85	2,336.00	(1,661.85)	37,199.11	16,352.00	(20,847.11)
Consulting Fees - Accounting	7,179.00	8,576.00	1,397.00	52,016.00	60,032.00	8,016.00
Consulting Fees - Government Compliance	523.00	2,417.00	1,894.00	11,766.00	16,919.00	5,153.00
Consulting Fees - CFO	1,059.00	2,167.00	1,108.00	12,975.70	15,169.00	2,193.30
Continuing Education	58.90	2,606.00	2,547.10	11,593.81	18,242.00	6,648.19
Depreciation Expense	1,942.90	1,886.00	(56.90)	12,897.13	13,202.00	304.87
Donations/Contributions	649.18	580.00	(69.18)	1,372.43	4,060.00	2,687.57
Dues & Subscriptions	2,136.24	1,841.00	(295.24)	17,932.80	12,887.00	(5,045.80)
Employment Advertising	0.00	15.00	15.00	0.00	105.00	105.00
Employee Recognition	247.95	0.00	(247.95)	13,953.21	0.00	(13,953.21)
Equipment Lease	1,180.36	1,789.00	608.64	13,234.66	12,523.00	(711.66)
Fundraising Allocation	(1,805.07)	(878.00)	927.07	(8,493.07)	(5,894.00)	2,599.07
Infectious Waste Disposal	1,650.00	1,812.00	162.00	14,723.85	12,684.00	(2,039.85)
Insurance-General	2,795.86	3,933.00	1,137.14	22,219.28	27,531.00	5,311.72
Insurance-D&O	3,148.26	1,924.00	(1,224.26)	19,616.52	13,468.00	(6,148.52)
Insurance-Malpractice	878.00	1,060.00	182.00	6,128.00	7,420.00	1,292.00
Interest Expense	88.75	41.00	(47.75)	321.41	287.00	(34.41)
Lab Services	3,647.10	5,785.00	2,137.90	26,180.29	40,495.00	14,314.71

REDWOOD COAST MEDICAL SERVICES, INC.**Schedule of Expenses****From 1/1/2024 Through 1/31/2024**

	<u>Actual</u>	<u>Budget</u>	<u>Variance</u>	<u>YTD Actual</u>	<u>YTD Budget</u>	<u>Variance</u>
Memberships & Publications	709.00	187.00	(522.00)	751.00	1,309.00	558.00
Minor Equipment	148.86	2,473.00	2,324.14	4,498.93	17,311.00	12,812.07
Outreach & Hlth Ed Matls Exp	1,340.00	2,486.00	1,146.00	7,607.25	17,402.00	9,794.75
Payroll Service Fees	2,313.91	2,054.00	(259.91)	16,030.10	14,378.00	(1,652.10)
Penalties & Late Fees	40.52	0.00	(40.52)	151.40	0.00	(151.40)
Postage & Shipping	1,507.33	1,193.00	(314.33)	6,755.79	8,351.00	1,595.21
Publicity/Advertising	1,358.72	1,423.00	64.28	6,036.30	9,961.00	3,924.70
Recruiting Expense	0.00	6,839.00	6,839.00	6,600.00	47,873.00	41,273.00
Recruiting-Moving Expense	0.00	125.00	125.00	0.00	875.00	875.00
Provider Housing	2,342.08	2,302.00	(40.08)	17,561.39	16,114.00	(1,447.39)
Repairs & Maint-Equipment	3,820.91	2,414.00	(1,406.91)	30,449.56	16,898.00	(13,551.56)
Retirement Administration	155.00	78.00	(77.00)	1,702.50	546.00	(1,156.50)
Supplies-Office	19,014.83	5,656.00	(13,358.83)	52,987.32	39,608.00	(13,379.32)
Supplies-Clinical	53,802.61	27,661.00	(26,141.61)	206,029.12	193,627.00	(12,402.12)
Supplies-Vaccines	25,650.46	3,736.00	(21,914.46)	43,662.93	26,152.00	(17,510.93)
Supplies-Pharmaceutical	6,209.38	4,161.00	(2,048.38)	20,141.90	29,127.00	8,985.10
Supplies-340B Pharmaceutical	4,497.72	5,247.00	749.28	17,004.21	36,729.00	19,724.79
Taxes & Licenses	1,479.34	1,240.00	(239.34)	10,688.34	8,680.00	(2,008.34)
Telephone/Communication	8,970.70	9,444.00	473.30	69,797.13	66,108.00	(3,689.13)
Transcription Services	4,284.13	7,782.00	3,497.87	44,289.71	54,474.00	10,184.29
Travel & Conferences	2,187.32	4,059.00	1,871.68	25,234.88	28,413.00	3,178.12
X-Ray Expenses	4,241.94	4,292.00	50.06	29,139.04	30,044.00	904.96
Total Other Expenses	<u>220,810.84</u>	<u>174,215.00</u>	<u>(46,595.84)</u>	<u>1,205,089.31</u>	<u>1,239,773.00</u>	<u>34,683.69</u>
Total Operating Expenses	<u>838,989.54</u>	<u>779,669.00</u>	<u>(59,320.54)</u>	<u>4,973,323.45</u>	<u>5,278,785.00</u>	<u>305,461.55</u>
Total Operating Expenses After Allocation	<u>838,989.54</u>	<u>779,669.00</u>	<u>(59,320.54)</u>	<u>4,973,323.45</u>	<u>5,278,785.00</u>	<u>305,461.55</u>

REDWOOD COAST MEDICAL SERVICES, INC.

Statement of Cash Flows

As of 1/31/2024

	Current Period	Current Year
Operating Activities		
Change in Net Assets	(11,303.86)	98,366.95
Adjustments to Reconcile Change in Net Assets to Cash		
Depreciation and Amortization	6,915.58	46,857.79
(Increase)/Decrease in Accounts Receivable	(57,478.05)	156,422.19
(Increase)/Decrease in Grants Receivable	(34,523.00)	(66,910.00)
(Increase)/Decrease Estimated Medi-Cal Receivable	(15,110.00)	(73,942.00)
(Increase)/Decrease in Prepaid Expenses	(5,816.67)	(28,523.21)
(Increase)/Decrease Other Assets	0.00	0.00
Increase/(Decrease) in Accounts Payable	56,263.56	96,675.44
Increase/(Decrease) in Accrued Expenses	63,256.29	65,240.03
Increase/(Decrease) in Estimated Medi-Cal Payable	0.00	(12,075.10)
Increase/(Decrease) in Deferred Revenue	(5,242.00)	(27,194.00)
Increase/(Decrease) in Other Board Approved Liability	0.00	0.00
Total Adjustments to Reconcile Change in Net Assets to Cash	8,265.71	156,551.14
Total Operating Activities	(3,038.15)	254,918.09
Cash Flows from Investing Activities		
Investing Activities		
Land Purchases & Sales	0.00	0.00
Building Improvements	0.00	(12,719.06)
Equipment Purchases & Disposals	(7,031.30)	(7,031.30)
Construction in Progress	(9,116.33)	(155,492.69)
Total Investing Activities	(16,147.63)	(175,243.05)
Total Cash Flows from Investing Activities	(16,147.63)	(175,243.05)
Cash Flows from Financing Activities		
Financing Activities		
Increase/(Decrease) in Notes Payable	0.00	0.00
Total Financing Activities	0.00	0.00
Total Cash Flows from Financing Activities	0.00	0.00
Prior Period Adj. to Net Assets	0.00	0.00
Net Increase(Decrease) in Cash	(19,185.78)	79,675.04
Cash at Beginning of Period	3,654,788.55	3,555,927.73
Cash at End of Period	3,635,602.77	3,635,602.77