

MINUTES OF THE CASWELL COUNTY BOARD OF HEALTH

The Caswell County Board of Health met at 7:00 P.M. on January 27, 2015 in the Caswell County Health Department's downstairs meeting room in Yanceyville, North Carolina.

ATTENDANCE:

Position	Name	Present	Not Present
County Commissioner	Nate Hall	X	
Pharmacist	Andrew Foster, Pharm. D, R.Ph.	X	
Dentist	Rose Satterfield, DMD	X	
Veterinarian	Christine Frenzel, DVM	X	
Physician (Gen. Pub.)	Cecil Page		X
Engineer (Gen. Pub.)	Jennifer White, RN	X	
Registered Nurse	Carla Lipscomb, RN	X	
Optometrist (Gen. Pub.)	Carl Carroll, RS, MBA	X	
General Public	Carol Komondy	X	
General Public	Elin Armeau-Claggett, PA-C, PhD	X	
General Public	Sharon Kupit		X

Others Present: Frederick Moore, MD – Health Director
 Sharon Hendricks – Finance Officer
 Jennifer Eastwood, MPH – QI Specialist

I. Call to Order

A. After a brief delay, the January 27, 2015 meeting of the Caswell County Board of Health was called to order by the Chair at 7:00 P.M.

II. Public Comment

A. None

III. Action Items

A. Approval of Minutes

A motion was made by Elin Armeau-Claggett and seconded by Christine Frenzel to approve the minutes of the Board of Health for November 25, 2014 and December 18, 2014. The motion was approved on a vote of 9 to 0.

B. Budget Amendment #6

1. The purpose of this amendment is to move funds from one expense line to another and to increase state funds by \$4,773 in the WIC and Family Planning programs and to increase the Administration program by \$2,977 to account for and unbudgeted refund check from last fiscal year. this Budget Amendment results in a net increase in the Health Department budget of \$7,750.

A motion was made by Nate Hall and seconded by Christine Frenzel to approve Budget Amendment #6 as presented. The motion was approved on a vote of 9 to 0.

IV. Informational Items

A. Board Of Health Training

1. Dr. Moore reminded the board that at the last meeting he had been instructed to try to set up Board of Health training. A tentative date for the training provided by the NCIPH is the June meeting of the Board of Health. In addition the board had requested that Health Department staff members give a brief update at each board meeting. Dr. Moore asked Jennifer Eastwood to provide an update about the agencies QI activities.
2. Jennifer Eastwood introduced herself as the agencies Q I Specialist and said that she had been working for the Health Department for 12 years. she started out as a health educator and has now transitioned into quality improvement.
3. she said that there were two components to a job. One part was Quality Assurance and the other is Quality Improvement. QA involves making sure the agency is compliant with rules and regulations and is following its policies. QI is a process that helps to improve

efficiency and productivity of the agency. Much of QI involves working with front-line staff to help them come up with solutions to routine problems. QI is a “bottom up” process rather than a “top down” process.

4. While QA has the potential to be punitive, QI uses tools to solve problems, improve efficiency and streamline processes. QI uses “lean” methodology which is a way of cutting out the waste. The state has provided training, called QI 101, that our health department has participated in. This training required many hours of work by many staff members and during the process we worked on a project to streamline our Adult Health clinic. In addition, Jennifer has participated in advanced QI training. We have also use some of these tools in our efforts to improve efficiency in Home Health.
5. Jennifer and then described the three of the many tools that are used in QI.
 - a. The first tool is called “5S” (Sort, Systematic arrangement, Spic and span, Standardize, Sustain). As a way of demonstrating the concept that organization improves efficiency, the board participated in an exercise of connecting the dots with different levels of organization, showing that the more organize the dots were the faster the process went.
 - b. The other tool is called “5 Whys”. It is an iterative question-asking technique used to explore the cause-and-effect relationships underlying a particular problem. The primary goal of the technique is to determine the root cause of a defect or problem. The “5” in the name derives from an empirical observation on the number of times you typically need to ask “Why?” in order to find the root cause of a problem.
 - c. PDSA (Plan, Do, Study, Act) is a tool and process used to systematically address a problem by taking small steps, seeing what the results are, and then taking another small step. This cycle is repeated as many times as is needed to solve the problem.
6. Dr. Moore told the board that a big part of Jennifer's job was to organize and lead our accreditation efforts in both Home Health and the Health Department as a whole. He felt like much of the success the Health Department has had in accreditation can be attributed to Jennifer's efforts.

B. Health Director Annual Evaluation

1. Dr. Moore told the board that the January meeting was typically used as the start of the Health Director's annual evaluation. The the forms that have being used for the last several years were included in the packet.
2. The Chair asked the board members to complete the form at home before the next meeting and the evaluation would be discussed at the February meeting.

C. Fiscal Year 2016 Budget

1. Dr. Moore asked the board and how they wanted to handle the budget process this year. He reviewed several ways that the board had worked on the budget in previous years. Dr. Moore said that he had not yet received budget instructions from the county finance office. The new County Manager has said there will be some changes in the process but we are not sure what those changes will be.
2. The consensus of the board was to have a draft budget presented to them at one meeting and then approve the budget at the next meeting after any changes have been made.
3. Elin Armeau-Claggett commented that during the budget process last year, the Health Department eliminated several large items from the budget before they got to the commissioners. She felt like we gave up too much. Dr. Moore said that he plans to put the big items that were removed last year back into the budget for next year.

D. Budget Status

1. Dr. Moore reviewed the budget status reports that were included in the packet. He said that the unearned revenue was being used faster than it should be but as a whole the Health Department was at 45% of expenses and 44% of revenue. He said that this bubble could burst when the unearned revenue has been used up. At the end of January the Health Department was showing \$32,000 of “excess” revenue.

2. Jennifer White asked if the delayed Medicaid in that was discussed several months previously had ever come in. Dr. Moore said that revenue arrives in “fits and starts” so it is difficult to tell exactly what has or has not come in. The agency works to bring in as much revenue as possible until it gets to the point where it has to be written off.
 3. Dr. Moore reviewed in detail the year to date budget sheets for the CAP and Home Health programs.
- E. Policies
1. Dr. Moore pointed out the board a group of policies in the packet that the Board of Health needs to approve annually. These policies were included in the packet so the board could review them over the next month and then there would be a vote at the February board meeting.
 2. Changes that staff are recommending have been highlighted. Jennifer Eastwood said that most of the changes were recommended by a state consultants who have reviewed these policies. On the whole, the recommended changes are relatively minor.
- F. Statistics
1. Dr. Moore reviewed the usual statistical reports that were included in the packet. He explained that the bottom graph on page 62 showed a major decrease in productivity in our CAP Program. He said that this was because we lost a staff member and we were now fully staffed and trying to climb back to the previous productivity level.
 2. Jennifer White asked about the “AR Greater Than 120 Days” graph on page 64. Dr. Moore agreed that the AAR had come down nicely on that graph but said that some of that was due to write offs rather than revenue coming in.
- G. Board of Commissioner Actions
1. Dr. Moore said the commissioners had approved the last two requests that the Board of Health had sent to them. One was the fee increase in Environmental Health and the other was the full-time physical therapy position. The minutes from the Commissioner meeting where the physical therapist position was discussed were included in the packet.
 2. Dr. Moore said that the physical therapy position had been advertised for several weeks and we have yet to get a single “nibble”. He told the board that Home Health was using a part-time, contract physical therapist at present but they were not providing as many hours as we wanted. The staffing agency has said they will try to get us some more hours.
- H. Other Business
1. Dr. reviewed several are other items included in the packet including a blog about the future of public health and the flu season progress. Dr. Moore commented that for whatever reason Caswell County had bypassed much of the flu season that hit the rest of the state.
 2. Jennifer White said that she had been elected to the Association of North Carolina Boards Of Health. She attended a meeting of this Association recently and shared several relevant items with the rest of the board.
 - a. She discussed some of the things the Institute of Medicine was doing for rural North Carolina counties.
 - b. She discussed some possible assistance in recruiting nurses to rural counties.
 - c. She also shared some issues surrounding the consolidation of human services in several counties. she said that so far the end result of consolidation has given Boards of Commissioners more power but there have been no significant cost savings.
 - d. She said that the ANCBH acted as an advocate for Boards of Health across the state. Dr. Moore commented that one of the most hands-on things this association does is participate in the Accreditation Board for Health Departments.
 3. Nate Hall asked if the board would consider moving its meeting up from 7 PM to 6 PM. The Chairman asked if this would be a problem with any of the board members present.

A motion was made by Nate Hall and seconded by Carl Carroll to permanently move the start of the regular Board of Health meeting to 6 PM. The motion was approved on a vote of 9 to 0.

4. Nate Hall said that he had recently attended a meeting of the North Carolina Association of County Commissioners.
 - a. An item that he wanted this association to advocate for was to require restrooms to be open in all public facilities during regular work hours. This issue was tabled, and one of the reasons given was that the matter may be able to be handled by the local Board of Health and thus avoid having to take it to the state level.
 - b. The situation that initially raised the concern was that during the last election restrooms were not available to the public at every polling place in Caswell County.
 - c. Dr. Moore was asked to investigate this possibility and bring the information back to the Board of Health. Dr. Moore said he would check with Jill Moore from the UNC School of Government.

V. Adjournment

- A. The Chair adjourned the meeting without objection.

Approved By: _____
Health Director

Date

Board of Health

Date

Health Director's Report – February 24, 2015

I. FY 2014-2015 Budget

A. Budget Status

1. We are now 58% of the way through the fiscal year and we have spent approximately 54% of the expense budget.
2. Also included in the packet is the more detailed report for the Home Health and CAP budgets.

B. Budget Amendment #7

1. This amendment moves funds from one expense line to another to cover expenses and it decreases state funds by \$2,563 in the Immunization program. It also increases Private Insurance revenue by \$2,500 and decreased Medicaid by the same amount to balance the budget.

II. FY 2015-2016 Budget

A. Statewide Budget Cuts

1. To set the tone for the budget discussion, I have included an email from another Health Director who took an informal survey of what cuts Health Departments have been dealing with over the last two years.
2. In summary there have been cuts in positions and programs across the state.

B. Budget time line for next fiscal year

1. I received the budget timeline from the County Finance Office on 2/16. I need to turn in some early information by March 6th and then present the full budget to the County Manager on 4/1. The commissioners want to receive a proposed budget on 4/20. This has shortened the process for the Health Department by a month.
2. This means that the Board of Health needs to discuss the draft budget at the February meeting and then approve a budget at the March meeting.

C. Fund Balance

1. We received the fund balance figures from the County Finance Office last week.
2. On June 30, 2014 the Health Department had a total Fund Balance of \$463,124.
3. I have included several reports that show where the fund balance comes from and how it compares to the last 15 years.

D. Budget Draft #1 Summary

1. At the last Board of Health meeting, comments were made encouraging the inclusion of some expensive items. The budget included in the packet is just the first draft. We have spent many hours working on this draft but there is more work to do and the Board of Health needs to provide some guidance and priorities.
2. Total Expenses Budget: \$2,884,908
3. Total Request of County Dollars: \$907,030

E. Budget Narrative

1. Copies of this draft budget are included in the packet and the discussion below includes the significant changes and potential changes in the budget.
2. Expenses
 - a. Capital
 - 1) Three trucks for Environmental Health staff.....\$75,000
 - 2) Restroom / shower for Environmental Health staff.....\$15,000
 - 3) Medical record scanning contract.....\$100,000
 - b. Personnel
 - 1) Includes the full time Physical Therapist Supervisor position. This replaces two RN positions.
 - 2) Includes the 4% salary increase for 7 employees coming off probation. Cost: \$10,596.
 - 3) New Medical Office Assistant position to replace a position lost in January. Cost: \$21,972
 - 4) Reclassification and increase of FTE of current employees. Cost:

\$37,311

3. Revenue
 - a. Earned revenue projections continue to decline. This has been the biggest budget issue over the last several years.
4. Unknown Issues
 - a. Possible FLSA changes to Exempt Employee criteria.
 - b. Board of Health stipend.
 - c. Possible new phone system.
 - d. Several long time employees have said they may be retiring either late this fiscal year or next fiscal year. Nothing yet has been provided in writing.
 - e. What impact will bringing the billing back in house and the cost cutting efforts have on revenue and expenses in Home Health.

III. Public Restroom Issue

- A. Included in the packet is a copy of my email communication with Jill Moore, an attorney with the UNC School of Government concerning the restroom we discussed at the last meeting.
- B. After listening to the last Board of Health meeting again, I realized I may not have asked Jill Moore the question I should have. I have sent her another email that I think asks the question more clearly and I am awaiting a reply.
- C. I have also included in the packet some other documents that may be relevant to the discussion.

IV. Policies

- A. Included in the packet are several policies for the board to vote on. These were provided in the packet for the January meeting your review.
 1. POL-ADM-ADM-005_Collections
 2. POL-ADM-ADM-008_Eligibility
 3. POL-ADM-GOV-001_Board of Health General Health Dept Policy
 4. POL-ADM-GOV-002_Board of Health Operating Procedures
 5. POL-ADM-GOV-003_Chain of Authority In H Dir Absence
 6. POL-ADM-GOV-004_Observing Public Health Law

V. Informational

- A. January Environmental Health statistics
- B. Flu Season Surveillance
- C. 2015 Smoking & Health Talking Points
- D. Caswell County Immunization Assessment
- E. Home Health and CAP Advisory Committee Minutes

CASWELL COUNTY HEALTH DEPARTMENT - FY 2014-2015

	Budget	Actual YTD	Balance	YTD = 58.33%	YTD Est Budg Variance
SALARY & BENEFITS SUB-TOTAL	2,064,379.00	1,144,294.48	920,084.52	55.43%	59,857.79
Board Expenses 120	0.00	0.00	0.00	0.00%	0.00
Salary 121	1,554,444.00	873,258.66	681,185.34	56.18%	33,448.53
Call 122	45,640.00	19,001.89	26,638.11	41.63%	7,619.92
Longevity 127	24,618.00	22,577.40	2,040.60	91.71%	2,040.60
SS / FICA 181	122,167.00	67,081.66	55,085.34	54.91%	4,178.35
Retirement 182	113,353.00	61,924.33	51,428.67	54.63%	4,194.47
Health Insurance 183	204,157.00	100,450.54	103,706.46	49.20%	18,634.24
OPERATIONAL SUB-TOTAL	909,945.00	455,367.87	454,577.13	50.04%	75,403.05
Contracted Services 199	424,363.00	224,639.72	199,723.28	52.94%	22,891.22
Food & Provisions 220	350.00	132.62	217.38	37.89%	71.54
Program Supplies 230	35,610.00	15,257.67	20,352.33	42.85%	5,513.64
Pharmaceuticals 238	49,626.00	16,865.51	32,760.49	33.99%	12,081.34
HH/CAP Med Supplies 239	192,808.00	102,734.09	90,073.91	53.28%	9,730.82
Office Supplies 260	9,220.00	8,616.28	603.72	93.45%	(3,238.25)
Small Tools & Equip. 295	14,743.00	7,067.39	7,675.61	47.94%	1,532.20
Mileage 311	104,245.00	42,433.48	61,811.52	40.71%	18,372.63
Travel Subsistence 312	5,182.00	1,473.62	3,708.38	28.44%	1,549.04
Telephone 321	10,219.00	5,564.73	4,654.27	54.45%	396.01
Postage 325	5,175.00	3,440.75	1,734.25	66.49%	(422.17)
Printing 340	3,113.00	2,233.99	879.01	71.76%	(418.18)
Maint & Repair 352	6,459.00	3,081.00	3,378.00	47.70%	686.53
Advertising 370	7,061.00	3,504.41	3,556.59	49.63%	614.27
Laundry 392	790.00	387.48	402.52	49.05%	73.33
Training 395	12,594.00	5,112.12	7,481.88	40.59%	2,233.96
Rental of Copier 431	9,000.00	5,409.76	3,590.24	60.11%	(160.06)
Rental of Post Meter 432	800.00	408.00	392.00	51.00%	58.64
Ins & Bonding 450	4,960.00	3,607.98	1,352.02	72.74%	(714.81)
Dues, Subsc. & Pub. 491	13,627.00	3,397.27	10,229.73	24.93%	4,551.36
Capital Outlay 500	0.00	0.00	0.00	0.00%	0.00
EXPENSES TOTAL	2,974,324.00	1,599,662.35	1,374,661.65	53.78%	135,260.84
REVENUE TOTAL	2,974,324.00	1,541,087.08	1,433,236.92	51.81%	(193,830.11)
STATE SUB-TOTAL	607,757.00	225,278.24	382,478.76	37.07%	(129,226.42)
(101) COUNTY APPROP	664,264.00	528,435.59	135,828.41	79.55%	140,970.40
(102) WCH FUND BAL	156,906.00	114,359.00	42,547.00	72.88%	22,835.73
(102) PPC FUND BAL	29,945.00	15,763.57	14,181.43	52.64%	(1,703.35)
OTHER SUB-TOTAL	851,115.00	658,558.16	192,556.84	77.38%	162,102.78
(102) MCD – REGULAR	939,800.00	395,621.25	544,178.75	42.10%	(152,564.09)
(102) MCD – SETTLEMENT	0.00	0.00	0.00	0.00%	0.00
(103) MCR – REGULAR	450,500.00	191,957.12	258,542.88	42.61%	(70,819.53)
(103) MCR – HMO	35,000.00	14,280.40	20,719.60	40.80%	(6,135.10)
(103) PRIVATE INS	25,675.00	23,638.52	2,036.48	92.07%	8,662.29
(103) DIRECT FEES	64,477.00	31,753.39	32,723.61	49.25%	(5,856.04)
EARNED SUB-TOTAL	1,515,452.00	657,250.68	858,201.32	43.37%	(226,712.47)
BALANCE	0.00	-58,575.27			

Actual (Includes Receipt of State Delay) 20,230.62

	ACTUAL	BUDGET	BALANCE	YTD %
45,555.75	57,549.00	45,551.25	56.02%	
37,882.52	73,700.00	35,817.48	51.40%	
257.18	707.00	449.82	36.38%	
2,803.05	6,008.00	3,204.95	46.69%	
2,886.49	5,618.00	2,921.51	48.00%	
5,349.51	11,907.00	6,557.49	44.93%	
24,645.22	39,090.00	14,444.78	63.05%	
9.00	1,500.00	1,491.00	0.60%	
21,425.37	30,629.00	9,203.63	69.95%	
851.64	852.00	0.36	99.96%	
0.00	500.00	500.00	0.00%	
1,142.75	4,293.00	3,150.25	26.62%	
597.11	620.00	22.89	96.31%	
25.00	100.00	75.00	25.00%	
140.60	141.00	0.40	99.72%	
453.75	455.00	1.25	99.73%	
73,633.97	137,030.00	63,396.03	53.74%	

82,544.69	137,939.00	54,488.31	60.24%
20,805.01	26,030.00	5,224.99	79.93%
61,739.68	111,000.00	49,260.32	55.62%

419,366.65	781,984.00	362,617.35	53.53%
323,453.53	591,616.00	268,162.47	54.67%
11,249.89	27,283.00	16,033.11	41.23%
6,884.55	6,885.00	0.45	99.99%
25,275.45	47,717.00	22,441.55	52.97%
22,392.28	41,323.00	18,930.72	54.19%
30,130.95	67,180.00	37,049.05	44.85%
214,284.90	415,107.00	203,822.10	51.25%
99,414.04	170,511.00	71,096.96	56.30%
132.62	300.00	167.38	44.21%
81,308.72	162,179.00	80,870.28	50.14%
851.64	852.00	0.36	99.96%
0.00	500.00	500.00	0.00%
29,723.18	72,766.00	43,042.82	40.85%
6.00	500.00	494.00	1.20%
825.00	1,199.00	374.00	68.81%
245.85	500.00	280.01	44.00%
143.79	1,500.00	1,356.21	9.59%
565.12	2,000.00	1,434.88	28.26%
848.95	5,000.00	4,151.05	16.98%
633,651.55	1,200,091.00	566,439.45	52.80%

	JUN	JUL	AUG	SEP	OCT	NOV	DEC	JAN
0.00	8,347.18	7,978.58	6,705.06	4,945.67	4,214.83	5,513.10	11,283.31	
0.00	6,431.40	6,197.71	5,356.00	3,615.78	3,221.01	3,996.98	8,961.64	
0.00	0.00	0.00	0.00	0.00	0.00	257.18	0.00	
0.00	462.21	447.01	330.48	275.12	232.13	333.48	662.63	
0.00	454.70	438.18	379.81	269.78	227.73	300.77	626.52	
0.00	998.97	896.68	577.80	564.99	533.96	624.69	1,132.52	
0.00	2,871.42	3,283.82	7,912.52	3,112.05	4,332.97	2,022.22	1,110.32	
0.00	0.00	4.00	0.00	0.00	0.00	0.00	5.00	
0.00	2,742.00	2,781.29	7,389.67	2,925.62	3,114.37	1,546.09	916.33	
0.00	0.00	0.00	0.00	0.00	851.64	0.00	0.00	
0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	
0.00	0.00	347.93	284.15	186.43	119.36	135.52	69.36	
0.00	119.42	0.00	238.70	0.00	0.00	119.36	119.63	
0.00	10.00	0.00	0.00	0.00	0.00	15.00	0.00	
0.00	0.00	140.60	0.00	0.00	0.00	0.00	0.00	
0.00	0.00	0.00	0.00	0.00	247.50	206.25	0.00	
0.00	11,218.60	11,263.40	14,617.60	8,057.72	8,547.70	7,535.32	12,393.63	
0.00	6,659.40	15,622.60	14,617.60	9,381.98	7,243.44	24,176.65	4,663.02	
0.00	6,659.40	4,032.68	2,869.49	0.00	7,243.44	0.00	0.00	
0.00	0.00	11,789.92	11,748.11	9,367.98	0.00	24,176.65	4,663.02	

54,430.05	60,702.11	48,851.51	64,377.33	60,689.35	70,712.36	69,823.92
42,279.44	39,725.69	37,829.69	50,325.49	47,671.49	49,693.57	55,938.16
1,922.00	1,602.00	1,860.00	1,661.99	1,224.00	1,568.00	1,202.00
0.00	0.00	0.00	0.00	0.00	6,864.55	0.00
3,286.92	3,072.80	2,954.09	3,841.81	3,685.57	4,292.48	4,241.98
0.00	2,969.98	2,650.92	3,420.51	3,769.11	3,798.12	3,738.12
0.00	3,971.71	3,650.70	3,564.40	4,927.89	4,977.98	4,544.67
0.00	65,063.45	27,192.54	31,908.91	17,860.73	35,717.26	18,410.95
0.00	48,703.80	13,400.12	8,931.54	4,149.17	16,030.58	4,675.46
0.00	0.00	67.26	0.00	50.00	15.36	0.00
0.00	15,888.80	7,330.89	16,553.90	8,252.40	13,545.73	8,426.36
0.00	0.00	0.00	0.00	0.00	851.64	0.00
0.00	0.00	0.00	0.00	0.00	0.00	0.00
0.00	0.00	5,786.53	5,338.47	4,879.04	5,167.95	4,584.14
0.00	0.00	125.00	125.00	100.00	100.00	125.00
0.00	100.00	0.00	0.00	0.00	0.00	119.99
0.00	245.85	0.00	0.00	0.00	0.00	0.00
0.00	0.00	143.79	0.00	0.00	0.00	0.00
0.00	0.00	0.00	0.00	130.12	0.00	0.00
0.00	0.00	338.95	0.00	0.00	0.00	435.00
0.00	119,493.50	77,894.55	79,839.42	82,038.06	96,366.61	89,123.33
0.00	34,375.74	98,239.39	102,689.72	79,901.75	76,607.57	93,782.97
0.00	90,983.24	46,682.01	38,939.68	0.78	27,855.49	4,724.01
28,327.79	0.00	33,118.48	20,343.99	41,052.86	18,813.71	41,121.95
6,047.95	2,743.07	19,937.09	17,095.72	62,300.10	26,262.11	44,547.16
0.00	3,685.08	3,172.14	2,346.88	0.00	311.99	3,633.61
0.00	628.00	0.00	855.39	1,563.25	4,072.56	2,771.86
0.00	0.00	0.00	318.09	0.00	675.00	276.00
0.00	0.00	0.00	0.00	0.00	0.00	0.00

80	REVENUE	34,375.74	98,239.39	102,689.72	79,901.75	76,607.57	93,782.97	80,184.23
88	(101) COUNTY APPROP	0.00	90,983.24	46,682.01	38,939.68	0.78	27,855.49	4,724.01
89	(102) MCD - REGULAR	28,327.79	0.00	33,118.48	20,343.99	41,052.86	18,813.71	41,121.95
90	(103) MCR - REGULAR	6,047.95	2,743.07	19,937.09	17,095.72	62,300.10	26,262.11	44,547.16
91	(103) MCR - HMO	0.00	3,685.08	3,172.14	2,346.88	0.00	311.99	3,633.61
92	(103) PRIVATE INS	0.00	628.00	0.00	855.39	1,563.25	4,072.56	2,771.86
93	(103) DIRECT FEES	0.00	0.00	0.00	318.09	0.00	675.00	276.00

CASWELL COUNTY BUDGET AMENDMENT # _____
Health Department Amendment # 7

Be it ordained, the FY 2014-2015 Annual Budget Ordinance is hereby amended as follows:

PUBLIC HEALTH - 5110

<i>Expenditure Line</i>	<i>Account Code</i>	<i>Increase / (Decrease)</i>	<i>Amended Budget</i>
Salary 121	100.5110.121.000	\$6,954.00	\$1,554,444.00
Longevity 127	100.5110.127.000	(\$392.00)	\$24,618.00
SS / FICA 181	100.5110.181.000	(\$3,783.00)	\$122,167.00
Retirement 182	100.5110.182.000	(\$1,902.00)	\$113,353.00
Health Insurance 183	100.5110.183.000	\$1.00	\$204,157.00
Contracted Services 199	100.5110.199.000	(\$235.00)	\$424,363.00
Program Supplies 230	100.5110.230.000	(\$1,515.00)	\$35,610.00
Pharmaceuticals 238	100.5110.238.000	\$1,386.00	\$49,626.00
Mileage 311	100.5110.311.000	(\$449.00)	\$104,245.00
Travel Subsistence 312	100.5110.312.000	\$94.00	\$5,182.00
Telephone 321	100.5110.321.000	\$120.00	\$10,219.00
Postage 325	100.5110.325.000	\$24.00	\$5,175.00
Printing 340	100.5110.340.000	\$15.00	\$3,113.00
Advertising 370	100.5110.370.000	(\$7.00)	\$7,061.00
Laundry 392	100.5110.392.000	\$10.00	\$790.00
Training 395	100.5110.395.000	(\$2,884.00)	\$12,594.00
TOTAL EXPENSE BUDGET:		(\$2,563.00)	\$2,974,324.00

<i>Revenue Lines</i>	<i>Account Code</i>	<i>Increase / (Decrease)</i>	<i>Amended Budget</i>
State - Public Health	100.3510.360.000	(\$2,563.00)	\$607,757.00
Medicaid - Public Health	100.3510.421.008	(\$2,500.00)	\$939,800.00
Private Insurance	100.3510.420.008	\$2,500.00	\$25,675.00
TOTAL REVENUE BUDGET:		(\$2,563.00)	\$2,974,324.00

Justification:

To move funds from one expense line to another to cover expenses and decrease state funds by \$2,563 in Immunization funds. Private Insurance revenue was increased by \$2,500 to use revenue that has come in at a greater than expected amount. Medicaid revenue was decreased by the same amount to prevent an increase in the total budget.

That all Ordinances or portions of Ordinances in conflict are hereby repealed.

 Approved by Health Director

 Date

 Approved by Board of Health

 Date

 Paula Seamster, Clerk to the Board

 Date

Approved by the Caswell County Board of Commissioners

Subject: [NHealthdirectors] FW: staff/program cuts
From: Colleen Bridger <cbridger@orangecountync.gov>
Date: 2/11/2015 1:49 PM
To: "Local Health Directors (Nhealthdirectors@ncapha.org)" <Nhealthdirectors@ncapha.org>
CC: "Danny Staley \\\(Danny.Staley@dhhs.nc.gov\\)" <Danny.Staley@dhhs.nc.gov>

Thanks for sending me your updated information on budget/program/position cuts. At their request, I will be sharing this information with the NC County Commissioner's Association.

I've now heard from 30 Health Departments who cut staff/programs. Note: I added the recent data to the information I collected in August to come up with these totals. They are not in addition to what I sent out in August.

In total local health departments cut approximately 242 FTEs from their ranks in the last two years.

Specifically:

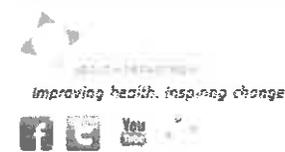
- 127 Home Health positions
- 14 Environmental Health positions
- 9 Social work positions
- 22.5 nurse/midlevel positions
- 69.5 other positions to include health educators, animal control officers, preparedness coordinators, administrative staff, physicians/dentists etc...

Also during these last two years these Health Departments eliminated 16 programs

Specifically:

- Vector Control (3 Departments)
- Dental Clinic (5 Departments)
- Tobacco Prevention (4 Departments)
- OB delivery services
- Asthma prevention
- Prenatal care (outsourced to FQHC)
- Teen Pregnancy prevention
- Animal Control (only do state mandates of rabies and dangerous dogs)
- Baby Love Plus
- Dental Hygiene (2 Departments)
- Home Health (2 Departments)
- Child Health (outsourced)
- Preparedness (outsourced)
- Child Care Health Consultant
- Primary Care

Colleen Bridger, MPH, PhD
Orange County Health Director
Phone: 919.245.2412 / Cell: 919.612.2053



From: Nhealthdirectors [mailto:nhealthdirectors-bounces@ncapha.org] **On Behalf Of** Colleen Bridger
Sent: Tuesday, August 19, 2014 11:33 AM
To: Local Health Directors (Nhealthdirectors@ncapha.org)
Cc: Penny Slade-Sawyer (penelope.slade-sawyer@dhhs.nc.gov); Danny Staley (Danny.Staley@dhhs.nc.gov)
Subject: [NHealthdirectors] staff/program cuts

Hi folks- this is my last email to the list serve today I promise!

Here are the results from the survey I sent out asking about staff/program cuts. I heard from 25 Health Departments who had cut staff/programs

In total these local health departments cut approximately 200 FTEs from their ranks in the last two years.

Specifically:

- 127 Home Health positions
- 14 Environmental Health positions
- 9 Social work positions
- 22.5 nurse/midlevel positions
- 69.5 other positions to include health educators, animal control officers, preparedness coordinators, administrative staff, physicians/dentists etc...

Also during these last two years these Health Departments eliminated 16 programs Specifically:

- Vector Control (3 Departments)
- Dental Clinic (5 Departments)
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- Animal Control (only do state mandates of rabies and dangerous dogs)
- Baby Love Plus
- Dental Hygiene (2 Departments)
- Home Health (2 Departments)
- Child Health (outsourced)
- Preparedness (outsourced)
- Child Care Health Consultant
- Primary Care

Multiple counties talked about budget cuts in terms of "lost half our county funding".

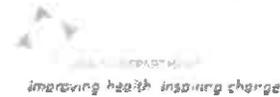
I guess I'm glad I know this, but man is it depressing. If this email reminds you that you meant to send me your county's staff cut info but didn't, please continue to do so. I can update this pretty easily.

Thanks to those of you who sent me this information. Please keep your chins up...things have got to get better!

Colleen Bridger, MPH, PhD

Orange County Health Director

Phone: 919.245.2412 / Cell: 919.612.2053



Nhealthdirectors mailing list
Nhealthdirectors@ncapha.org
<https://pairlist2.pair.net/mailman/listinfo/nhealthdirectors>

Attachments:

ATT00001.txt

171 bytes

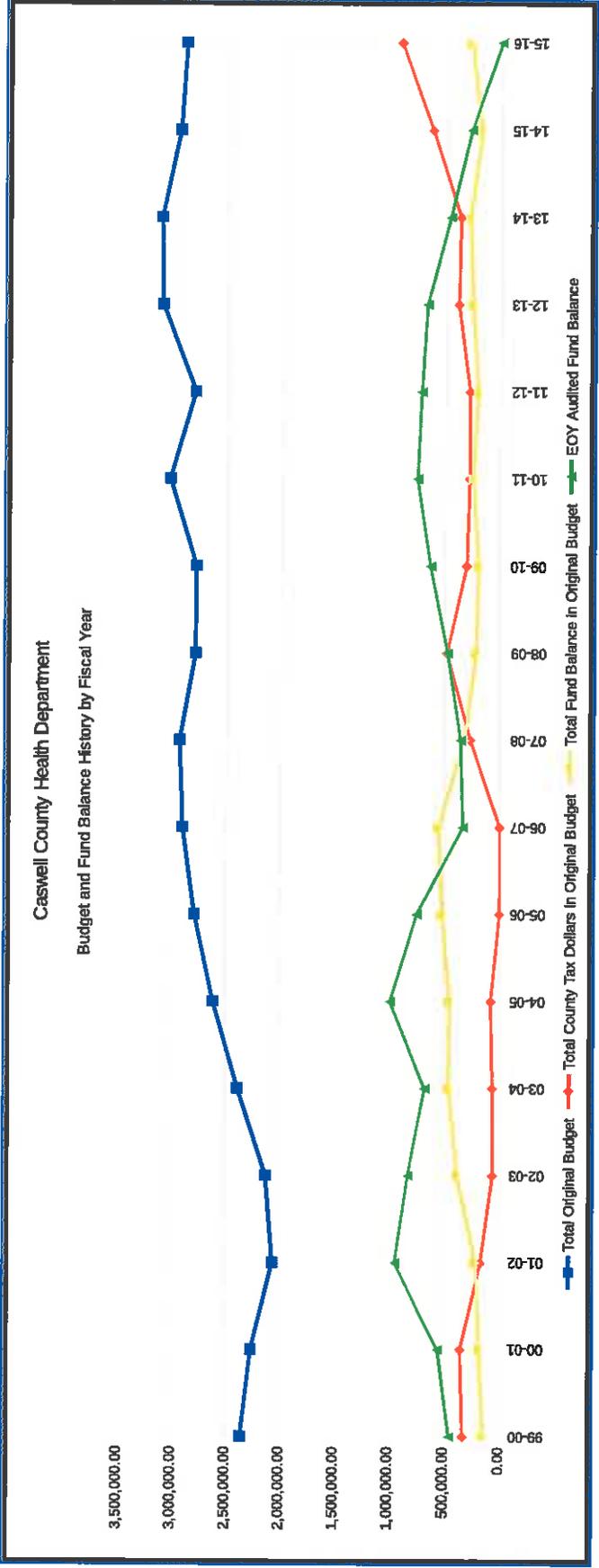
CCHD FY 13 - 14		WCH FUND BALANCE							TOTAL
Fund Balance Report		Child Hlth	CSC	CC4C	OBCM	Fam. Plan	Mat. H.	TOTAL	
Fund Bal. At Beginning Of FY 13 - 14		87,146.00	180,700.00	10,471.00	3,550.00	-	-	281,867.00	
Expense									
EOY Total Expenses		163,976.24		42,104.37	62,825.31	172,849.44	102,878.96	544,634.32	
Revenue									
State		31,056.84				67,636.73	9,566.43	108,260.00	
Local Tax Appropriation		12,116.00			12,049.00		14,495.00	38,660.00	
Medicaid		67,943.69		39,835.64	47,486.14	45,932.92	28,236.93	229,435.32	
Medicaid Settlement		65,133.00				41,449.00	39,535.00	146,117.00	
Medicare									
Medicare HMO									
Private Insurance		393.45				1,491.44	19.39	1,904.28	
Direct Fees		190.00				1,663.20	565.00	2,418.20	
Unused									
FB Used In Other Program (Manual Entry)			-10,000.00					-10,000.00	
Total Revenue		176,832.98	(10,000.00)	39,835.64	59,535.14	158,173.29	92,417.75	516,794.80	
EOY Net Gain/Loss		12,856.74	(10,000.00)	(2,268.73)	(3,290.17)	(14,676.15)	(10,461.21)	(27,839.52)	
HH Fund Balance Used Outside Prog.		-	-	-	-	-	-	-	
WCH Fund Balance Used Outside Prog.		-	-	-	-	-	-	-	
PPC Fund Balance Used Outside Prog.		-	-	-	-	-	-	-	
Balance Adjustment			(25,137.36)			14,676.15	10,461.21	(0.00)	
Un-Audited EOY Fnd Bal FY 13 - 14		100,002.74	145,562.64	8,202.27	299.83	-	-	254,027.48	
%		24.95%	36.32%	2.05%	0.06%	0.00%	0.00%	63.38%	
Audited, Total Fund Balance									
Adjusted & Audited Final FB EOY FY 13 - 14		115,544.00	168,184.00	9,477.00	300.00	-	-	293,505.00	
FY 14-15									
Amount Budgeted FY 14-15									
WCH		71,565.00			2,000.00	37,436.00	45,905.00	156,906.00	
CC4C								-	
OBCM								-	
PPC								-	
Unrestricted								-	
Total Fund Bal. Budgeted Into FY 14-15		71,565.00	-	-	2,000.00	37,436.00	45,905.00	156,906.00	
Unencumbered FB EOY FY 14-15		43,979.00	168,184.00	9,477.00	(1,700.00)	(37,436.00)	(45,905.00)	136,599.00	

INDIVIDUAL PROGRAM FUND BALANCE UNRESTRICTED BUND BALANCE									
Fund Balance Report	CAP	Admin.	Adult Hlth	Env. Health	PHP	H Hlth	TOTAL		
Fund Bal. At Beginning Of FY 13 - 14	-	-	-	-	-	297,140.00	384,917.00		
Expense									
EOY Total Expenses	159,450.58	327,472.02	171,217.13	220,438.00	28,979.76	1,123,940.02	2,348,292.79		
Revenue									
State		287,307.68		7,124.00	29,019.76		462,688.97		
Local Tax Appropriation		20,174.00	86,488.00	163,713.00		30,139.00	363,055.00		
Medicaid	128,357.30		27,575.51			439,147.10	667,629.95		
Medicaid Settlement			33,986.00				81,494.00		
Medicare						420,721.45	420,721.45		
Medicare HMO						30,368.51	30,368.51		
Private Insurance			2,405.70			13,873.46	16,806.09		
Direct Fees		68.35	4,571.74	47,667.26		3,638.88	57,416.23		
Unused									
FB Used In Other Program (Manual Entry)						-86,092.34	-91,092.34		
Total Revenue	128,357.30	307,550.03	155,026.95	218,504.26	29,019.76	851,796.06	2,009,087.86		
EOY Net Gain/Loss	(31,093.28)	(19,921.99)	(16,190.18)	(1,933.74)	40.00	(272,143.96)	(339,204.93)		
HH Fund Balance Used Outside Prog.	31,093.28	5,000.00	49,999.06	-	-	-	86,092.34		
WCH Fund Balance Used Outside Prog.	-	10,000.00	-	-	-	-	10,000.00		
PPC Fund Balance Used Outside Prog.	-	5,000.00	-	-	-	-	5,000.00		
Balance Adjustment	-	(78.01)	(33,808.88)	1,933.74	-	73,622.12	-		
Un-Audited EOY Fnd Bal FY 13 - 14	-	-	-	-	40.00	98,618.16	146,804.41		
%	0.00%	0.00%	0.00%	0.00%	0.01%	24.60%	36.62%		
Audited, Total Fund Balance									
Adjusted & Audited Fnd Bal EOY FY 13 - 14	-	-	-	-	46.00	113,944.00	159,619.00		
FY 14-15									
Amount Budgeted FY 14-15									
WCH	-	-	-	-	-	-	-		
CCAC	-	-	-	-	-	-	-		
OBCM	-	-	-	-	-	-	-		
PPC	-	-	-	-	-	-	-		
Unrestricted	-	-	-	-	-	-	-		
Total Fund Bal. Budgeted Into FY 14-15	-	-	-	-	-	-	-		
Unencumbered FB EOY FY 14-15	-	-	-	-	46.00	113,944.00	139,674.00		

Caswell County Health Department Recent Budget & Fund Balance History

Fiscal Year	Original Budget		County Tax Dollars		Fund Balance	
	Total Original Budget	% Change From Prior FY	Total County Tax Dollars In Original Budget	% of Budget	Total Fund Balance In Original Budget	% of Budget
99-00	2,344,628.00	0.00%	315,625.00	13.46%	131,000.00	5.59%
00-01	2,250,377.00	-4.02%	339,241.00	15.07%	169,373.00	7.53%
01-02	2,056,049.00	-8.64%	159,828.00	7.77%	204,183.00	9.93%
02-03	2,120,474.00	3.13%	53,019.00	2.50%	371,356.00	17.51%
03-04	2,395,359.00	12.49%	57,468.00	2.41%	451,254.00	18.92%
04-05	2,611,872.00	9.50%	74,804.00	2.86%	444,230.00	17.01%
05-06	2,787,941.00	6.74%	0.00	0.00%	517,505.00	18.56%
06-07	2,896,919.00	3.91%	0.00	0.00%	549,750.00	18.98%
07-08	2,925,271.00	0.98%	269,957.00	9.23%	322,146.00	11.01%
08-09	2,782,496.00	-4.88%	481,769.00	17.31%	219,148.00	7.88%
09-10	2,778,888.00	-0.13%	308,421.00	11.10%	195,350.00	7.03%
10-11	3,021,153.00	8.72%	285,253.00	9.44%	251,909.00	8.34%
11-12	2,790,669.00	-7.63%	285,253.00	10.22%	204,966.00	7.34%
12-13	3,093,245.00	10.84%	387,076.00	12.51%	256,526.00	8.29%
13-14	3,105,817.00	0.41%	371,576.00	11.96%	286,046.00	9.21%
14-15	2,934,771.00	-5.51%	622,879.00	21.22%	176,942.00	6.03%
15-16	2,884,908.00	-1.70%	907,030.00	31.44%	276,227.00	9.57%

Budgeted FB + County Tax Dollars	Variance From Average	% of Orig Budget
446,625.00	(\$138,499.12)	19%
508,614.00	(\$76,510.12)	23%
364,011.00	(\$221,113.12)	18%
424,375.00	(\$160,749.12)	20%
508,722.00	(\$76,402.12)	21%
519,034.00	(\$66,090.12)	20%
517,505.00	(\$67,619.12)	19%
549,750.00	(\$35,314.12)	19%
592,103.00	\$6,978.88	20%
700,917.00	\$115,792.88	25%
503,771.00	(\$81,353.12)	18%
537,162.00	(\$47,962.12)	18%
490,219.00	(\$94,905.12)	18%
643,602.00	\$58,477.88	21%
657,622.00	\$72,497.88	21%
799,821.00	\$214,696.88	27%
1,183,257.00	\$598,132.88	41%
585,124.12 = Average		



		1	2	3	4	5
Net --		0.00	0.00	0.00	0.00	0.00
		ADM	HP	PHP	EH	CAP
REVENUE						
82	TOTAL STATE GRANTS	280,080.00	26,831.00	30,720.00	0.00	0.00
83	Medicaid	0.00	0.00	0.00	0.00	106,243.00
84	Medicare	0.00	0.00	0.00	0.00	0.00
85	MCR-HMO	0.00	0.00	0.00	0.00	0.00
86	Private Ins.	0.00	0.00	0.00	0.00	0.00
87	Direct Fees	100.00	0.00	0.00	45,000.00	0.00
89	County Tax Appropriation	102,623.00	0.00	0.00	255,129.00	0.00
90	WCH Fund Balance	0.00	0.00	0.00	0.00	0.00
91	HH Fund Balance	0.00	0.00	0.00	0.00	0.00
92	PC Fund Balance	0.00	0.00	0.00	0.00	0.00
93	TB Fund Balance	0.00	0.00	0.00	0.00	0.00
99	TOTAL NON-STATE REVENUE	102,723.00	0.00	0.00	300,129.00	106,243.00
100	GRAND TOTAL REVENUE	382,803.00	26,831.00	30,720.00	300,129.00	106,243.00
EXPENSES						
1	Board Salary & Expenses (120)	4,800.00	0.00	0.00	0.00	0.00
2	Salaries (121)	6,123.00	12,887.00	17,113.00	149,005.00	76,403.00
3	On Call (122)	0.00	0.00	0.00	0.00	0.00
4	Longevity (127)	89.00	52.00	74.00	2,937.00	585.00
5	SS/FICA (181)	476.00	990.00	1,315.00	11,624.00	5,890.00
6	Retirement (182)	415.00	863.00	1,147.00	10,135.00	5,136.00
7	Health Ins. (183)	1,160.00	2,320.00	3,083.00	18,528.00	13,729.00
8	Other	0.00	0.00	0.00	0.00	0.00
13	TOTAL SALARY & BENEFITS	13,063.00	17,112.00	22,732.00	192,229.00	101,743.00
14	Contracted Services (199)	215,000.00	500.00	0.00	2,000.00	50.00
15	Food & Provisions (220)	0.00	0.00	0.00	0.00	0.00
16	Program Supplies (230)	0.00	7,219.00	5,688.00	5,000.00	0.00
17	Pharmaceuticals (238)	0.00	0.00	0.00	0.00	0.00
18	HH/CAP Medical Supplies (239)	0.00	0.00	0.00	0.00	0.00
19	Office Supplies (260)	7,000.00	0.00	0.00	0.00	0.00
20	Small Tools/Equipment (295)	8,000.00	0.00	0.00	750.00	0.00
21	Travel Mileage (311)	1,100.00	1,500.00	1,500.00	5,000.00	3,000.00
22	Travel Subsistence (312)	400.00	0.00	500.00	1,200.00	0.00
23	Telephone (321)	7,100.00	0.00	0.00	900.00	1,200.00
24	Postage (325)	140.00	0.00	50.00	1,200.00	50.00
25	Printing (340)	2,500.00	0.00	0.00	100.00	150.00
26	Maintenance & Repair (352)	5,000.00	0.00	0.00	300.00	0.00
27	Advertising (370)	0.00	0.00	0.00	300.00	50.00
28	Laundry & Dry Cleaning (392)	0.00	0.00	0.00	0.00	0.00
29	Training/Employee Ed. Exp. (395)	1,500.00	500.00	250.00	1,000.00	0.00
30	Rental of Copier (431)	10,000.00	0.00	0.00	0.00	0.00
31	Rental of Postage Meter (432)	0.00	0.00	0.00	0.00	0.00
32	Insurance & Bonding (450)	4,000.00	0.00	0.00	0.00	0.00
33	Dues & Subscriptions (491)	8,000.00	0.00	0.00	150.00	0.00
34	Capital Outlay (550)	100,000.00	0.00	0.00	90,000.00	0.00
49	TOT. OPERATING EXPENSES	369,740.00	9,719.00	7,988.00	107,900.00	4,500.00
50	GRAND TOTAL	382,803.00	26,831.00	30,720.00	300,129.00	106,243.00

	6	9	10	11	12	
Net →	0.00	0.00	0.00	0.00	0.00	
	HH	CC4C	CD	CH	FP	
REVENUE						
82	TOTAL STATE GRANTS	0.00	691.00	10,911.00	28,262.00	66,396.00
83	Medicaid	300,000.00	35,000.00	0.00	40,000.00	37,000.00
84	Medicare	340,000.00	0.00	0.00	0.00	0.00
85	MCR-HMO	25,000.00	0.00	0.00	0.00	0.00
86	Private Ins.	20,078.00	0.00	0.00	2,000.00	5,500.00
87	Direct Fees	2,000.00	0.00	0.00	300.00	1,000.00
89	County Tax Appropriation	124,056.00	0.00	2,165.00	40,646.00	10,295.00
90	WCH Fund Balance	0.00	2,713.00	0.00	66,677.00	67,209.00
91	HH Fund Balance	113,944.00	0.00	0.00	0.00	0.00
92	PC Fund Balance	0.00	0.00	0.00	0.00	0.00
93	TB Fund Balance	0.00	0.00	0.00	0.00	0.00
99	TOTAL NON-STATE REVENUE	925,078.00	37,713.00	2,165.00	148,623.00	121,004.00
100	GRAND TOTAL REVENUE	925,078.00	38,404.00	13,076.00	177,885.00	187,400.00

EXPENSES						
1	Board Salary & Expenses (120)	0.00	0.00	0.00	0.00	0.00
2	Salaries (121)	513,143.00	28,150.00	9,590.00	113,788.00	106,328.00
3	On Call (122)	23,998.00	0.00	0.00	0.00	0.00
4	Longevity (127)	4,432.00	6.00	375.00	2,331.00	2,251.00
5	SS/FICA (181)	41,431.00	2,154.00	763.00	8,920.00	8,380.00
6	Retirement (182)	34,943.00	1,878.00	665.00	7,549.00	7,079.00
7	Health Ins. (183)	61,831.00	4,500.00	1,008.00	14,992.00	13,952.00
8	Other	0.00	0.00	0.00	480.00	960.00
13	TOTAL SALARY & BENEFITS	679,778.00	36,688.00	12,401.00	148,060.00	138,950.00
14	Contracted Services (199)	75,000.00	75.00	150.00	20,500.00	6,000.00
15	Food & Provisions (220)	300.00	0.00	0.00	0.00	0.00
16	Program Supplies (230)	0.00	691.00	0.00	2,200.00	4,000.00
17	Pharmaceuticals (238)	0.00	0.00	0.00	3,000.00	35,000.00
18	HH/CAP Medical Supplies (239)	100,000.00	0.00	0.00	0.00	0.00
19	Office Supplies (260)	500.00	100.00	0.00	0.00	0.00
20	Small Tools/Equipment (295)	0.00	0.00	0.00	0.00	100.00
21	Travel Mileage (311)	60,000.00	750.00	200.00	250.00	200.00
22	Travel Subsistence (312)	200.00	0.00	200.00	100.00	200.00
23	Telephone (321)	1,500.00	0.00	0.00	0.00	0.00
24	Postage (325)	500.00	100.00	50.00	600.00	400.00
25	Printing (340)	300.00	0.00	0.00	0.00	125.00
26	Maintenance & Repair (352)	0.00	0.00	0.00	0.00	250.00
27	Advertising (370)	1,500.00	0.00	0.00	2,000.00	1,000.00
28	Laundry & Dry Cleaning (392)	0.00	0.00	25.00	150.00	125.00
29	Training/Employee Ed. Exp. (395)	1,500.00	0.00	50.00	1,000.00	1,000.00
30	Rental of Copier (431)	0.00	0.00	0.00	0.00	0.00
31	Rental of Postage Meter (432)	0.00	0.00	0.00	0.00	0.00
32	Insurance & Bonding (450)	0.00	0.00	0.00	0.00	0.00
33	Dues & Subscriptions (491)	4,000.00	0.00	0.00	25.00	50.00
34	Capital Outlay (550)	0.00	0.00	0.00	0.00	0.00
49	TOT. OPERATING EXPENSES	245,300.00	1,716.00	675.00	29,825.00	48,450.00
50	GRAND TOTAL	925,078.00	38,404.00	13,076.00	177,885.00	187,400.00

		13	14	15	16	17
Net -		0.00	0.00	0.00	0.00	0.00
		MH	PC	PCM	STI	TB
REVENUE						
82	TOTAL STATE GRANTS	15,743.00	0.00	0.00	2,035.00	2,242.00
83	Medicaid	16,000.00	75,000.00	44,000.00	4,500.00	75.00
84	Medicare	0.00	0.00	0.00	0.00	0.00
85	MCR-HMO	0.00	0.00	0.00	0.00	0.00
86	Private Ins.	5,000.00	5,000.00	0.00	1,200.00	280.00
87	Direct Fees	300.00	5,500.00	0.00	0.00	570.00
89	County Tax Appropriation	60,288.00	244,421.00	12,102.00	49,720.00	5,533.00
90	WCH Fund Balance	0.00	0.00	0.00	0.00	0.00
91	HH Fund Balance	0.00	0.00	0.00	0.00	0.00
92	PC Fund Balance	0.00	21,497.00	0.00	0.00	0.00
93	TB Fund Balance	0.00	0.00	0.00	0.00	4,187.00
99	TOTAL NON-STATE REVENUE	81,588.00	351,418.00	56,102.00	55,420.00	10,645.00
100	GRAND TOTAL REVENUE	97,331.00	351,418.00	56,102.00	57,455.00	12,887.00
EXPENSES						
1	Board Salary & Expenses (120)	0.00	0.00	0.00	0.00	0.00
2	Salaries (121)	68,124.00	240,749.00	41,907.00	36,333.00	8,837.00
3	On Call (122)	0.00	15,999.00	0.00	0.00	0.00
4	Longevity (127)	1,559.00	4,205.00	6.00	822.00	269.00
5	SS/FICA (181)	5,347.00	20,116.00	3,207.00	2,870.00	697.00
6	Retirement (182)	4,662.00	16,868.00	2,796.00	2,363.00	608.00
7	Health Ins. (183)	8,214.00	32,331.00	6,736.00	4,158.00	1,176.00
8	Other	200.00	2,000.00	0.00	360.00	0.00
13	TOTAL SALARY & BENEFITS	88,106.00	332,268.00	54,652.00	46,906.00	11,587.00
14	Contracted Services (199)	1,000.00	6,000.00	100.00	3,000.00	450.00
15	Food & Provisions (220)	50.00	0.00	0.00	0.00	0.00
16	Program Supplies (230)	2,000.00	4,000.00	0.00	5,000.00	50.00
17	Pharmaceuticals (238)	1,000.00	6,000.00	0.00	1,074.00	400.00
18	HH/CAP Medical Supplies (239)	0.00	0.00	0.00	0.00	0.00
19	Office Supplies (260)	0.00	0.00	0.00	0.00	0.00
20	Small Tools/Equipment (295)	200.00	200.00	0.00	100.00	0.00
21	Travel Mileage (311)	600.00	200.00	1,000.00	400.00	175.00
22	Travel Subsistence (312)	400.00	150.00	0.00	0.00	150.00
23	Telephone (321)	0.00	400.00	0.00	0.00	0.00
24	Postage (325)	200.00	700.00	150.00	150.00	25.00
25	Printing (340)	50.00	200.00	0.00	50.00	25.00
26	Maintenance & Repair (352)	100.00	200.00	0.00	100.00	0.00
27	Advertising (370)	500.00	400.00	0.00	100.00	0.00
28	Laundry & Dry Cleaning (392)	100.00	250.00	0.00	50.00	25.00
29	Training/Employee Ed. Exp. (395)	3,000.00	400.00	200.00	500.00	0.00
30	Rental of Copier (431)	0.00	0.00	0.00	0.00	0.00
31	Rental of Postage Meter (432)	0.00	0.00	0.00	0.00	0.00
32	Insurance & Bonding (450)	0.00	0.00	0.00	0.00	0.00
33	Dues & Subscriptions (491)	25.00	50.00	0.00	25.00	0.00
34	Capital Outlay (550)	0.00	0.00	0.00	0.00	0.00
49	TOT. OPERATING EXPENSES	9,225.00	19,150.00	1,450.00	10,549.00	1,300.00
50	GRAND TOTAL	97,331.00	351,418.00	56,102.00	57,455.00	12,887.00

		20	21	22	23
Net →		0.00	0.00	0.00	0.00
		WBF	WCS	WGA	WNE
REVENUE					
82	TOTAL STATE GRANTS	15,500.00	74,994.00	7,800.00	22,800.00
83	Medicaid	0.00	0.00	0.00	0.00
84	Medicare	0.00	0.00	0.00	0.00
85	MCR-HMO	0.00	0.00	0.00	0.00
86	Private Ins.	0.00	0.00	0.00	0.00
87	Direct Fees	0.00	0.00	0.00	0.00
89	County Tax Appropriation	52.00	0.00	0.00	0.00
90	WCH Fund Balance	0.00	0.00	0.00	0.00
91	HH Fund Balance	0.00	0.00	0.00	0.00
92	PC Fund Balance	0.00	0.00	0.00	0.00
93	TB Fund Balance	0.00	0.00	0.00	0.00
99	TOTAL NON-STATE REVENUE	52.00	0.00	0.00	0.00
100	GRAND TOTAL REVENUE	15,552.00	74,994.00	7,800.00	22,800.00

EXPENSES					
1	Board Salary & Expenses (120)	0.00	0.00	0.00	0.00
2	Salaries (121)	12,688.00	52,042.00	4,744.00	14,957.00
3	On Call (122)	0.00	0.00	0.00	0.00
4	Longevity (127)	98.00	738.00	97.00	309.00
5	SS/FICA (181)	979.00	4,038.00	371.00	1,168.00
6	Retirement (182)	275.00	3,521.00	323.00	1,019.00
7	Health Ins. (183)	512.00	10,043.00	779.00	2,198.00
8	Other	0.00	0.00	0.00	0.00
13	TOTAL SALARY & BENEFITS	14,552.00	70,382.00	6,314.00	19,651.00
14	Contracted Services (199)	100.00	150.00	100.00	0.00
15	Food & Provisions (220)	0.00	0.00	0.00	0.00
16	Program Supplies (230)	250.00	4,262.00	0.00	2,849.00
17	Pharmaceuticals (238)	0.00	0.00	0.00	0.00
18	HH/CAP Medical Supplies (239)	0.00	0.00	0.00	0.00
19	Office Supplies (260)	0.00	0.00	0.00	0.00
20	Small Tools/Equipment (295)	0.00	100.00	0.00	0.00
21	Travel Mileage (311)	250.00	100.00	486.00	100.00
22	Travel Subsistence (312)	0.00	0.00	0.00	0.00
23	Telephone (321)	0.00	0.00	0.00	0.00
24	Postage (325)	0.00	0.00	700.00	0.00
25	Printing (340)	0.00	0.00	100.00	0.00
26	Maintenance & Repair (352)	0.00	0.00	0.00	0.00
27	Advertising (370)	200.00	0.00	100.00	100.00
28	Laundry & Dry Cleaning (392)	0.00	0.00	0.00	0.00
29	Training/Employee Ed. Exp. (395)	200.00	0.00	0.00	100.00
30	Rental of Copier (431)	0.00	0.00	0.00	0.00
31	Rental of Postage Meter (432)	0.00	0.00	0.00	0.00
32	Insurance & Bonding (450)	0.00	0.00	0.00	0.00
33	Dues & Subscriptions (491)	0.00	0.00	0.00	0.00
34	Capital Outlay (550)	0.00	0.00	0.00	0.00
49	TOT. OPERATING EXPENSES	1,000.00	4,612.00	1,486.00	3,149.00
50	GRAND TOTAL	15,552.00	74,994.00	7,800.00	22,800.00

Net →	30	31	32	33	34	
	0.00	0.00	0.00	0.00	0.00	
	GA-TOTAL	EH-TOTAL	HH-TOTAL	PH-TOTAL	WIC-TOTAL	
REVENUE						
82	TOTAL STATE GRANTS	337,631.00	0.00	0.00	126,280.00	121,094.00
83	Medicaid	0.00	0.00	406,243.00	251,575.00	0.00
84	Medicare	0.00	0.00	340,000.00	0.00	0.00
85	MCR-HMO	0.00	0.00	25,000.00	0.00	0.00
86	Private Ins.	0.00	0.00	20,078.00	18,980.00	0.00
87	Direct Fees	100.00	45,000.00	2,000.00	7,670.00	0.00
89	County Tax Appropriation	102,623.00	255,129.00	124,056.00	425,170.00	52.00
90	WCH Fund Balance	0.00	0.00	0.00	136,589.00	0.00
91	HH Fund Balance	0.00	0.00	113,944.00	0.00	0.00
92	PC Fund Balance	0.00	0.00	0.00	21,497.00	0.00
93	TB Fund Balance	0.00	0.00	0.00	4,187.00	0.00
99	TOTAL NON-STATE REVENUE	102,723.00	300,129.00	1,031,321.00	866,678.00	52.00
100	GRAND TOTAL REVENUE	440,354.00	300,129.00	1,031,321.00	991,958.00	121,146.00

EXPENSES						
1	Board Salary & Expenses (120)	4,800.00	0.00	0.00	0.00	0.00
2	Salaries (121)	36,123.00	149,005.00	589,546.00	653,806.00	84,431.00
3	On Call (122)	0.00	0.00	23,998.00	15,999.00	0.00
4	Longevity (127)	215.00	2,937.00	5,017.00	11,824.00	1,242.00
5	SS/FICA (181)	2,781.00	11,624.00	47,321.00	52,454.00	6,556.00
6	Retirement (182)	2,425.00	10,135.00	40,079.00	44,468.00	5,138.00
7	Health Ins. (183)	6,563.00	18,528.00	75,560.00	87,067.00	13,532.00
8	Other	0.00	0.00	0.00	4,000.00	0.00
13	TOTAL SALARY & BENEFITS	52,907.00	192,229.00	781,521.00	869,618.00	110,899.00
14	Contracted Services (199)	215,500.00	2,000.00	75,050.00	37,275.00	350.00
15	Food & Provisions (220)	0.00	0.00	300.00	50.00	0.00
16	Program Supplies (230)	12,907.00	5,000.00	0.00	17,941.00	7,361.00
17	Pharmaceuticals (238)	0.00	0.00	0.00	46,474.00	0.00
18	HH/CAP Medical Supplies (239)	0.00	0.00	100,000.00	0.00	0.00
19	Office Supplies (260)	7,000.00	0.00	500.00	100.00	0.00
20	Small Tools/Equipment (295)	8,000.00	750.00	0.00	600.00	100.00
21	Travel Mileage (311)	4,100.00	5,000.00	63,000.00	3,775.00	936.00
22	Travel Subsistence (312)	900.00	1,200.00	200.00	1,200.00	0.00
23	Telephone (321)	7,100.00	900.00	2,700.00	400.00	0.00
24	Postage (325)	190.00	1,200.00	550.00	2,375.00	700.00
25	Printing (340)	2,500.00	100.00	450.00	450.00	100.00
26	Maintenance & Repair (352)	5,000.00	300.00	0.00	650.00	0.00
27	Advertising (370)	0.00	300.00	1,550.00	4,000.00	400.00
28	Laundry & Dry Cleaning (392)	0.00	0.00	0.00	725.00	0.00
29	Training/Employee Ed. Exp. (395)	2,250.00	1,000.00	1,500.00	6,150.00	300.00
30	Rental of Copier (431)	10,000.00	0.00	0.00	0.00	0.00
31	Rental of Postage Meter (432)	0.00	0.00	0.00	0.00	0.00
32	Insurance & Bonding (450)	4,000.00	0.00	0.00	0.00	0.00
33	Dues & Subscriptions (491)	8,000.00	150.00	4,000.00	175.00	0.00
34	Capital Outlay (550)	100,000.00	90,000.00	0.00	0.00	0.00
49	TOT. OPERATING EXPENSES	387,447.00	107,900.00	249,800.00	122,340.00	10,247.00
50	GRAND TOTAL	440,354.00	300,129.00	1,031,321.00	991,958.00	121,146.00

		35	FY 14-15		Prop. Line
Net →		0.00	Budget	Variance	% of Tot.
		HD-TOTAL			
REVENUE					
82	TOTAL STATE GRANTS	585,005.00	607,757.00	-22,752.00	20.28%
83	Medicaid	657,818.00	939,800.00	-281,982.00	22.80%
84	Medicare	340,000.00	450,500.00	-110,500.00	11.79%
85	MCR-HMO	25,000.00	35,000.00	-10,000.00	0.87%
86	Private Ins.	39,058.00	25,675.00	13,383.00	1.35%
87	Direct Fees	54,770.00	64,477.00	-9,707.00	1.90%
89	County Tax Appropriation	907,030.00	664,264.00	242,766.00	31.44%
90	WCH Fund Balance	136,599.00	156,906.00	-20,307.00	4.73%
91	HH Fund Balance	113,944.00	0.00	113,944.00	3.95%
92	PC Fund Balance	21,497.00	15,108.00	6,389.00	0.75%
93	TB Fund Balance	4,187.00	0.00	4,187.00	0.15%
99	TOTAL NON-STATE REVENUE	2,299,903.00	2,351,730.00	-51,827.00	79.72%
100	GRAND TOTAL REVENUE	2,884,908.00	2,959,487.00	-74,579.00	100.00%

EXPENSES					
1	Board Salary & Expenses (120)	4,800.00	0.00	4,800.00	0.17%
2	Salaries (121)	1,512,911.00	1,554,444.00	-41,533.00	52.44%
3	On Call (122)	39,997.00	45,640.00	-5,643.00	1.39%
4	Longevity (127)	21,235.00	24,618.00	-3,383.00	0.74%
5	SS/FICA (181)	120,736.00	122,167.00	-1,431.00	4.19%
6	Retirement (182)	102,245.00	113,353.00	-11,108.00	3.54%
7	Health Ins. (183)	201,250.00	204,157.00	-2,907.00	6.98%
8	Other	4,000.00	0.00	4,000.00	0.14%
13	TOTAL SALARY & BENEFITS	2,007,174.00	2,064,379.00	-57,205.00	69.57%
14	Contracted Services (199)	330,175.00	424,363.00	-94,188.00	11.44%
15	Food & Provisions (220)	350.00	350.00	0.00	0.01%
16	Program Supplies (230)	43,209.00	35,610.00	7,599.00	1.50%
17	Pharmaceuticals (238)	46,474.00	49,626.00	-3,152.00	1.61%
18	HH/CAP Medical Supplies (239)	100,000.00	192,808.00	-92,808.00	3.47%
19	Office Supplies (260)	7,600.00	9,220.00	-1,620.00	0.26%
20	Small Tools/Equipment (295)	9,450.00	14,743.00	-5,293.00	0.33%
21	Travel Mileage (311)	76,811.00	104,245.00	-27,434.00	2.66%
22	Travel Subsistence (312)	3,500.00	5,182.00	-1,682.00	0.12%
23	Telephone (321)	11,100.00	10,219.00	881.00	0.38%
24	Postage (325)	5,015.00	5,175.00	-160.00	0.17%
25	Printing (340)	3,600.00	3,113.00	487.00	0.12%
26	Maintenance & Repair (352)	5,950.00	6,459.00	-509.00	0.21%
27	Advertising (370)	6,250.00	7,061.00	-811.00	0.22%
28	Laundry & Dry Cleaning (392)	725.00	790.00	-65.00	0.03%
29	Training/Employee Ed. Exp. (395)	11,200.00	12,594.00	-1,394.00	0.39%
30	Rental of Copier (431)	10,000.00	9,000.00	1,000.00	0.35%
31	Rental of Postage Meter (432)	0.00	800.00	-800.00	0.00%
32	Insurance & Bonding (450)	4,000.00	4,960.00	-960.00	0.14%
33	Dues & Subscriptions (491)	12,325.00	13,618.00	-1,293.00	0.43%
34	Capital Outlay (550)	190,000.00	0.00	190,000.00	6.59%
49	TOT. OPERATING EXPENSES	877,734.00	909,936.00	-32,202.00	30.43%
50	GRAND TOTAL	2,884,908.00	2,974,315.00	-89,407.00	100.00%

Net →	REVENUE VARIANCE																			
	ADM	HP	PHP	EH	CAP	HH	CCAC	CO	CH											
Board Salary & Expenses (120)	4,800																			
Salaries (121)	(5,711)	2,368	(3,287)	486	2,703	(78,473)	136	(686)												
On Call (122)						(3,285)														
Longevity (127)	(23)	(15)	(27)	518	(122)	(2,433)	(6)	97												
SS/FICA (181)	(438)	(267)	(254)	(10)	(118)	(6,286)	10	(45)												
Retirement (182)	(442)	(353)	(324)	(769)	(482)	(6,380)	(131)	(92)												
Health Ins. (183)	(1,455)	(716)	(583)	(57)	1,822	(5,349)	147	(44)												
Other																				
TOTAL SALARY & BENEFITS	(3,269)	1,017	(4,475)	168	3,803	(102,206)	156	(770)												
Contracted Services (199)		500		(500)	(1,450)	(95,511)	(25)	74												
Food & Provisions (220)																				
Program Supplies (230)		2,062	3,917	(132)			691													
Pharmaceuticals (238)																				
HH/CAP Medical Supplies (239)																				
Office Supplies (260)	223				(852)	(62,179)														
Small Tools/Equipment (295)	3,723			(250)	(500)	(500)	(19)													
Travel Mileage (311)		(2,273)		(8,000)	(1,293)	(12,766)	(1,221)	50												
Travel Subsistence (312)			96			(300)	(75)	(364)												
Telephone (321)					580	301														
Postage (325)					(50)		(100)													
Printing (340)	860				9															
Maintenance & Repair (352)				(200)																
Advertising (370)	(300)				(405)		(50)													
Laundry & Dry Cleaning (392)																				
Training/Employee Ed. Exp. (395)	(1,000)	(1,500)				(500)	(200)	(150)												
Rental of Copier (431)	1,000																			
Rental of Postage Meter (432)	(800)																			
Insurance & Bonding (450)	(950)																			
Dues & Subscriptions (491)				(50)		(1,000)	(75)													
Capital Outlay (550)	100,000			90,000																
TOT. OPERATING EXPENSES	102,746	(1,211)	4,013	80,868	(34,590)	(172,807)	(1,074)	(390)												
GRAND TOTAL EXPENSE VARIANCE	99,477	(194)	(462)	81,036	(30,787)	(275,013)	(918)	(1,160)												

REVENUE VARIANCE																				
State	0	0	0	(6,000)	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Medicaid	0	0	0	0	(4,757)	(150,000)	(3,000)	0	0	0	0	0	0	0	0	0	0	0	0	0
Medicare	0	0	0	0	0	(110,000)	0	0	0	0	0	0	0	0	0	0	0	0	0	0
MCR-HMO	0	0	0	0	0	(10,000)	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Private Ins.	0	0	0	0	0	7,078	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Direct Fees	(2,877)	0	0	(5,000)	0	500	0	0	0	0	0	0	0	0	0	0	0	0	0	0
County	102,354	(194)	(462)	92,036	(26,030)	(126,535)	(631)	(1,160)												
WCH FB	0	0	0	0	0	0	2,713	0	0	0	0	0	0	0	0	0	0	0	0	0
UR FB	0	0	0	0	0	113,944	0	0	0	0	0	0	0	0	0	0	0	0	0	0
PPC FB	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
TB FB	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
GRAND TOTAL REVENUE VARIANCE	99,477	(194)	(462)	81,036	(30,787)	(275,013)	(918)	(1,160)												

Net --	REVENUE										
	FP	AH	PC	PCM	STI	TB	WRF	WCS	WGA		
Board Salary & Expenses (120)	17,977	(766)	44,497	1,415	(4,512)	2,478	(1,204)	1,115			
Salaries (121)			(2,358)								(2,111)
On Call (122)	(909)	(580)	177	(9)	(132)	164	(43)	110			8
Longevity (127)	140	(187)	1,983	66	(437)	286	(104)	497			(113)
SS/FICA (181)	(378)	(510)	(908)	(148)	(599)	222	(230)	(51)			(145)
Retirement (182)	(841)	(585)	2,495	1,425	(653)	342	(282)	2,199			(195)
Health Ins. (183)	960	200	2,000		360						
Other	16,949	(2,428)	47,886	2,749	(5,973)	3,492	(1,863)	3,870			(2,556)
TOTAL SALARY & BENEFITS	(304)	(3,005)	(189)			1		15			57
Contracted Services (199)											
Food & Provisions (220)											
Program Supplies (230)	(304)	(302)	(783)		1,941			1,180			
Pharmaceuticals (238)	(1,134)	(281)	(27)		(1,000)	150					
HH/CAP Medical Supplies (239)											
Office Supplies (260)				(380)							
Small Tools/Equipment (295)	(150)	(300)	(450)					66			
Travel Mileage (311)	(10)	227	(500)		61	5	(904)	33			24
Travel Subsistence (312)		144		(100)		10	(500)				(661)
Telephone (321)											
Postage (325)	(80)	(127)	50	60		5					10
Printing (340)	(68)	(40)	(100)			10					16
Maintenance & Repair (352)	(35)	(124)	(150)								
Advertising (370)	700	400	50	(144)		15	(300)				(180)
Laundry & Dry Cleaning (392)	(13)	(2)	(100)								
Training/Employee Ed. Exp. (395)	200	2,328	(400)	(50)	(268)						
Rental of Copier (431)											
Rental of Postage Meter (432)											
Insurance & Bonding (450)											
Dues & Subscriptions (491)			(66)	(65)		(25)					
Capital Outlay (550)											
TOT. OPERATING EXPENSES	(1,196)	(1,082)	(2,665)	(679)	734	171	(1,770)	1,294			(734)
GRAND TOTAL EXPENSE VARIANCE	15,751	(3,510)	45,221	2,070	(5,239)	3,663	(3,633)	5,164			(3,290)

REVENUE VARIANCE

State	(5,553)	897	(10,167)	0	(589)	15	(3,377)	7,583			(2,637)
Medicaid	(16,500)	(9,000)	(47,000)	(2,000)	(500)	(225)	0	0			0
Medicare	0	0	(500)	0	0	0	0	0			0
MCR-HMO	0	0	0	0	0	0	0	0			0
Private Ins.	1,000	(100)	2,300	0	1,100	280	0	0			0
Direct Fees	(1,000)	100	(650)	0	0	(830)	0	0			0
County	8,031	50,498	109,877	6,070	(5,250)	236	(308)	(2,419)			(653)
WCH FB	29,773	(45,905)	0	(2,000)	0	0	0	0			0
UR FB	0	0	0	0	0	0	0	0			0
PPC FB	0	0	6,389	0	0	0	0	0			0
TB FB	0	0	0	0	0	4,187	0	0			0
GRAND TOTAL REVENUE VARIANCE	15,751	(3,510)	60,049	2,070	(5,239)	3,663	(3,685)	5,164			(3,290)

Net --		GA-TOTAL	PH-TOTAL	HH-TOTAL	PH-TOTAL	WIC-TOTAL	HD-TOTAL
MINE		0.00	0.00	0.00	0.00	0.00	0.00
REVENUE							
EXPENSE VARIANCE							
Board Salary & Expenses (120)		4,800.00	0.00	0.00	0.00	0.00	4,800.00
Salaries (121)	(236)	6,630.00	486.00	-75,770.00	42,817.00	-2,436.00	-41,533.00
On Call (122)		0.00	0.00	-3,285.00	-2,258.00	0.00	-5,543.00
Longevity (127)	(9)	65.00	818.00	-2,555.00	-1,347.00	66.00	-3,163.00
SS/FICA (181)	(19)	959.00	-10.00	-6,404.00	5,681.00	261.00	-1,431.00
Retirement (182)	(94)	-1,119.00	-769.00	-6,862.00	-1,838.00	-520.00	-11,108.00
Health Ins. (183)	(44)	-2,754.00	-67.00	-3,527.00	1,753.00	1,678.00	-2,907.00
Other		0.00	0.00	0.00	4,950.00	0.00	4,950.00
TOTAL SALARY & BENEFITS	(402)	-6,727.00	168.00	-98,403.00	48,708.00	-951.00	-57,205.00
Contracted Services (199)		500.00	-500.00	-96,961.00	2,761.00	72.00	-94,188.00
Food & Provisions (220)		0.00	0.00	0.00	0.00	0.00	0.00
Program Supplies (230)	268	5,979.00	-132.00	0.00	304.00	1,448.00	7,599.00
Pharmaceuticals (238)		0.00	0.00	0.00	-3,152.00	0.00	-3,152.00
HH/CAP Medical Supplies (239)		0.00	0.00	-92,808.00	0.00	0.00	-92,808.00
Office Supplies (260)		223.00	0.00	-1,204.00	-439.00	0.00	-1,620.00
Small Tools/Equipment (295)		3,723.00	-250.00	-1,000.00	-7,832.00	66.00	-5,283.00
Travel Mileage (311)		-2,273.00	8,060.00	-14,059.00	-2,255.00	-847.00	-27,434.00
Travel Subsistence (312)		94.00	0.00	-300.00	-317.00	-1,161.00	-1,682.00
Telephone (321)		0.00	0.00	881.00	0.00	0.00	881.00
Postage (325)		0.00	0.00	-50.00	-120.00	10.00	-160.00
Printing (340)		860.00	0.00	9.00	-398.00	16.00	487.00
Maintenance & Repair (352)		0.00	2,000.00	0.00	-369.00	0.00	-509.00
Advertising (370)		-300.00	0.00	-405.00	274.00	-480.00	-811.00
Laundry & Dry Cleaning (392)		0.00	0.00	0.00	-65.00	0.00	-65.00
Training/Employee Ed. Exp. (395)	(100)	-2,500.00	0.00	-500.00	1,772.00	-166.00	-1,394.00
Rental of Copier (431)		1,000.00	0.00	0.00	0.00	0.00	1,000.00
Rental of Postage Meter (432)		-800.00	0.00	0.00	0.00	0.00	-800.00
Insurance & Bonding (450)		-860.00	0.00	0.00	0.00	0.00	-860.00
Dues & Subscriptions (491)		0.00	-90.00	-1,000.00	-243.00	0.00	-1,293.00
Capital Outlay (550)		100,000.00	90,000.00	0.00	0.00	0.00	190,000.00
TOT. OPERATING EXPENSES	168	105,548.00	80,868.00	-207,397.00	-10,179.00	-1,042.00	82,202.00
GRAND TOTAL EXPENSE VARIANCE	(234)	98,821.00	81,036.00	-305,800.00	36,529.00	-1,993.00	89,407.00
REVENUE VARIANCE							
State	115	0.00	-6,000.00	0.00	-10,436.00	1,684.00	-22,752.00
Medicaid	0	0.00	0.00	-154,787.00	-127,275.00	0.00	-281,982.00
Medicare	0	0.00	0.00	-110,000.00	-500.00	0.00	-110,500.00
MCR-HMO	0	0.00	0.00	-10,000.00	0.00	0.00	-10,000.00
Private Ins.	0	0.00	0.00	7,078.00	6,309.00	0.00	13,383.00
Direct Fees	0	-2,877.00	5,000.00	500.00	-2,310.00	0.00	-9,707.00
County	(349)	101,698.00	92,036.00	-152,955.00	205,274.00	-3,729.00	242,714.00
WCH FB	0	0.00	0.00	0.00	-20,307.00	0.00	-20,307.00
UR FB	0	0.00	0.00	113,944.00	0.00	0.00	113,944.00
PPC FB	0	0.00	0.00	0.00	6,389.00	0.00	6,389.00
TB FB	0	0.00	0.00	0.00	4,167.00	0.00	4,167.00
GRAND TOTAL REVENUE VARIANCE	(234)	98,821.00	81,036.00	-305,800.00	53,357.00	-2,045.00	-74,631.00

Subject: Re: Question from Caswell Board of Health
From: "Frederick E. Moore, MD" <fmoore@caswellinc.us>
Date: 2/22/2015 6:27 PM
To: "Moore, Jill D" <moore@sog.unc.edu>

Would this issue be looked at any differently from a public health perspective if it were couched in terms of a rule requiring all public restrooms in public buildings be open to the public during normal working hours? The polling place issue would then become just a small part of a bigger issue. Thanks for your help.

Frederick E. Moore, MD
Caswell County Health Department
PO Box 1238
Yanceyville, NC 27379

336-694-4129 x157

On 2/19/2015 3:37 PM, Moore, Jill D wrote:

Fred,

I don't think the straw you're reaching for applies to most voters. The state statute refers to a federal law, the Voting Accessibility for the Elderly and Handicapped Act (P.L. 98-435). I am not the SOG's elections law specialist, but my informed-layperson's understanding of that law is that its purpose is to ensure access to voting places by people who meet the law's definition of "handicapped," which means having a temporary or permanent physical disability. The state law requires accommodations for a person who is disabled, which is defined as meeting the federal law's definition of "handicapped."

You can never be sure you know for certain what a law means if you haven't researched the case law, and I haven't, but the plain language of the law doesn't support a conclusion that the law creates a duty for a local board of elections to provide access to restroom facilities for non-disabled voters.

As for the letter or resolution, it would be within the legal authority of the board of health to express its opinion about the situation, but I can't answer the question of whether it would be considered proper in your county.

Regards,
Jill

-----Original Message-----

From: Frederick E. Moore, MD [<mailto:fmoore@caswellinc.us>]
Sent: Wednesday, February 18, 2015 10:14 PM
To: Moore, Jill D
Subject: Re: Question from Caswell Board of Health

I was wondering what you thought of the following:

§ 163-131. Accessible polling places.

(a)

The State Board of Elections shall promulgate rules to assure that any disabled or elderly voter assigned to an inaccessible polling place, upon advance request of such voter, will be assigned to an accessible polling place. Such rules should allow the request to be made in advance of the day of the election.

(b)

Words in this section have the meanings prescribed by P.L. 98-435, except that the term "disabled" in this section has the same meaning as "handicapped" in P.L. 98-435.

While it still gives the authority to regulate polling places to the BOE, could access to a restroom fall under the "accessibility" responsibilities of the BOE? Just grasping at "straws".

Another thought I had was for the BOH to pass a resolution or send a letter to the BOE expressing their concerns about the health consequences of this "no restroom" policy. Whether it does anything or not, is such a letter within the scope of practice of a BOH or is one board meddling with another board not considered to be proper?

Frederick E. Moore, MD
Caswell County Health Department
PO Box 1238
Yanceyville, NC 27379

336-694-4129 x157

On 2/18/2015 2:49 PM, Moore, Jill D wrote:

Fred,

Thank you for your patience while I've done some research.

I don't think the board of health is the appropriate entity to address this issue. It appears to me that the board of elections has some legal authority in this matter and that would seem the logical place to start.

There is a state statute that authorizes the board of elections to demand and use any school; State, county, or municipal building; or other building that is wholly or partly maintained or supported by tax revenues. G.S. 163-129. The statute specifically authorizes the board of elections to require the person in control of such a building to provide parking. While the statute doesn't specifically address restroom facilities, I believe it could reasonably be interpreted to permit the board of elections to require the property controller to provide access to restrooms as well.

In addition to the statute, there is an Attorney General advisory opinion that specifically addresses a county board of election's authority to demand and use part of a public facility as a voting place. It concludes that the board of elections and the building operator must cooperate to make parts of the building and parking facilities available, while avoiding disruption of the essential functions of the facility. In other words, it tells the board of elections and the operators of properties that are subject to the statute that they need to work it out, taking into account each other's needs. The AG advisory opinion is available at <http://www.ncdoj.gov/About-DOJ/Legal-Services/Legal-Opinions/Opinions/Authority-to-Demand-and-Use-Part-of-Public-Facilit.aspx>.

I hope this is helpful. Thanks again for your patience.

Jill

Jill D. Moore
Associate Professor of Public Law & Government School of Government
UNC-Chapel Hill

919.966.4442

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----- Forwarded Message -----

Subject: Question from Caswell Board of Health

Date: Thu, 05 Feb 2015 15:51:22 -0500

From: Fred Moore <fmoore@caswellinc.us>

To: Moore, Jill D <moore@sog.unc.edu>

I am hoping you can give my BOH some guidance on the following issue. The primary question they are asking is if this is an issue that was appropriate for the BOH to address or is it better addressed in another forum.

During the election last November several Caswell County polling places locked the doors of their restrooms so the public could not access them and there were several instances where a voter had to leave the line and seek "relief" elsewhere. Apparently the local Board of Elections felt like they either could not or did not want to require the sites to allow access to a restroom.

Lack of restroom access was thought to be a barrier to voting but also has the potential of creating a mess if the voter does not leave the line. Many of our polling places are in very rural settings so there are not nearby options at most locations.

The Board of Commissioner who is on the Board of Health tried to get a resolution passed by the local Board of Commissioners but the resolution failed. This same member was at a state wide Board of Commissioner meeting recently and brought up this matter and was told by several of his fellow attendees that this sounded like a Public Health issue and should be addressed by the local Board of Health.

My Board of Health felt like this was a matter of common courtesy and thought it was ridiculous to lock the restroom door but would like your opinion if this issue really was a Public Health matter that was appropriate for the BOH or was it better addressed elsewhere.

Thanks for your help.

U.S. Department of Justice
Civil Rights Division
Disability Rights Section



The Americans with Disabilities Act and Other Federal Laws Protecting the Rights of Voters with Disabilities

Voting is one of our nation's most fundamental rights and a hallmark of our democracy. Yet for too long, many people with disabilities have been excluded from this core aspect of citizenship. People with intellectual or mental health disabilities have been prevented from voting because of prejudicial assumptions about their capabilities. People who use wheelchairs or other mobility aids, such as walkers, have been unable to enter the polling place to cast their ballot because there was no ramp. People who are blind or have low vision could not cast their vote because the ballot was completely inaccessible to them.

Important federal civil rights laws were enacted to combat such forms of discrimination and protect the fundamental right to vote for all Americans. This document provides guidance to states, local jurisdictions, election officials, poll workers, and voters on how the Americans with Disabilities Act and other federal laws help ensure fairness in the voting process for people with disabilities.

FEDERAL LAWS PROTECTING THE RIGHT TO VOTE

The **Americans with Disabilities Act (ADA)** is a federal civil rights law that provides protections to people with disabilities that are similar to protections provided to individuals on the basis of race, color, sex, national origin, age, and religion. Title II of the ADA requires state and local governments ("public entities") to ensure that people with disabilities have a full and equal opportunity to vote. The ADA's provisions apply to all aspects of voting, including voter registration, site selection, and the casting of ballots, whether on Election Day or during an early voting process.

The **Voting Rights Act of 1965 (VRA)** also contains provisions relevant to the voting rights of people with disabilities. The VRA requires election officials to allow a voter who is blind or has another disability to receive assistance from a person of the voter's choice (other than the voter's employer or its agent or an officer or agent of the voter's union). The VRA also prohibits conditioning the right to vote on a citizen being able to read or write, attaining a particular level of education, or passing an interpretation "test."

The **Voting Accessibility for the Elderly and Handicapped Act of 1984 (VAEHA)** requires accessible polling places in federal elections for elderly individuals and people with disabilities. Where no accessible location is available to serve as a polling place, voters must be provided an alternate means of voting on Election Day.

The **National Voter Registration Act of 1993 (NVRA)** aims, among other things, to increase the historically low registration rates of persons with disabilities. The NVRA requires all offices that provide public assistance or state-funded programs that primarily serve persons with disabilities to also provide the opportunity to register to vote in federal elections.

The **Help America Vote Act of 2002 (HAVA)** requires jurisdictions responsible for conducting federal elections to provide at least one accessible voting system for persons with disabilities at each polling place in federal elections. The accessible voting system must provide the same opportunity for access and participation, including privacy and independence, that other voters receive.

The remainder of this document discusses how these laws apply to common aspects of the election process.

MAKING VOTER REGISTRATION ACCESSIBLE TO ALL

The first step in the voting process is registration. The NVRA requires all offices that provide public assistance or state-funded programs that primarily serve persons with disabilities to provide the opportunity to register to vote by providing voter registration forms, assisting voters in completing the forms, and transmitting completed forms to the appropriate election official. The NVRA requires such offices to provide any citizen who wishes to register to vote the same degree of assistance with voter registration forms as it provides with regard to completing the office's own forms. The NVRA also requires that if such office provides its services to a person with a disability at the person's home, the office shall provide these voter registration services at the home as well.

In a 2011 NVRA case, the Department reached a settlement with the State of Rhode Island that required state officials to ensure that voter registration opportunities are offered at all disability services offices in the state and to develop and implement training and tracking programs for those offices.

In addition to the registration opportunities guaranteed by the NVRA, the ADA requires states to ensure that all aspects of the voter registration process are accessible to persons with disabilities. The ADA also prohibits a state from categorically disqualifying all individuals who have intellectual or mental health disabilities from registering to vote or from voting because of their disability.

PROVIDING ACCESSIBLE POLLING PLACES

In communities large and small, people cast their ballots in a variety of facilities that temporarily serve as polling places, such as libraries, schools, and fire stations, or churches, stores, and other private buildings. The ADA requires that public entities ensure that people with disabilities can access and use their voting facilities. The ADA's regulations and the ADA Standards for Accessible Design set out what makes a facility accessible and should be used to determine the level of accessibility at any facility being considered for use as a polling place. The Justice Department's [ADA Checklist for Polling Places](#) | [PDF](#) provides guidance to election officials for determining whether a polling place already has the basic accessibility features needed by most voters with disabilities or can be made accessible using temporary solutions.

An additional Justice Department publication, [Solutions for Five Common ADA Access Problems at Polling Places](#) | [PDF](#), illustrates suggested temporary solutions for several common problems found at polling places. For example, if parking is provided at a polling place but there are no accessible parking spaces, election administrators can create temporary accessible parking by using traffic cones and portable signs to mark off the accessible spaces and access aisles.

The Department of Justice has expanded the scope of the Election Day monitoring conducted by Civil Rights Division staff to include assessments of the physical accessibility of polling places. For the 2012 general election, the Department's Election Day monitors conducted accessibility surveys of approximately 240 polling places in 28 jurisdictions throughout the country.

In some circumstances, when a public entity is unable to identify or create an accessible polling place for a particular voting precinct or ward, election administrators may instead use an alternative method of voting at the polling place. While absentee balloting can be offered to voters with disabilities, it cannot take the place of in-person voting for those who prefer to vote at the polls on Election Day. Any alternative method of voting must offer voters with disabilities an equally effective opportunity to cast their votes in person. For example, the only suitable polling site in a precinct might be an inaccessible building. In this rare circumstance, election administrators may provide “curbside voting” to allow persons with disabilities to vote outside the polling place or in their cars. In order to be effective, however, the curbside voting system must include: (1) signage informing voters of the possibility of voting curbside, the location of the curbside voting, and how a voter is supposed to notify the official that she is waiting curbside; (2) a location that allows the curbside voter to obtain information from candidates and others campaigning outside the polling place; (3) a method for the voter with a disability to announce her arrival at the curbside (a temporary doorbell or buzzer system would be sufficient, but not a telephone system requiring the use of a cell phone or a call ahead notification); (4) a prompt response from election officials to acknowledge their awareness of the voter; (5) timely delivery of the same information that is provided to voters inside the polling place; and (6) a portable voting system that is accessible and allows the voter to cast her ballot privately and independently.

Curbside voting is permissible only under these limited circumstances. Under the ADA, jurisdictions must select polling sites that are or can be made accessible, so that voters with disabilities can participate in elections on the same terms and with the same level of privacy as other voters.

In February 2014, the Department of Justice and Blair County, Pennsylvania, entered into a Settlement Agreement under the ADA concerning the accessibility of the County's polling places. The County agreed that by the 2014 general election, all of its polling places would be accessible on Election Day to voters with mobility and vision impairments. The County agreed to relocate some polling places that were not accessible and to provide temporary measures at others such as portable ramps and doorbells to make sure that they are accessible on Election Day.

ENSURING POLICIES AND PROCEDURES DO NOT DISCRIMINATE AGAINST PEOPLE WITH DISABILITIES

Public entities must ensure that they do not have policies, procedures, or practices in place that interfere with or prohibit persons with certain disabilities from registering to vote or voting based on their disability. For example, an election official cannot refuse to provide an absentee ballot or voter registration form to a person with a disability because the official knows the voter resides in a nursing home.

In addition, the ADA requires public entities to modify their voting policies, practices, and procedures when such modifications are necessary to avoid discrimination on the basis of a voter’s disability. That requirement is relaxed only if election administrators can show that the proposed modification would fundamentally alter the nature of the voting program. For example, voters who use crutches may have difficulty waiting in a long line to vote. The ADA does not require that these voters be moved to the front of the line, but the public entity should provide a chair for them while they wait. For a voter with multiple sclerosis who may be unable to tolerate extreme temperatures, providing a chair inside the polling place may be an appropriate modification.

Similarly, election officials must modify a “no animals/pets” policy to allow voters with disabilities to be accompanied by their service animals in all areas of the polling place where the public is allowed to go. Additionally, if a jurisdiction requires voters to provide identification, the ADA requires that election officials not restrict the permissible forms of identification from voters with disabilities to ones that are not available to those voters. For example, individuals with severe vision impairments, certain developmental disabilities, or epilepsy are ineligible in many states to receive a driver’s license. Thus,

accepting only a driver's license would unlawfully screen out these voters.

PROVIDING ACCESSIBLE VOTING SYSTEMS AND EFFECTIVE COMMUNICATION

HAVA requires jurisdictions conducting **federal** elections to have a voting system (such as the actual voting machines) that is accessible, including to citizens who are blind or visually impaired, at each polling place. The accessible voting system must provide the same opportunity for access and participation, including privacy and independence, that other voters enjoy. States can satisfy this accessibility requirement through use of a direct recording electronic voting system or other voting system equipped for individuals with disabilities. In addition to HAVA, the ADA requires officials responsible for conducting all public elections to make sure that any accessible voting systems are maintained and function properly in each election, and that election officials have been adequately trained to operate them.

Following the enactment of HAVA, the Department monitored the nationwide implementation of the accessible voting systems requirements and successfully resolved litigation in Maine, New York, and Pennsylvania to ensure that accessible voting systems were established in every polling place in those states.

The ADA requires election officials conducting **any** elections at the federal, state, or local level to provide communication with voters with disabilities that is as effective as that provided to others. To ensure that voters with disabilities can fully participate in the election process, officials must provide appropriate auxiliary aids and services at each stage of the process, from registering to vote to casting a ballot. Only if providing an aid or service would result in a fundamental alteration or undue financial and administrative burdens is a jurisdiction not required to provide the aid or service. However, the jurisdiction still has an obligation to provide, if possible, another aid or service that results in effective communication. In determining the type of auxiliary aid and service to be provided, officials must give primary consideration to the request of the voter.

Examples of auxiliary aids and services for people who are blind or have low vision include a qualified reader (a person who is able to read effectively, accurately, and impartially using necessary specialized vocabulary); information in large print or Braille; accessible electronic information and information technology; and audio recording of printed information. Examples of auxiliary aids and services for people who are deaf or have hearing loss include sign language interpreters, Video Remote Interpreting, captioning, and written notes. For additional information about auxiliary aids and services, see ADA Requirements: Effective Communication at <http://www.ada.gov/effective-comm.htm>.

For example, suppose that a jurisdiction is conducting an election for mayor and city council members using a paper ballot system. A blind voter requests an accessible ballot. A Braille ballot would have to be counted separately and would be readily identifiable, and thus would not constitute a secret ballot.

Other aids and services would better afford voters who are blind the opportunity to vote privately and independently and to cast a secret ballot, just like other voters. These may include ballot overlays or templates, electronic information and information technology that is accessible (either independently or through assistive technology such as screen readers), or recorded text or telephone voting systems.

The requirement to provide effective communication also extends to other information related to the voting process, such as poll workers obtaining address and registration information from voters. Whatever information the public entity provides relating to the voting process must be accessible and usable by all who come to cast their ballots. For example, election officials should have pen and paper available and be prepared to write out questions at the polling place check-in table for a voter who is deaf and can communicate through written communications.

In 2009, the Department entered into a landmark ADA settlement agreement with the City of Philadelphia, Pennsylvania, that transformed the historic city into a model program of accessible polling places. A key component of the settlement was training for poll workers, election officials, and election administration staff.

TRAINING

Prior to Election Day or the beginning of early voting, election staff and volunteers receive training so they can appropriately interact with people with disabilities. Staff and volunteers should understand the specific auxiliary aids and services that are available. They should be aware that service animals must be allowed to accompany voters inside the polling place, that accessibility features at the polling place need to be operational, that people with disabilities are allowed assistance from a person of their choice, and that other modifications may be needed to accommodate voters with disabilities. Many local disability organizations, including Centers for Independent Living and Protection and Advocacy Systems, conduct ADA and disability trainings in their communities. The Department of Justice and the National Network of ADA Centers can provide local contact information for these organizations.

FOR MORE INFORMATION

For information about how the ADA applies to voting, please visit our website or call our toll-free number.

ADA Information Line

800-514-0301 (Voice) and 800-514-0383 (TTY)

24 hours a day to order publications by mail.

Monday-Wednesday, Friday 9:30 a.m. – 5:30 p.m., Thursday 12:30 p.m. – 5:30 p.m. (Eastern Time) to speak with an ADA Specialist. Calls are confidential.

ADA Website

www.ADA.gov

To receive e-mail notifications when new ADA information is available, visit the ADA Website's home page and click the link under ADA.gov Updates in the lower right corner of the page.

For information about the VRA, VAEHA, NVRA, and HAVA, please visit the Voting Section's website: www.justice.gov/crt/about/vot/

To report complaints of possible violations of the federal voting rights laws, you may contact the Voting Section: www.justice.gov/crt/about/vot/misc/contact.php.

You can contact the Voting Section through our toll free number (800-253-3931) or our email address (voting.section@usdoj.gov).

For persons with disabilities, this publication is available in large print, Braille, audio tape, and on computer disk.

Reproduction of this publication is encouraged.

September 2014



[461] April 14, 2000

Angie Crews Director of Elections Surry County Board of Elections

P.O. Box 372 Dobson, N.C. 27017

Re: Advisory Opinion; Authority to Demand and Use Part of Public Facility as Voting Place; N.C. Gen. Stat. § 163-129

Dear Ms. Crews:

On behalf of the Surry County Board of Elections you have requested an advisory opinion on whether the Board of Elections may demand a certain part of a public facility to use as a voting place. The pertinent statute, N.C. Gen. Stat. § 163129, provides in part:

At the voting place in each precinct established under the provisions of G.S. 163-128, the county board of elections shall provide or procure by lease or otherwise a suitable structure or part of a structure in which registration and voting may be conducted. To this end, the county board of elections shall be entitled to demand and use any school or other State, county, or municipal building, or a part thereof, or any other building, or a part thereof, which is supported or maintained, in whole or in part by or through tax revenues . . . for the purpose of conducting registration and voting for any primary or election, and it may require that the requisitioned premises, or a part thereof, be vacated for these purposes.

If a county board of elections requires that a tax-supported building be used as a voting place, that county board of elections may require that those in control of that building provide parking that is adequate for voters at the precinct, as determined by the county board of elections.

The statute clearly gives a county board of elections the authority to demand and use a part of a public facility or a facility supported in part through tax revenues for voting on primary or election days, even over the objection of those otherwise in control of the public facility. In exercising this authority, however, it is incumbent on the Board of Elections to act for the benefit of the public. See *Avery County v. Braswell*, 215 N.C. 270, 275 (1939). Likewise, those in control of the facility sought to be used by the Board of Elections must act for the benefit of the public. Accordingly, in our opinion both bodies must cooperate (1) to make available for elections parts of the public building and its parking facilities which meet federal and state requirements for the conduct of elections, including accessibility requirements, and (2) at the same time to avoid disruption of the essential functions of the public facility.

Signed by:

Ann Reed Senior Deputy Attorney General

Susan K. Nichols Special Deputy Attorney General

cc: Gary O. Bartlett, Executive Secretary-Director State Board of Elections

North Carolina Department of Justice / Roy Cooper, Attorney General (919) 716-6400



CASWELL COUNTY HEALTH DEPARTMENT POLICY

- I. POLICY TITLE: Eligibility Policy**
 - A. Policy
 - 1. In accordance with the NC Administrative Code, Title X regulations (NCAC43A) and individual program rules, the Caswell County Health Department will assure each client seeking care at the Health Department are will be treated fairly and given an opportunity to participate in our sliding scale fee program.
 - B. Policy Type
 - 1. Board of Health Policy
 - 2. Administrative Policy
 - C. Purpose
 - 1. This policy is intended to assure that all clients seeking care at the Health Department are treated fairly and given an opportunity to participate in our sliding scale fee option.
 - D. Target
 - 1. This policy shall be followed by all Health Department Staff except in Environmental Health
 - 2. All Caswell County residents could benefit from this policy
 - E. References
 - 1. NC Administrative Code
 - 2. Title X Regulations
 - 3. Individual Program Rules

- II. DEFINITIONS:**
 - A. "Economic Unit" is defined as individuals related or non-related, living in the same household who share in their production of income and consumption of goods. An economic unit must have its own source of income. Everyone is a part of some sort of economic unit.
 - B. "Gross Income" is the total of all income before any deductions
 - C. "Good Faith Effort" is making a consistent payment (monthly); even if it is not the amount designated on the payment agreement.
 - D. "True Emergency" is an injury or illness that is acute and poses an immediate risk to a person's life or long term health.

- III. PROCEDURE:**
 - A. General Conditions:
 - 1. The confidentiality of all patients will be upheld while determining the income and sliding scale fee status.
 - 2. Reimbursement for services will be sought through third party coverage, including Medicaid and Medicare, private insurance and individual patient pay.
 - 3. Services are available to all clients without regard to race, religion, national origin, disability, gender, marital status, disability, or age.

- B. Residency Criteria:**
1. With the exception of OBCM and CC4C programs, all services will be provided regardless of the patient's county or state of residence.
 - a. Patients receiving OBCM or CC4C services will be required to show proof of residency due to state program requirements
 - b. Listed below are items which may be accepted as "Proof of Residency". At least one form of proof is required.
 - 1) Driver's License
 - 2) Medicaid Card
 - 3) Division of Motor Vehicle ID card
 - 4) Paycheck stub with person's address, greater than 60 days old
 - 5) Utility Bill (electric, gas, phone, water, cable) that is at least 60 days old.
 - 6) Mortgage/Rental Agreement
 - 7) Bank Statement
 - 8) Current School Record
 - c. Once proof of residency is obtain the item used to proof residency must be copied, dated and put in the chart.
 - d. Clients residing in a shelter can use a written statement signed by the shelter director as proof of residency.
 2. Any other exceptions will be guided by program and agency policy
- C. Financial Requirements:**
1. No one will be denied services based solely on inability to pay, as established during the eligibility process.
 2. Most health department programs are mandated to provide eligible services at no charge to the patients who are found to be at 100% of poverty and below.
 3. According to current Federal and State and program rules, patients requesting services in our Communicable Disease, Sexually Transmitted Infections, Family Planning, or Immunization programs will be provided services regardless of income status.
 4. Family Planning Program cannot require a proof of income. For these patients a declaration of income is accepted.
- D. Sliding Fee Scales/Fees:**
1. The 101% to 250% Federal Poverty Scale will be used to determine fees for services in all programs.
 2. Patient's are responsible for paying their assessed charges in full and are encouraged to do so at the time that services are rendered or at least within a thirty date time period.
 - a. Charges for services are based on the patient's ability to pay.
 - b. If a payment plan is needed then one may be offered based on agency guidelines. (See the Collection Policy).
- E. It is the practice of this Health Department to use the Economic Unit to assess the patient's "ability to pay".**
1. Family Planning
 - a. Use declaration of income
 - b. Economic unit is the individual, not the household
 - c. Child support cannot be included as income during the eligibility process
 2. Other programs
 - a. Income information will be obtained from each client based on the past twelve month's of income from everyone who makes up the economic

- unit. This information along with the economic unit size will be used to determine their “ability to pay”.
- b. Current gross income for past twelve months will be used to determine pay status unless income for the past six months is a better indicator of their current economic status: i.e., seasonal workers, temporary leave of absences, etc.
 - c. ~~Un-emanicipated minors~~, Any client requesting confidential services will be considered as an economic unit of one and charged based on their own income.
 - d. Gross annual income is calculated as follows:
 - 1) Weekly pay x 52, or
 - 2) Biweekly pay x 26, or
 - 3) Monthly pay x 12
 - e. Income included in the eligibility process includes:
 - 1) Salaries and wages
 - 2) Overtime pay
 - 3) Earnings from self-employment
 - 4) Investment income as identified on tax returns
 - 5) Public assistance money
 - 6) Unemployment compensation
 - 7) Alimony or child support payments
 - 8) Military allotments
 - 9) Social Security Benefits
 - 10) Veteran’s Administration Benefits
 - 11) Retirement and pension plans
 - 12) Worker’s compensation
 - 13) Regular contributions from individuals not living in the household.
 - 14) Supplementary Security Income (SSI) benefits
 - 15) Lawn Maintenance, as a business
 - 16) Housekeeping, as a business
 - f. Income that is not included in the eligibility process includes:
 - 1) Income that minors may earn babysitting, mowing lawns or other miscellaneous tasks.
 - 2) Military housing (on or off base)
 - 3) Payments provided by the Low Income Energy Assistance Act
 - 4) Assistance to a child or families for Free Lunch and Food Stamps
3. All clients will be given the option to participate in the “sliding fee” program. This program will be explained to the client at the beginning of the eligibility process.
 - a. If the client elects to participate in the sliding fee program then income verification process will be initiated. For Family Planning Clients, declaration of income will be accepted.
 - b. If the client does not choose to participate, they will be charged 100% of the established rates (with the exception of Family Planning) for all services rendered, unless otherwise approved by Health Director.
 4. During the eligibility process the client will be asked for all sources of income. We will require at least the last check stub; however, if the client is not currently working the last tax return is requested.

- a. It is our policy that no client will be refused services when presenting for care based on lack of documentation, however each client will be billed at 100% until proof of income and family size is provided to the agency. The client will have 30 days to present this documentation in order to change the previous 100% charge to a sliding fee.
- b. If no documentation is produced in 30 days then the charge stands at 100% for that visit. **EXCEPTION: FAMILY PLANNING (TITLE X) STATES THAT IF A PATIENT PRESENTS FOR SERVICES WITHOUT PROOF OF INCOME, YOU CANNOT CHARGE THEM AT THE 100% RATE SO MUST USE INCOME DECLARATION FOR THAT VISIT.**
5. Client's reporting an income that qualifies for a 0% pay level will be requested to go to the Department of Social Services to apply for assistance.
6. All persons wanting to receive Family Planning services will be given an application for the Family Planning Waiver program and instructed to complete the form and return it to the Department of Social Services within 14 days of the visit.
7. If dealing with a client seeking Communicable Disease, Immunizations, Sexually Transmitted Infections or Family Planning services and they are unable to provide income data, this should be documented on the Financial Data Sheet but it may not hinder the services provided to the client. This is considered as taking "Declaration of Income Statement"
8. Clients who present for clinical services and say they do not work, have no income of any kind, do not receive Department Of Social Services assistance, but state they have a friend living outside the home paying the bills will be required to bring in proof of the "friends" income.
 - a. Following the same guidelines listed earlier.
 - b. This does not apply to family planning
- F. Certification/Eligibility Procedures
 1. After the client has provided all needed information relating to finances and economic unit, the client will be asked to sign in block 17 "Applicant's Signature" of the "Financial Eligibility Application".
 2. It will be explained to the client that this gives us the right to verify income and if discrepancies are found then patient's charges may be adjusted. Verification can be performed by checking with DSS, Employment Security Commission or by contacting the employer when warranted.
- G. Sliding Fee Chart
 1. An updated sliding fee chart that is based on 250% of the Federal Poverty is provided each year by the Division of Public Health.
 2. Once the income and number of members from the economic unit have been determined, the sliding fee chart will be used to determine placement on the sliding scale.
 3. Clients at 100% or below of the poverty level pay nothing for the services that are provided. Clients at 250% or greater than the poverty level pay 100% of the charges. Those who fall between 100% and 250% pay on a sliding scale based on the Sliding Fee Chart.
- H. Service Denials or Restrictions
 1. Service restrictions may be applied to patients who do not make a "good faith" effort to pay or honor their payment agreement unless restricted by State and Federal regulations.

- a. Communicable Disease, Family Planning, Sexually Transmitted Infection or Immunization services cannot be denied because of an outstanding balance.
- b. Patients in other programs will be informed of the possibility that service restrictions or denial of services may be imposed for non-payment of charges.
- 2. If a client requests services and has a balance due, the eligibility worker will discuss the delinquent account and request payment; if no payment is given the eligibility worker will then set up a payment plan which will be placed in the financial section of the client's chart. (See Collections Policy)
- 3. No patient will be denied services based solely on their inability to pay as determined by the sliding fee program and every reasonable effort will be made to ensure that clients receive the services that are needed.
- 4. Cases of delinquent payment agreements will be discussed with the Health Department's Finance Officer and Clinical Director on a case by case basis. In extreme and/or unusual circumstances, the Health Director or designee, in consultation with staff is authorized to circumvent the guidelines outlined above.
- I. Frequency of Eligibility
 - 1. A full eligibility evaluation should be done at least every 6 months or whenever there is a change in the client's employment/income.
 - 2. It may be done more often if there is a change in client's financial status or the agency deems it necessary.
 - a. On each visit the client will be asked if there is a change in their financial status.
 - b. The staff will indicate there has been "*no change*" by writing "NC" followed by their initials on the Financial Sheet used for eligibility documentation.
 - c. May use reported income through other programs offered at CCHD rather than re-verify income or rely solely on client's self report.
- J. General Information
 - 1. Upon completion of the clinical visit, all direct pay patients (0%-100%) in the following programs should stop by the front desk to receive a statement showing the amount of charges and payment for services will be requested.
 - a. Adult Health
 - b. Child Health
 - c. Family Planning
 - d. Maternal Health
 - e. Pediatric Primary Care
 - 2. If client cannot make a payment in full a payment agreement will be completed (see Collections Policy for payment plan instructions and form).
 - 3. All charges are available to the client upon request.

IV. ATTACHMENTS

- A. Sliding Fee Chart
- B. ~~Financial Eligibility Application~~

V. POLICY HISTORY

- A. Date Originally Approved:
 - 1. 05/26/09

- B. Effective Date:
 - 1. 05/26/09
- C. Dates Policy Reviewed:
 - 1. 05/01/2010
 - 2. 07/20/2011
 - 3. 10/23/2012
 - 4. 07/17/2013
 - 5. 03/25/2014
 - 6. 01/08/2015
 - 7. _____
 - 8. _____
- D. Dates Policy Revised:
 - 1. 10/23/2012
 - 2. 01/08/2015

VI. APPROVAL

Health Director

Date

Chairman, Board of Health

Date

N. C. Division of Public Health
Women's and Children's Health Section
Women's Health Branch, Family Planning & Reproductive Health Unit
Annual Gross Family Income
Sliding Fee Scale – 101% to 250% of Poverty
Family Planning Waiver Eligibility Included

Effective 2/2014

Family Size	Federal Poverty	Partial-Pay Bracket Twenty Percent		Partial-Pay Bracket Forty Percent		Partial-Pay Bracket Sixty Percent		Partial-Pay Bracket Eighty Percent		Full Pay	
		From	To	From	To	From	To	From	To		
1	\$11,670	\$11,671	\$16,046	\$16,047	\$20,423	\$20,424	\$21,550	\$24,799	\$24,800	\$29,174	\$29,175
2	\$15,730	\$15,731	\$21,629	\$21,630	\$27,528	\$27,529	\$29,101	\$33,426	\$33,427	\$39,324	\$39,325
3	\$19,790	\$19,791	\$27,211	\$27,212	\$34,633	\$34,634	\$36,672	\$42,054	\$42,055	\$49,474	\$49,475
4	\$23,850	\$23,851	\$32,794	\$32,795	\$41,738	\$41,739	\$44,123	\$50,681	\$50,682	\$59,624	\$59,625
5	\$27,910	\$27,911	\$38,376	\$38,377	\$48,843	\$48,844	\$51,634	\$59,309	\$59,310	\$69,774	\$69,775
6	\$31,970	\$31,971	\$43,959	\$43,960	\$55,948	\$55,949	\$59,145	\$67,936	\$67,937	\$79,924	\$79,925
7	\$36,030	\$36,031	\$49,541	\$49,542	\$63,053	\$63,054	\$66,656	\$76,564	\$76,565	\$90,074	\$90,075
8	\$40,090	\$40,091	\$55,124	\$55,125	\$70,158	\$70,159	\$74,167	\$85,191	\$85,192	\$100,224	\$100,225
9	\$44,150	\$44,151	\$60,706	\$60,707	\$77,263	\$77,264	\$81,678	\$93,819	\$93,820	\$110,374	\$110,375
10	\$48,210	\$48,211	\$66,269	\$66,270	\$84,368	\$84,369	\$89,189	\$102,446	\$102,447	\$120,524	\$120,525
11	\$52,270	\$52,271	\$71,871	\$71,872	\$91,473	\$91,474	\$96,700	\$111,074	\$111,075	\$130,674	\$130,675
12	\$56,330	\$56,331	\$77,454	\$77,455	\$98,578	\$98,579	\$104,211	\$119,701	\$119,702	\$140,824	\$140,825

* at or below
185% of federal
poverty level



CASWELL COUNTY HEALTH DEPARTMENT POLICY

I. POLICY TITLE: Board of Health General Health Department Policy

A. Policy

1. It is the policy of the Caswell County Board of Health that the Caswell County Health Department will:
 - a. Hire, train, maintain and retain a high quality public health workforce;
 - b. Provide a secure, safe, clean and well maintained environment for its workforce and clients;
 - c. Provide high quality public health services to its clients and will take systematic measures to improve the quality of these services;
 - d. Comply with all applicable federal, state and local laws, rules, regulations and ordinances;
 - e. Fulfill all of its duties and obligations in an ethical and lawful manner.

B. Policy Type

1. Board of Health Policy
2. Administrative Policy

C. Purpose

1. The Caswell County Board of Health is the policy-making, rule-making and adjudicatory body for the Caswell County Health Department.
2. The Board of Health will establish general policies and guidelines that the Health Department will then use to develop more detailed administrative policies.

D. Target

1. This policy applies to the administration and staff of the Caswell County Health Department.

E. References

1. NC General Statutes 130A-35 (a)

II. PROCEDURE:

- A. The Caswell County Health Department will develop, maintain and comply with policies and procedures that reflect the general policies of the Board of Health.

III. POLICY HISTORY:

A. Date Originally Approved

1. 02/24/2009

B. Effective Date

1. 02/24/2009

C. Dates Policy Reviewed

- | | |
|---------------|---------------|
| 1. 06/30/2010 | 6. 02/24/2015 |
| 2. 06/15/2011 | 7. _____ |
| 3. 07/03/2012 | 8. _____ |
| 4. 07/17/2013 | 9. _____ |
| 5. 03/25/2014 | 10. _____ |

D. Dates Policy Revised

- 1. 02/24/2015
- 2. _____
- 3. _____
- 4. _____
- 5. _____
- 6. _____
- 7. _____
- 8. _____
- 9. _____
- 10. _____

IV. APPROVAL:

Board of Health, Chairperson

Date

Health Director

Date



CASWELL COUNTY HEALTH DEPARTMENT POLICY

- I. POLICY TITLE: Observing Public Health and Related Laws and Regulations**
- A. Policy**
1. The workforce and Board of Health of Caswell County Health Department consults and follows federal, state, and local laws and regulations.
 2. And, follows the most current recommendations of regulatory and advisory bodies in the delivery of essential and mandated public health services.
- B. Policy Type**
1. Board of Health
 2. Administrative
- C. Purpose**
1. The purpose of this policy is to provide CCHD workforce and Board of Health with laws, regulations and guidelines applicable to public health practices
- D. Target**
1. This policy targets the workforce and the Board of Health of CCHD
 2. This policy protects all clients of CCHD
- E. References**
1. Authority of Regulatory and Accrediting Bodies Policy
- II. DEFINITIONS**
- A. CDC—Centers for Disease Control and Prevention—**An agency of the United States government. The CDC serves as the national focus for developing and applying disease prevention and control, environmental health, and health promotion and education activities designed to improve the health of the people of the United States. The Internet home page for the CDC is <http://www.cdc.gov>.
- B. DHHS—North Carolina Department of Health and Human Services—**A department of State government that is charged with “protecting health, fostering self-reliance and protecting the vulnerable.” <http://www.dhhs.state.nc.us/>
- C. Essential public health services—**“Essential public health services” means those services that the State shall ensure because they are essential to promoting and contributing to the highest level of health possible for the citizens of NC.
- D. Mandated public health services—**The public health services that the State requires a local public health department to implement.
- E. FR—Federal Register—**The official daily publication for rules, proposed rules, and notices of Federal agencies and organizations, as well as executive orders and other presidential documents. The Internet search page for the CFR is located at <http://www.gpoaccess.gov/fr/>.
- F. USCFR—United States Code of Federal Regulations—**The codification of the general and permanent rules published in the Federal Register by the executive departments and agencies of the Federal Government. It is divided into 50 titles that represent broad areas subject to Federal regulation. Each volume of the CFR is updated once each calendar year and is issued on a quarterly basis. The Internet search page for the FR is located at <http://www.gpoaccess.gov/cfr/index.html>.
- G. NCAC—North Carolina Administrative Code—**A compilation of the administrative rules of approximately 26 state agencies and 50+ occupational licensing boards. Compilation

and publication of the NCAC is mandated by G.S. 150B21.18. NCAC is located on the web at http://ncrules.state.nc.us/ncadministrativ_/default.htm.

- H. NCGS—North Carolina General Statutes—the laws of the state. Public health laws are located in the publication, Public Health and Related Laws of North Carolina, NCDHHS, Division of Public Health, 2002; and on the web at <http://www.ncleg.net/statutes/statutes.asp>.
- I. Ordinance—Ordinances are local rules adopted by the Board of County Commissioners. They cover animal control, subdivisions, cable TV, noise, land use, manufactured homes, solid waste, erosion control and many other issues.
- J. Regulating and advisory agencies—Agencies that are created by a governing body to recommend best practices for Public Health or are charged with interpreting and enforcing Public Health law. (Examples: NC Department of Health and Human Services, Centers for Disease Control and Prevention)
- K. Workforce—The agency staff. Employees, (including contract personnel), volunteers, trainees, students, and other persons whose actions, in the performance of work for CCHD are under direct control of CCHD, whether or not they are paid by the CCHD.

III. PROCEDURES

- A. Responsibilities
 - 1. Department supervisors must develop procedures and/or task outlines to assure effective and efficient service delivery within the scope of the most current public health laws and regulations.
 - 2. The workforce must follow laws, established guidelines, and consistent procedure in order to assure that the public receives fair, efficient, and effective services.
 - 3. The workforce must consult legal counsel such as the Buncombe County attorney, the NC Attorney General or the University of North Carolina School of Government Institute of Government whenever legal assistance is indicated to interpret laws and rules.
- B. CCHD relies on the Caswell County Health Department Board of Health to set public health policy and rules and to guide decision making related to public health practice, as required by NCGS 130-A, Article 2.
- C. CCHD observes applicable laws and regulations when dispersing and utilizing funds that support public health programs (NCGS 159, NCGS 130A, Article 1; 10A NCAC 45A, 10A NCAC 46; NC Session Law 2001-424) (NC Division of Medical Assistance eligibility manuals) (ICD-9 / CPT / HCPCS Manual)
- D. CCHD Administration follows the requirements of applicable laws, and licensing and certifying bodies for the process of hiring, training, and ensuring the credentials and competence of the public health workforce. (Examples: NCGS 90, NCGS 90A, NCGS 126, NCGS 130A; 25 NCAC Chapter 01, 21 NCAC)
- E. CCHD takes the appropriate steps to ensure that confidential information is protected and public information is available when requested. (Examples of documents that address confidentiality and public record are 45 CFR Parts 160 and 164, the HIPAA Privacy Rule; NCGS 130A, NCGS 122C, NCGS 132 various chapters of 10A NCAC) (NC Health Information Management Legal Reference Manual)
- F. CCHD takes steps to ensure that services are available to everyone regardless of race, color, national origin, sex, religion, age or disability. (Federal Civil Right Act of 1964 and Title VI of the Civil Rights Act of 1964) (Title II of the Americans with Disabilities Act)
- G. CCHD takes steps to ensure the safety and well being of the workforce. (Occupational Safety and Health Act, 29 CFR Part 1910) (13 NCAC 7A &7F) North Carolina

- H. Occupational Safety and Health Standards for General Industry, February 1, 2001
The workforce utilizes the appropriate laws, rules and manuals and other applicable publications in providing essential public health services as outlined in 10A NCAC.

IV. ATTACHMENTS

- A. Resources for Caswell County Health Department Workforce

V. POLICY HISTORY

- A. Date Originally Approved
 - 1. 02/04/2014
- B. Effective Date
 - 1. 02/04/2014
- C. Dates of Review
 - 1. 02/24/2015
 - 2. _____
 - 3. _____
 - 4. _____
 - 5. _____
 - 6. _____
 - 7. _____
 - 8. _____
- D. Dates of Revision
 - 1. _____

VI. APPROVAL

Board of Health, Chairperson

Date

Health Director, Secretary to Board of Health

Date

Resources for the Caswell County Health Department Workforce

The list of statutes, rules, resources and manuals here is not a complete listing of all available information and regulations.

I. HEALTH SUPPORT

- A. Assessment of health status, health needs, and environmental risks to health; (NCGS 130A-1.1)
 - 1. Caswell County Community Health Assessment Report 2011
 - 2. State of the County Health Report 2012 and updates
- B. Patient and community education;
 - 1. Guidelines & Resource Materials for SIDS Grief Counselors, NC Department of Environmental Health &
 - 2. Natural Resources; Jan 1994.
- C. Public health laboratory support for essential public health services ;(NCGS 130A-88 through 89; 10A NCAC 42) (42CFR Part 493, Fed. Reg. Vol. 68 and Vol. 16, January 2003) (Federal Clinical Laboratory Improvement Amendment (CLIA) of 1988) Laboratory Procedure Manual, Federal government)
- D. Registration of vital events; (NCGS 130A, Article 4; 10ANCAC 41H)

II. ENVIRONMENTAL HEALTH

- A. Environmental Health (NCGS 130A ; 15A NCAC Subchapter15A)
- B. Rules Governing The Sanitation Of Restaurants And Other Food Handling Establishments 15a NCAC 18a .2600
- C. Rules Governing The Sanitation Of Bed And Breakfast Homes 15A NCAC 18A .2200
- D. Rules Governing The Sanitation Of Summer Camps 15A NCAC 18A .1000
- E. Rules Governing The Sanitation Of Lodging Establishments 15A NCAC 18A .1800
- F. Rules Governing The Sanitation Of Meat Markets 15A NCAC 18A .2700
- G. Rules Governing The Sanitation Of Hospitals, Nursing Homes, Rest Homes, And Other Institutions 15A NCAC 18A .1300
- H. Rules Governing The Sanitation Of Child Care Centers 15A NCAC 18A .2800
- I. Rules Governing The Sanitation Of Residential Care Facilities 15A NCAC 18A .1600
- J. Rules Governing The Sanitation Of Public, Private And Religious Schools 15A NCAC 18A .2400
- K. Rules Governing The Sanitation Of Local Confinement Facilities 15A NCAC 18A .1500
- L. Rules Governing The Sanitation Of Adult Day Service Facilities 15A NCAC 18A .3300
- M. Rules Governing Public Swimming Pools 15A NCAC 18A .2500
- N. Rules Governing Tattooing
- O. Rules Governing The Sanitation and Protection Of Water Supplies 15A NCAC 18A .1700
- P. Laws And Rules For Sewage Treatment, And Disposal Systems ,
- Q. Munsell Soil Color Charts, 1990
- R. Lodging and institutional sanitation; (NCGS 130A, Article 8)
- S. On-site domestic sewage and wastewater disposal; (NCGS 130A, Article 9)
- T. Water and food sanitation and safety:
- U. Private water supply sanitation;
- V. Milk sanitation; (NCGS 130A-274 through 279)
- W. Shellfish sanitation;
- X. Public swimming pool sanitation; (NCGS 130A-280 through 282)
- Y. Food sanitation; (NCGS 130A-235 through 259)
- Z. Mosquito Control (NCGS 130A, Article 12)

III. PERSONAL HEALTH: (NCGS 90-171.20(7))

- A. Public Health Nurse Manual, NCDHHS, 1999
- B. NC Breast and Cervical Cancer Program Policy and Procedure Manual, NCDHHS
- C. Pharmacy Laws of NC, NC Board of Pharmacy/August 2002 (21NCA C 46) (CFR 21 Chapter 11 Part 1300)
- D. Medicaid Manuals, NCDHHS, Division of Medical Assistance
- E. BCHC P&Pform- Revised 11/2002-1000.56_ADM P&P_Observing Public Health and Related Laws and RegulationsOriginal_011604doc.doc
- F. Child health: (NCGS 130A, Article 5, Article 18; 10A NCAC 43D (WIC), 10A NCAC 43E) (Section 17 (a),
 - 1. Public Law 95-627, Child Nutrition Amendment of 1978.)
 - 2. NC WIC Program Manual, DHHS, 2004
 - 3. Breastfeeding Promotion of Support Guidelines for Healthy Full Term Infants, NCDHHS, 1995
 - 4. Problem Oriented Health Record Child Health Training Book; Division of Public Health Dec. 2000
 - 5. Child Care Sanitation: Facilities Practice and Procedure, NC Department of Environment and Natural Resources; May 2002
 - 6. Child Care Handbook Division of Child Development; Jan. 2003
 - 7. Program Regulations for Head Start & Early Head Start Manual
 - 8. Lead poisoning prevention; (NCGS 130A-131.7 through 131.9) NC Childhood
 - 9. Lead Screening and Follow-up Manual, NC Department of Environment and Natural Resources
 - 10. Well-child care Child Health Program Manual, 1986
 - 11. Genetic services (10A NCAC 43H)
 - 12. Services to the developmentally-disabled child (10A NCAC 43G)
 - 13. Child care coordination; N.C. CSC Program Manual, DHHS, 2002; N.C. Infant-Toddler Program Manual, MH/DD/SAS 1996
 - 14. Adolescent health services
 - a. School health services; School Health Program Manual, 1999
 - b. Chronic Disease Control: (NCGS 130A, Article 7;)
 - c. Early detection and referral;
 - d. Patient education;
 - e. Chronic disease monitoring and treatment;
- G. Communicable Disease Control: NCGS 130A, Article 6; 10A NCAC 41A)
 - 1. Control of Communicable Diseases Manual, American Public Health Association, 2000
 - 2. NC Communicable Disease Manual, NCDHHS, 1987
 - 3. Tuberculosis control (10A NCAC 41A & 41E; NC TB Policy Manual, NCDHHS, 1999)
 - 4. Immunization; (NCGS 130A-152 through 158; 10A NCAC 41A)
 - a. Manual for the Surveillance of Vaccine Preventable Diseases, DHHS, 2003
 - b. Epidemiology and Prevention of Vaccine Preventable Diseases, CDC, 2002
 - c. Health Information for International Travel, CDC, 2003
 - 5. Epidemiological investigation, surveillance and general communicable disease control; (NCGS 130A-134 through 138)
 - 6. HIV/STD control; Sexually Transmitted Diseases Treatment Guidelines, CDC, 2002

- 7. Rabies control; (NCGS 130A-184 through 201; 10A NCAC 41G)
 - H. Dental Public Health: (NCGS 130A-366 through 367; 10A NCAC 40A, 40B, 40C) (Title 21 of the US Social Security Act)
 - 1. NC Health Choice Manual, NC DHHS, Division of Medical Assistance)
 - a. Dental health education;
 - b. Fluoride prophylaxis;
 - c. Sealant utilization;
 - d. Dental screening and referral;
 - I. Family Planning: NCGS 130A, Article 5; 10A NCAC 43A & 43D; 42CFR Part 59
 - 1. Program Guidelines for Project Grants for Family Planning Services, USDHHS, January 2001 (Title X Manual)
 - 2. Women's Health Resource Manual, NC DHHS, May 2001
 - a. Preconception counseling;
 - b. Contraceptive care;
 - c. Fertility services;
 - d. Health Promotion and Risk Reduction;
 - e. Lifestyle behavior modification;
 - f. Injury control (10A NCAC 41B)
 - g. Nutrition counseling; (NCGS 130A -361; 10A NCAC 43D)
 - h. Bright Futures In Practice: Nutrition, USDHHS, 2002
 - J. Maternal Health Services: (NCGS 130A, Article 5; 10A NCAC 43B, 43C, 43D)(1986 SOBRA)
 - 1. Women's Health Resource Manual, NCDHHS, May 2001
 - 2. NC WIC Program Manual, DHHS, 2004)
 - a. Prenatal and postpartum care;
 - b. Maternity care coordination.
 - 3. Baby Love, A Technical Manual for Maternity Care Coordination, DHHS, Division of Medical Assistance 5/99;
 - 4. Baby Love Maternal Outreach Worker Service Manual, 5/95)
 - 5. Maternal Outreach Worker Field Manual DHHS, DMA and Office of Rural Health;
 - 6. Maternal Outreach Worker Supervisor's Training Manual, DHHS, DMA and Office of Rural Health 1/95)
- IV. PUBLIC HEALTH EMERGENCIES:**
- A. Terrorist event (NCGS 130A-475 through 479; 10A NCAC 41A)
 - B. Caswell County Emergency Operations Plan, BC Office of Emergency Preparedness
- V. HOME HEALTH SERVICES**
- A. 42 CFR PART 484
 - B. North Carolina Medicaid Community Alternatives Program for Adults (CAP/DA) Manual; Community Care Section
 - C. Accreditation Commission for Home Care Accreditation Standards



I. POLICY NAME: Board of Health Operating Procedure

- A. Policy
 - 1. The Board of Health shall follow these operating procedures in accordance with General Statutes.
- B. Policy Type
 - 1. Board of Health
 - 2. Health Department
- C. Purpose
 - 1. The purpose of this policy is to set guidelines for Board of Health operations.
 - 2. This policy outlines the roles and responsibilities for the Board of Health
- D. Target
 - 1. This policy is followed by the Board of Health.
 - 2. This policy is also followed by the Health Director and other staff who interact with the Board of Health.
- E. References
 - 1. General Statutes
- F. Table of Contents

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II. PROCEDURES

- A. Name and Location
 - 1. The name of this organization is the Caswell County Board of Health, hereinafter referred to as “Board of Health”.
 - 2. The principal office of the Board is located at the Caswell County Health Department, 189 County Park Road, Yanceyville, NC 27379.
- B. Purpose of the Board
 - 1. The Board of Health is the policy-making, rule-making and adjudicatory body for the Caswell County Health Department (§ 130A-35 (a)).
 - 2. The Caswell County Board of Health has the responsibility to protect and promote the public health.
 - 3. The Board of Health has the authority to adopt rules necessary for that purpose. (§ 130A-39 (a)).

- C. **Caswell County Health Department Mission Statement**
 - 1. The mission of the Caswell County Health Department is to protect the health and welfare of Caswell County citizens and to meet the county's health needs through direct services, assessment and evaluation, and community partnerships.
 - 2. We hold the following core values to fulfill this mission:
 - a. **Health Promotion:** We emphasize the importance of healthy lifestyles and behaviors that lead to an enhanced quality of life and lower health risk.
 - b. **Prevention:** We act promptly to prevent the spread of communicable diseases and to lower risk factors that lead to chronic disease.
 - c. **Sanitation:** We work to ensure food safety, clean drinking water, clean air and a safe environment.
 - d. **Partnerships:** We cooperate with community, state and national partners to meet the needs of the citizens.
 - e. **Quality:** We strive to meet the highest standards of quality as we provide services to our citizens.
 - 3. **Caswell County Health Department Vision Statement**
 - a. The Caswell County Health Department prevents disease, promotes health and protects the environment.
 - 4. **Caswell County Health Department Tag Line**
 - a. Caswell County Health Department: Preventing Disease, Promoting Health, Protecting the Environment.
- D. **Membership**
 - 1. **Membership (§ 130A-35 (b))**
 - a. The members of a county board of health shall be appointed by the county board of commissioners.
 - b. The board shall be composed of 11 members who shall be residents of Caswell County.
 - c. The composition of the board shall reasonably reflect the population makeup of Caswell County and shall include:
 - 1) One physician licensed to practice medicine in this State
 - 2) One licensed dentist
 - 3) One licensed optometrist
 - 4) One licensed veterinarian
 - 5) One registered nurse
 - 6) One licensed pharmacist
 - 7) One county commissioner
 - 8) One professional engineer
 - 9) And three representatives of the general public
 - 2. **Absence of a Designated Professional (§ 130A-35 (b))**
 - a. If there is not a licensed physician, a licensed dentist, a licensed optometrist, a licensed veterinarian, a registered nurse, a licensed pharmacist, or a professional engineer available for appointment, an additional representative of the general public shall be appointed.
 - b. If however, one of the designated professions has only one person residing in the county, the county commissioners shall have the option of appointing that person or a member of the general public.
 - 3. **Terms (§ 130A-35 (c))**
 - a. Except as provided in this section, members of the county board of

- b. health shall serve three-year terms.
 - b. No member may serve more than three consecutive three-year terms unless the member is the only person residing in the county who represents one of the professions designated in Section 1 of this article.
 - c. The county commissioner member shall serve only as long as the member is a county commissioner.
 - d. When a representative of the general public is appointed due to the unavailability of a licensed physician, a licensed dentist, a licensed optometrist, a licensed veterinarian, a registered nurse, a licensed pharmacist, or a professional engineer, that member shall serve only until a licensed physician, a licensed dentist, a licensed optometrist, a licensed veterinarian, a registered nurse, a licensed pharmacist, or a professional engineer becomes available for appointment.
 - e. In order to establish a uniform staggered term structure for the board, a member may be appointed for less than a three-year term.
4. Removal (§ 130A-35 (g))
- a. A member may be removed from office only by the county board of commissioners.
 - b. The Board of Health may make recommendations to the Board of Commissioners based on the following reasons and procedure.
 - 1) Reasons:
 - a) Commission of a felony or other crime involving moral turpitude
 - b) Violation of a State law governing conflict of interest
 - c) Violation of a written policy adopted by the county board of commissioners
 - d) Habitual failure to attend meetings which is defined by the Caswell County Board of Commissioners as a member who misses three consecutive meetings of the Board of Health without just cause
 - e) Conduct that tends to bring the office into disrepute
 - f) Failure to maintain qualifications for appointment required by Section 2 of this Article.
 - 2) Procedure
 - a) The Chairperson will contact a member who meets any of the conditions for recommended removal listed in Section 4 (A) of this Article, to determine the member's interest or ability, or the propriety for them to continue to serving.
 - b) If the Chairperson determines that the member does not have an interest or ability, or it would be improper for them to continue serving on the Board of Health, the member will be given written notice of the Board of Health's intention to recommend to the Board of Commissioners their removal and the basis for this action.
 - c) The member will be given an opportunity to respond. If the member indicates that they do not wish to continue serving, or if there is no response within 10 working days the Chairperson will notify the Board of

Commissioners and will recommend that the member in question be removed from the Board of Health and a replacement be appointed for the remaining portion of their term.

- d) If the member responds within 10 working days and indicates that they wish to continue serving, the full board will discuss the matter at the next regularly scheduled Board of Health meeting and decide what action to take.

5. Resignation

- a. Any member of the Board of Health may resign at any time by giving written notice to the Chairperson of the board.
- b. The resignation of any member will take effect upon receipt of the notice thereof or at such later date as is specified in such a notice; and, unless otherwise specified therein, the acceptance of such resignation will not be necessary to make it effective.
- c. The Chairperson will notify the Board of Commissioners of the resignation so that they can satisfy their legal duty to fill the vacancy.

6. Per Diem (§ 130A-35 (h))

- a. A member may receive a per diem in an amount established by the county board of commissioners.
- b. Reimbursement for subsistence and travel shall be in accordance with a policy set by the county board of commissioners.

7. Conflict of Interest

- a. It is the policy of the Board of Health that no member of the board or member of a committee or board appointed by the Board of Health will participate in, discuss or cast a vote on any matter or issue in which such member stands potentially to receive any financial gain or in which a conflict of interest, as defined by N.C. law, may exist (§ 14-234).
 - 1) No member may derive a direct benefit from a contract with the Health Department except as allowed by law.
 - 2) A member who will derive a direct benefit from a contract with the Health Department, as allowed by law, shall not attempt to influence any other person who is involved in making or administering the contract.
 - 3) If a conflict of interest should arise, it is the responsibility of the member who is conflicted to inform the board or committee about the conflict in open session prior to any discussion or vote on the matter that is in conflict. The conflict will be documented in the board or committee minutes.
 - 4) No member may solicit or receive any gift, reward, or promise of reward in exchange for recommending, influencing, or attempting to influence the award of a contract with the Health Department.

8. Oath of Office

- a. A person appointed, or reappointed, to the Board of Health must take the required oath of office, administered by the Clerk to the Board of Commissioners or any other person authorized by N.C. law, before functioning as a board member.

9. Orientation and Continuing Education

- a. Members of the Caswell County Board of Health will receive orientation to their duties and responsibilities, and to the Health Department programs and facilities.
 - b. At or before their first Board of Health meeting
 - 1) A new member will be given a packet of information about their duties, responsibilities and legal obligations as well as a description of the various Health Department activities and budget.
 - 2) A tour of the Health Department facilities will also be offered.
 - c. Within one year of being first appointed
 - 1) Board of Health members will participate in the Board of Health training sponsored by the NC Division of Public Health, if available.
 - 2) Other board members will periodically participate in this training as determined by the board.
 - d. Continuing Education
 - 1) The Board of Health participate in continuing education about important public health issues and member duties and responsibilities.
 - 2) The board will decide each year as to the format and topics that will be covered by this continuing education.
- E. Officers
- 1. Officers
 - a. The Board of Health will elect its own Chairperson and Vice Chairperson annually.
 - b. These officers will perform the duties as prescribed by the operating procedure, the Laws of N.C., and the parliamentary authority adopted by the Board of Health.
 - c. No member shall hold more than one office at a time and no member shall be eligible to serve more than three consecutive terms as Chairperson or Vice Chairperson.
 - 2. Chairperson
 - a. The Chairperson will preside at all meetings and is authorized to sign documentation, and provide oral and written communication on behalf of the Board of Health.
 - b. The Chairperson will appoint appropriate temporary committees deemed necessary to carry on the work of the Board of Health.
 - c. The Chairperson is an ex officio (non-voting) member of all committees but has no obligation to participate at committee meetings and is not counted in determining if a quorum is present at a committee meeting.
 - d. The Chairperson will determine the composition, duration, and dissolution of all committees
 - 3. Vice-Chairperson
 - a. The Vice-Chairperson will preside in the absence of the Chairperson and will perform such duties as are assigned by the Chairperson.
 - b. Should the office of Chairperson be vacated for any reason, the Vice-Chairperson will fill the unexpired term of office and a new Vice-Chairperson will be elected by the Board.
 - 4. Secretary
 - a. The Health Director will serve as Secretary to the Board but will not be a

- only if permitted by and in accordance with the North Carolina open meetings laws.
- b. Any person may request that an item be placed on the Board's agenda by submitting a written request to the Secretary at least ten working days before the meeting.
 - c. For each regularly scheduled meeting of the Board of Health, the agenda and a packet of information related to the meeting will be sent to each board member so that it will arrive at least 24 hours prior to meeting.
 - d. Information contained in the packet includes
 - 1) Minutes from recent Board of Health meetings
 - 2) Any reports related to Health Department program audits by the state or other organizations
 - 3) Quality improvement reports
 - 4) Financial reports
 - 5) Information about current or pertinent public health matters and other information requested by the board or board Chair, or determined to be of significance by the Secretary.
3. Presiding Officer
- a. If present, the Chairperson of the Board of Health will preside at meetings of the Board of Health.
 - 1) In the absence of the Chairperson, the Vice-Chairperson will preside.
 - 2) In the absence of the Chairperson and the Vice-Chairperson another Board of Health member shall be designated to preside by a majority vote of the members who are present.
 - 3) The Secretary shall open such a meeting and as the first order of business, open the floor for nominations of a temporary chairperson for that meeting.
 - b. The presiding officer has the following powers
 - 1) To rule motions in or out of order
 - 2) To determine whether a speaker has gone beyond reasonable standards of time
 - 3) To vote on each motion; and to call a recess at any time.
 - c. The most recent edition of "Roberts' Rules of Order, Newly Revised" is followed in the conduct of the meetings.
4. Quorum
- a. A simple majority of current members, including the Board of Health Chairperson, constitutes a quorum for Board of Health meetings.
 - b. A member who has withdrawn from a meeting without being excused by a majority vote of the remaining members shall be counted as present for purposes of determining whether or not a quorum is present.
 - c. A majority of committee members, not including the Board of Health Chairperson, constitutes a quorum for Board of Health committees.
5. Voting
- a. A motion may be placed before the board by any member of the board but will only be discussed if the motion is seconded by another member of the board. However, motions coming to the board from a board committee do not require a second.
 - b. Each member shall have an equal vote on items that come before the board. A member must be physically present at the meeting to vote.

- c. A quorum must be present to vote on an issue and a majority is needed to approve any motion except for amendments to the Board of Health Operating Procedures which require at least eight affirmative votes.
 - d. Each Board member shall be permitted to abstain from voting, by so indicating when the vote is taken.
 - 1) A member must abstain from voting in cases involving conflicts of interest as defined by North Carolina law.
 - 2) If a member has withdrawn from a meeting without being excused by a majority vote of the remaining members, the member's vote shall be recorded as an abstention.
6. Special Meetings
- a. Special meetings may be called by the Chairperson or by three of the members of the Board of Health.
 - b. Special meetings may be called for any purpose. However, only those items of business specified in the notice may be discussed or transacted at a special meeting unless:
 - 1) All members are present, and
 - 2) The board determines in good faith at the meeting that it is essential to discuss or act on the item immediately.
 - c. (§ 143-318.12(b)(2)) The Chairperson or calling members shall inform the Secretary of the Board of the special meeting at least forty-eight hours before a special meeting is held in this manner, written notice of the meeting stating its time, place, and the subjects to be considered shall be
 - 1) Given to each board member
 - 2) Posted on the board room door
 - 3) And, mailed or delivered to any person or public media that has filed a written request for notice of special meetings with the Board's Secretary.
7. Emergency Meetings (§ 143-318.12(b)(3))
- a. The Chairperson, Vice Chairperson, or the Secretary of the Board of Health may at any time call an emergency meeting of the board by signing a written notice stating the time and place of the meeting and the subjects to be considered.
 - b. Prior to the emergency meeting, written or oral notice shall be
 - 1) Given to each board member
 - 2) Posted on the board room door
 - 3) And, given to any person or public media that has filed a written request for notice of special meetings with the Board's Secretary.
 - c. The Board may call emergency meetings only because of generally unexpected circumstances that require immediate consideration and only business connected with the emergency may be considered at the emergency meeting.
8. Recessed Meetings (§ 143-318.12(b)(1))
- a. A properly called regular, special or emergency meeting may be recessed to a time and place certain if approved in open session during a regular, special or emergency meeting.
 - b. No further notice need be given of such a recessed session of a properly called regular, special or emergency meeting.
9. Public Comment

- a. A reasonable period of public comment shall be a part of each regularly scheduled Board of Health meeting.
 - b. Each speaker will be given three minutes and up to five speakers will be allowed per meeting for a total of fifteen minutes of public comment.
 - c. The BOH may waive time limits or extend the public comment period upon the motion of any board member that is properly seconded and approved by a majority vote.
10. Closed Session
- a. Meetings will be closed only as permitted by and in accordance with the open meetings law (§ 143-318.11).
11. Disruption (§ 143-318.17)
- a. A person who willfully interrupts, disturbs, or disrupts an official meeting and who, upon being directed to leave the meeting by the presiding officer, willfully refuses to leave the meeting is guilty of a Class 2 misdemeanor.
12. Minutes
- a. The Secretary shall prepare full and accurate minutes of the board proceedings, including closed sessions.
 - b. The exact wording of each motion and the results of each vote shall be recorded in the minutes, and on the request of any member of the board, the entire board shall be polled by name on any vote.
 - c. Members' and other persons' comments may be included in the minutes if the board approves.
 - d. Copies of the minutes shall be made available to each Board member before the next regular Board meeting.
 - e. At each regular meeting, the Board shall review the minutes of the previous regular meeting as well as any special or emergency meetings that have occurred since the previous regular meeting, make any necessary revisions, and approve the minutes as originally drafted or as revised.
 - f. The public may obtain copies of the Board meeting minutes at the Caswell County Health Department.
- G. Rule-Making Authority (§ 130A-39)
- 1. The Board is responsible for protecting and promoting the public health and will adopt rules necessary for that purpose. These rules will apply to all municipalities within the Board's jurisdiction.
 - 2. In areas already under regulation by the Commission for Health Services or Environmental Management Commission, the local Board of Health may adopt a more stringent rule when, in its opinion, such is required to protect the public health.
 - a. Otherwise, the rules of the aforementioned State Commissions will prevail.
 - b. The Board may not adopt rules concerning the grading and permitting of food and lodging facilities, which come under the rules of the Commission for Health Services.
 - c. A local Board of Health may adopt rules concerning waste water collection, treatment and disposal systems which are not designed to discharge effluent to the land surface or surface waters only in accordance with G.S. 130A-335(c).
 - d. Legal advice should be obtained prior to the adoption of rules by the

Board of Health.

3. The following policy will apply before the adoption, amendment, or repeal of any local Board of Health rule. Not less than 10 days before the Board acts:
 - a. The proposed rule or rule change is available at the Office of the County Clerk.
 - b. A notice is published in a newspaper having general circulation within the area of the Board's jurisdiction. This notice will include
 - 1) The subject of the proposed rule or rule change or description of subjects and issues involved
 - 2) The effective date
 - 3) And a statement that copies of the rules proposed or to be changed are available at the local health department.
 4. Local Board of Health rules become effective upon adoption unless a later date is specified in the rule.
 5. Copies of rules are filed with the local health director.
 6. The Board of Health may, in its rules, adopt by reference any code, standard, rule or regulation of any agency of this state, another state, any agency of the United States or by a generally recognized association. Copies are filed with the other Board rules.
- H. Fees
1. The Caswell County Board of Health may impose a fee for services rendered by the Caswell County Health Department in accordance with NCGS 130A-39(g).
 2. Fees are based upon a plan recommended by the local health director and approved by both the Board of Health and Board of Commissioners.
- I. Appointment of the Local Health Director (§ 130A-40)
1. The Board of Health, after consulting with the Board of Commissioners, will appoint a local health director who possess the qualifications established by the Commission for Health Services and the State Personnel Commission.
 - a. If the Board of Health fails to appoint a local Health Director within 60 days of the vacancy, the State Health Director may appoint a Health Director in accordance with NC General Statutes.
 - b. The Board of Health has the ultimate responsibility for employing and dismissing the Health Director.
 2. The function of the Health Director shall be the administrative head of the Health Department and shall perform public health duties prescribed by and under the supervision of the local Board of Health and the NC Department of Health and Human Services. The specific duties and powers of the Health Director are detailed in the NC General Statutes.
 3. The Board of Health will perform an annual appraisal and review of the job performance of the local Health Director and a summary of this review is forwarded to the County Manager.
- J. Duties and Evaluation of Local Health Director
1. The powers and duties of the Local Health Director are described in § 130A-41 and the Health Director's job description
 - a. A local health director
 - 1) Shall be the administrative head of the local health department
 - 2) Shall perform public health duties prescribed by and under the supervision of the local board of health and the state
 - 3) Shall be employed full time in the field of public health.
 - b. A local health director shall have the following powers and duties:

- 1) To administer programs as directed by the local board of health
 - 2) To enforce the rules of the local board of health
 - 3) To investigate the causes of infectious, communicable and other diseases (including zoonotic diseases)
 - 4) To exercise quarantine authority and isolation authority
 - 5) To disseminate public health information and to promote the benefits of good health
 - 6) To advise local officials concerning public health matters
 - 7) To enforce the immunization requirements
 - 8) To examine and investigate cases of venereal disease
 - 9) To examine and investigate cases of tuberculosis
 - 10) To examine, investigate and control rabies
 - 11) To abate public health nuisances and imminent hazards
 - 12) To employ and dismiss employees of the local health department in accordance with Chapter 126 of the NC General Statutes
 - 13) To enter contracts, in accordance with The Local Government Finance Act, on behalf of the local health department without abrogating the authority of the board of county commissioners.
- c. Authority conferred upon a local health director may be exercised only within the borders of Caswell County.
2. The Board of Health will complete a performance evaluation of the Local Health Director each year or more often if indicated.
- a. The Board of Health will choose an appropriate evaluation tool
 - b. This tool will be distributed to each member in the packet for the first regular meeting of the Board of Health each calendar year. Each member will complete the tool to the best of their ability prior to this meeting.
 - c. During closed session at this meeting the board will formulate the annual performance evaluation.
 - d. At the next regular meeting of the board, while in closed session, the evaluation will be discussed with the Health Director.
 - e. A copy of the completed evaluation will be given to each of the following
 - 1) The Health Director's personnel file located at the Health Department
 - 2) The county's Human Resources Department
 - 3) The Health Director
- K. Appeal Hearings
1. Based on N.C. statutes (§130A-24), appeals may be heard by the Board of Health concerning interpretation and enforcement of rules adopted by the Board of Health and concerning the imposition of administrative penalties by the local health director.
 - a. The aggrieved person shall give written notice of appeal to the local health director within 30 days of the challenged action.
 - 1) The notice shall contain:
 - a) The name and address of the aggrieved person
 - b) A description of the challenged action and
 - c) A statement of the reasons why the challenged action is incorrect.
 - 2) Upon filing of the notice, the local health director shall, within five working days, transmit to the local board of health:

- a) The notice of appeal and
- b) The papers and materials upon which the challenged action was taken.
- 3) The local board of health shall hold a hearing within 15 days of the receipt of the notice of appeal.
 - a) The board shall give the person not less than 10 days' notice of the date, time and place of the hearing.
 - b) On appeal, the board shall have authority to affirm, modify or reverse the challenged action.
- 4) The local board of health shall issue a written decision based on the evidence presented at the hearing. The decision shall contain a concise statement of the reasons for the decision.
- 5) A person who wishes to contest a decision of the local board of health shall have a right of appeal to the district court having jurisdiction, within 30 days after the date of the decision by the board.

2. Employee Grievance

- a. As described in the Health Department Grievance Policy, the Board of Health may hear an appeal of an employment action made by the Health Director that meets either of the following criteria.
 - 1) The action resulted in demotion, suspension or dismissal.
 - 2) The action resulted in discrimination due to age, race, sex, color, national origin, religion, creed, political affiliation or disability.
 - 3) Under the above circumstances, the Board of Health will provide the Health Director with an advisory opinion on the Employee Grievance.

L. General Provisions

- 1. These operating procedures, except for those matters required by the NC General Statutes, may be amended or repealed by the vote of eight members at a properly noticed regular meeting of the Board of Health or at any properly called special meeting that includes amendment of the operating procedures as one of the stated purposes of the meeting.
- 2. A vote to amend the operating procedures shall be preceded by a discussion and distribution to all members, in writing, of a copy of the proposed change at the preceding regular meeting.
- 3. Should any provision contained in these operating procedures in any way conflict with any applicable laws, or for any reason be held to be invalid, illegal, or unenforceable in any respect, such conflict, invalidity, illegality, or unenforceability shall not affect any other provision and these operating procedures shall be construed as if such conflicting, invalid, illegal, or unenforceable provisions had never been contained herein.
- 4. These operating procedures shall apply fully to any committee or sub-committee of the board.

III. POLICY HISTORY

- A. Date Originally Approved
 - 1. 02/28/2006
- B. Effective Date
 - 1. 02/28/2006

C. Dates of Review

- | | | | |
|----|-------------------|-----|-------------------|
| 1. | <u>04/24/2007</u> | 7. | <u>10/22/2013</u> |
| 2. | <u>07/29/2008</u> | 8. | <u>02/04/2014</u> |
| 3. | <u>05/26/2009</u> | 9. | <u>02/24/2015</u> |
| 4. | <u>10/26/2010</u> | 10. | _____ |
| 5. | <u>09/27/2011</u> | 11. | _____ |
| 6. | <u>10/15/2012</u> | 12. | _____ |

D. Dates of Revision

1. 04/24/2007
2. 05/26/2009
3. 10/26/2010
4. 09/27/2011
5. 02/04/2014

IV. APPROVAL

Board of Health Chairperson or Vice-Chairperson

Date

Health Director/Secretary to the Board

Date



CASWELL COUNTY HEALTH DEPARTMENT POLICY

- I. **POLICY TITLE:** Collections for Personal and Home Health
 - A. **Policy**
 - 1. The Caswell County Health Department’s accounts receivable are reviewed on a regular basis, and every effort is made to collect outstanding balances within the constraints of State Rules and Local Policy.
 - 2. The Caswell County Health Department’s Finance Officer and the Health Director will use specific, Board of Health approved criteria to determine which debt is unlikely to be collected, and that debt will be placed in a separate accounts receivable category which will be addressed with a client as they request services from the Health Department.
 - 3. The Caswell County Health Department will not collect a co-pay that is higher than the percent of pay unless otherwise stipulated by State guidelines.
 - B. **Policy Type**
 - 1. Board of Health Policy
 - 2. Administrative Policy
 - C. **Purpose**
 - 1. The purpose of this policy is to furnish guidelines on how to handle the Personal and Home Health accounts receivable.
 - 2. It is the purpose of this policy to assure that all client accounts are managed fairly and handled in such a way as to not deny anyone future services based solely on their inability to pay.
 - D. **Target**
 - 1. This policy shall be followed by all Health Department Staff in the Personal and Home Health Units
 - 2. Health Department Personal and Home Health clients will benefit from this policy
 - E. **References:**
 - 1. Eligibility Policy
 - 2. “Collecting Co-Pays and Applying Sliding Fee Scales—A Job Aid for Front Desk Staff”
- II. **PROCEDURE:**
 - A. This policy does not apply to the Environmental Health program because payments for services are received prior to the service being provided and a refund is made when the requested service is not provided for any reason.
 - B. Policies and procedures have been put in place, and are frequently adjusted to improve efficiency, to maximize the amount of collected debt
 - 1. However, there will always be some debt that cannot be collected without extraordinary effort.
 - 2. This is especially true in an agency which has as part of its mission to serve as a “safety net” agency.
 - C. Removing this uncollectable debt from active accounts receivable collection efforts is a process that is recommended by financial consultants for the purpose of “cleaning up” the books.
 - 1. This process provides several benefits:
 - a. It gives a more accurate picture of the reasonable accounts receivable.

- b. It reduces the number of active accounts that need to be reviewed monthly, therefore saving time.
 - 2. This policy establishes a series of detailed steps that all uncollected debt must go through before becoming “inactive” or being “written off”. The use of these criteria may increase the amount of revenue collected by uncovering systemic problems and making sure all reasonable efforts are taken to collect the debt.
 - D. For the purposes of this policy, “Adjustments” and “Write Offs” are two distinct types of uncollectable debt:
 - 1. Adjustment:
 - a. These are reductions in the amount charged based on a prior agreement, rule, directive or policy. For example, we are required by Medicaid to charge the same rate to all other third party payers, yet there are usually written agreements between the other third party payers and the Health Department (as negotiated by the Health Director or his/her designee) to accept a greater or lesser amount.
 - b. Adjustments can involve any of the following:
 - 1) Third party payors such as:
 - a) Medicare
 - b) Medicaid
 - c) Private Insurance Companies
 - d) Contractual Arrangements with other agencies or businesses
 - 2) Local and/State polices that require the use of a Sliding Fee Program where charges are adjusted at the time of the visit based on the client’s income.
 - 2. Write Off:
 - a. This is not a reduction in the amount charged, nor is it a forgiveness of debt, but a method of “aging” outstanding accounts
 - b. This is reclassifying of a debt to a dormant status only after specific, Board of Health approved, criteria have been met (as described below) which indicate that there is little reasonable expectation that the debt can be collected.
 - c. Only after the following criteria have been met and documented, and no other payment sources are available, a debt may be considered uncollectable and may be written off.
 - 1) 120 days have passed with no payment activity on the account and the following criteria have been met.
 - a) All possible payer sources have been discussed with the client/responsible party and the discussion has been documented.
 - b) Accuracy of any insurance information has been double checked.
 - c) Direct contact has been made with all payors named by the client/responsible party. This includes the client or responsible party, all insurance carriers, etc.
 - d) Attempts to collect from a specific third party payer have been exhausted as documented by any of the following reasons:
 - (1) The services were billed in error
 - (2) The service or supply was not covered by the payer
 - (3) The time limit has expired for billing or rebilling
 - (4) The patient was not eligible at the time of service

- (5) The payor has documented a complete denial
 - e) If the responsible party is an individual, a series of four bills have been sent at approximately thirty day intervals and the appropriate collection letter has been attached to the bills sent at 60, 90 and 120 days.
 - (1) See attachments A, B, & C and “PAST DUE” has been stamped on the bills sent at 60, 90, and 120 days.
 - (2) When the account reaches the 120-day status it can be sent for Debt Set Off
 - f) There are no pending, outstanding or ongoing issues to be resolved with any potential payment source.
 - 2) The client has expired and there is no insurance or estate to be billed.
 - 3) The client has filed for bankruptcy and all standard requests for payment through the courts have been completed.
 - 4) At the Health Director’s discretion for unusual, documented circumstances.
 - d. If a client returns to the Caswell County Health Department and requests a service after any debt has been written off, the client will be notified (before being seen if the visit is not urgent) of their outstanding debt, requested to make a payment on their outstanding debt and a payment agreement set up for the remainder of the outstanding debt. When the client checks out the clinic, they will be asked to make a payment of at least the lesser of \$20 or their total charges.
 - e. All debt that is written off must have the approval of the Health Director and will follow the following process.
 - 1) A “Write Off Authorization Form” is completed by the Health Department Finance Officer/or billing staff.
 - 2) The Health Department’s Finance Officer must review and approved the write off.
 - 3) In addition to keeping a copy of the Write Off Authorization Form, (which is kept with the agency billing staff) the Health Department’s Finance Officer will keep a current summary spreadsheet (including at a minimum, the client’s name, date of service, program, amount) of all Write Off clients.
 - 4) The Health Director must then review this form and approve each individual write off.
 - 5) After the Health Director approves the Write Off, the form is returned to the Finance Officer for entry into the Write Off Tracking Spreadsheet.
 - 6) The Finance Officer then forwards the signed, approved Write Off sheet to the billing staff for entry into the client’s individual account.
 - 7) A copy of the “Write Off” form is placed in the client’s medical record under the tab that is labeled, “Financial”
 - f. When allowed by the state’s “Debt Set Off” policies and procedures, debts owed to the Caswell County Health Department will be submitted to the state for collection from the client’s tax refunds or other allowable funds.
 - g. The Caswell County Board of Health is given a summary report of the “Write Offs” ~~annually~~ or as requested or as deemed necessary by the Health Director.

E. Collections

1. Determination of payer responsibility – see eligibility policy
 - a. If a client has a third party payor, that payor will be billed 100% of charges.
 - 1) However, if the client has insurance and is also eligible for a sliding fee discount, the individual will be billed their percentage of only that portion of the charges not paid by the third party payer.
 - 2) Third parties authorized or legally obligated to pay for clients at or below 100% federal poverty level are properly billed
 - 3) For example if a client that is eligible for a 40% discount is charged \$100 for a service, and their insurance pays \$80, the client will then be billed 40% of the remaining \$20).
2. In all cases, the patient is responsible for payment of the assessed charges for services rendered and will sign a statement to that effect each visit (or at the beginning of care in Home Health).
3. Insurance will be billed as a courtesy for our patients. However, in the event that an insurance carrier does not meet their obligation on behalf of the client, the client becomes responsible for the payment based on the Sliding Scale Fee program rules.
4. Clients will be sent bills at 30, 60, 90 and 120 days as specified under the “Write Off” section of this policy. However, this does not apply to clients who request “Confidential” services, such as in Family Planning.
 - a. There will be no mail correspondence sent to the client who has identified themselves as wanting “Confidential Services”.
 - b. In the case of confidential services, it is allowed, with client’s approval, to contact the client on their personal cell phone.
5. Direct Fee Collection
 - a. Private pay clients will be strongly encouraged to pay a minimum of \$20 towards the charges when services are rendered.
 - 1) If a balance remains, a payment agreement will be generated with an amount to be paid each month and will be signed by the client or responsible party.
 - 2) Statements will be mailed monthly for as long as the client is paying on the account as long as confidentiality is not jeopardized.
 - b. Clients who are delinquent over 90 days may when applicable be given a courtesy call reminding them of their account balance when “confidentiality” is not jeopardized.
 - c. A computerized Accounts Receivable System will be used, which reflects the charge, adjustment, balance and collected amount.
 - 1) Self-pay clients will be given a statement/receipt showing the total charges for services received, discounted amount, amount paid (if applicable) and remaining balance at each visit.
 - 2) The Accounts Receivable will be balanced on a daily basis.
6. It is the policy of the Agency to provide initial billing to the appropriate payer in a timely manner.
 - a. Medicaid and Medicare will be billed according to the standard state and national policy and procedures.
 - b. The confidentiality of the client is taken into consideration in any billing procedure and billing efforts may be limited when confidentiality is an issue with a particular client.
 - c. Telephone contact will be made with third party payers as needed from the first billing date if payment has not been received.
7. Payment

- a. The Caswell County Health Department accepts, cash, money orders, personal checks and third party payments.
 - b. The Caswell County Health Department accepts donations should they become available.
 - c. Client's checks that are returned for insufficient funds or account closed will be processed with a fee of \$20 per check added to the patient's account.
 - d. In all cases, the patient/responsible payer will be liable for any and all fees incurred by the Caswell County Health Department in the collection of the client's past due account.
8. Consequences of non-payment of eligible charges
- a. Old debt that has been written off will be reviewed with the client and then reactivated prior to clinical services being provided unless there is an obvious emergency.
 - b. Services may be limited or denied to clients who have the ability to pay based on approved eligibility rules, but refuse if the clinical problem is not an emergency.
 - 1) The Clinical Director and the Finance Officer will determine on a case-by-case basis in keeping with the eligibility policy.
 - c. The rules of some programs may prohibit the denial of any services.

III. ATTACHMENTS:

- A. Write Off Authorization Form
- B. Client's Payment Plan Agreement Form
- C. Letters
 - 1. 60 days
 - 2. 90 days
 - 3. 120 days
- D. "Collecting Co-Pays and Applying Sliding Fee Scales—A Job Aid for Front Desk Staff"

IV. POLICY HISTORY:

- A. Date Originally Approved:
 - 1. 05/26/09
- B. Effective Date:
 - 1. 05/26/09
- C. Dates Policy Reviewed:

1. <u>06/25/2010</u>	5. <u>03/28/2014</u>
2. <u>05/15/2011</u>	6. <u>01/07/2015</u>
3. <u>10/23/2012</u>	7. _____
4. <u>07/17/2013</u>	8. _____
- D. Dates Policy Revised:
 - 1. 10/23/2012
 - 2. 01/07/2015

V. APPROVAL

Health Director

Date

Chairman, Board of Health

Date

**ATTACHMENT A
Caswell County Health Department
Write Off Authorization Form**

Patient ID _____

Patient Name _____

Payor Source(s) _____

Date(s) of Service	Amount Billed	Amount Paid	Adjustment	Write Off
TOTALS				

All Of The Following Write Off Criteria Have Been Met:

- It has been at least 60 days from the last billing
- It has been at least 180 days from the date of service
- There is a documented discussion with the client about all possible payor sources
- The accuracy of insurance information has been checked
- Direct contact has been made with all payors
- There are no known billing issues to be resolved

And, At Least One Of The Following Apply:

- The client was billed in error
- The service is not covered by payor
- The time limit for billing has expired
- The patient was not eligible at the time of service
- The payor has documented a complete denial
- If the payor is an individual, four bills have been sent (with appropriate letters)
- The client has died and there is no insurance or estate
- All appropriate court filings have been made if the client has filed for bankruptcy
- Health Director's discretion: _____

Comments: _____

Requested By: _____ Date: _____

Approved By Finance Officer: _____ Date: _____

Approved By Health Director: _____ Date: _____



CASWELL COUNTY HEALTH DEPARTMENT
189 County Park Rd., Yanceyville, NC 27379
336-694-4129

Date: _____

Dear _____

According to our records, it has been at least sixty days since you were provided services at the Caswell County Health Department and we have not yet been paid. We realize that this could be an oversight on your part and not a willful disregard of your legal obligation. Please contact us to discuss how you will fulfill your obligation.

In order for us to continue providing services to the citizens of Caswell County, we must be paid. If you have already paid this bill, please contact us to be sure your payment has been properly credited to your account.

Sincerely,

Frederick E. Moore, MD
Health Director



CASWELL COUNTY HEALTH DEPARTMENT
189 County Park Rd., Yanceyville, NC 27379
336-694-4129

Date: _____

Dear _____

We recently wrote to you concerning your past due account with us. That debt is now at least ninety days old and we have not yet heard from you. We would like to help you pay your bill in full by arranging a payment plan. Please call immediately to set this up.

If what you owe is not paid in full, you may risk being denied service by the Health Department and I'm sure you do not want this to happen.

Sincerely,

Frederick E. Moore, MD
Health Director



CASWELL COUNTY HEALTH DEPARTMENT
 189 County Park Rd., Yanceyville, NC 27379
 336-694-4129

Date: _____

Dear _____

Your account with us is seriously past due (over 120 days) and we have still not heard from you. In our last letter we advised you of the possible consequences connected with non-payment of a legitimate debt and offered to set up a payment plan, but you have chosen not to respond.

The best way to resolve this problem is to immediately pay your debt in full or to set up a payment plan. However, until your bill is paid or arrangements have been made to pay it, we are forced to limit or deny the services available to you at the Caswell County Health Department. In addition, we may be forced to submit your debt to the state for payment out of any future state tax refund or lottery winning.

Please call at once to discuss this matter.

Sincerely,

Frederick E. Moore, MD
 Health Director

Collecting Co-Pays and Applying Sliding Fee Scales A Job Aid for Front Desk Staff

5 STEPS FOR COLLECTING CO-PAYS AND APPLYING THE SLIDING FEE SCALE

- 1: Find out the client's income, family size and whether she/he has insurance.
- 2: Check the client's insurance eligibility and determine the client's co-pay amount based on her/his insurance plan.
- 3: Determine where the client's income puts her/him on the sliding fee scale.
- 4: If the co-pay is less than the client would pay on the sliding fee scale, she/he should pay the co-pay, and the agency should bill the insurance company the fee for the services.
- 5: If the co-pay is more than what the client would pay based on the sliding fee scale, the client pays what she/he would pay based on the sliding fee scale, and the agency should bill the insurance company the fee for the services.

REMEMBER!
Clients should never pay more than what they owe based on the sliding fee scale.

HOW IT WORKS

Below is a sample sliding fee scale and two scenarios to show how to determine the co-pay when the client has insurance. Your agency's scale may be different since each agency has its own sliding fee scale.

Sample Client:

- Your client's income is \$25,000/year.
- She has two children.
- She has insurance. Her co-pay is \$20.
- To apply the sliding fee scale, first, match her income to your sliding fee scale.
- The sliding fee scale will show you the discount she would receive. In this situation, her discount would be 80%.

Family Size	Federal Poverty Levels 2014								
	100%	120%	140%	160%	180%	200%	220%	240%	250%
1	\$11,670	\$14,004	\$16,338	\$18,672	\$21,006	\$23,340	\$25,674	\$28,008	\$29,175
2	\$15,730	\$18,876	\$22,022	\$25,168	\$28,314	\$31,460	\$34,606	\$37,752	\$39,325
3	\$19,790	\$23,748	\$27,706	\$31,664	\$35,622	\$39,580	\$43,538	\$47,496	\$49,475
4	\$23,850	\$28,620	\$33,390	\$38,160	\$42,930	\$47,700	\$52,470	\$57,240	\$59,625
5	\$27,910	\$33,492	\$39,074	\$44,656	\$50,238	\$55,820	\$61,402	\$66,984	\$69,775
6	\$31,970	\$38,364	\$44,738	\$51,152	\$57,546	\$63,940	\$70,334	\$76,728	\$79,925
7	\$36,030	\$43,236	\$50,442	\$57,648	\$64,854	\$72,060	\$79,266	\$86,472	\$90,075
8	\$40,090	\$48,108	\$56,126	\$64,144	\$72,162	\$80,180	\$88,198	\$96,216	\$100,225
9+	For families with more than 6 people add \$4,060 for each additional person								
	100%	90%	80%	70%	60%	50%	40%	20%	10%
	Discount								

Reference: US Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation. Available at <http://aspe.hhs.gov/poverty/14poverty.cfm>

SCENARIO 1:

- If fee for services = \$125
- With 80% discount, fee = \$25
- Insurance co-pay = \$20
- Client pays \$20
- Bill client's insurance the full fee
- Insurance co-pay is less than the fee, client pays the co-pay

SCENARIO 2:

- If fee for services = \$60
- With 80% discount, fee = \$12
- Insurance co-pay = \$20
- Client pays \$12
- Bill client's insurance the full fee
- Discounted fee is less than the co-pay, client pays the discounted fee

REMEMBER!
If the client requests confidential services, do not bill the insurance company.

Collecting Co-Pays and Applying Sliding Fee Scales As Job Aid for Front Desk Staff

FREQUENTLY ASKED QUESTIONS: COLLECTING CO-PAYS AND APPLYING THE SLIDING FEE SCALE

Q: Our insurance contract says that we need to charge a specific co-pay. What can we do about this if the client's discounted fee is less than the co-pay?

A: No matter what, the client should be charged the lesser of the two: the co-pay or the discounted fee based on the sliding fee scale. The agency should submit the full charge for the service to the insurance company.

Q: What is the federal rule that applies to collecting co-pays and applying the sliding fee scale?

A: Title X Program Requirements provide guidance on how clients should be charged. Family income should be assessed before determining whether co-pays or additional fees are charged. With regard to insured clients, clients whose family income is at or below 250% of the Federal Poverty Level (FPL) should not pay more (in co-pays or additional fees) than what they would otherwise pay when the sliding fee scale is applied. Fees must be waived for individuals with family incomes above 100% of the FPL who, as determined by the service site project director, are unable, for good cause, to pay for family planning services. (See page 13, Program Requirements for Title X Funded Family Planning Projects). These rules apply to all clients whether or not the client has insurance.

Q: Often clients with insurance do not want to tell us their income. What should we do?

A: Reassure your client that the reason you are asking for her/his income is because your agency's financial policy uses a sliding fee scale based on client's income and family size and that she/he may be eligible to pay less than her/his co-pay if the discounted fee is LESS than her/his co-pay. If the discounted fee is not less, she/he will only be charged the co-pay.

Q: How should we charge clients if they will not tell us their income?

A: Per the Title X Program Requirements (page 12), Title X agencies should follow their grantee's written policy on income verification and ensure that all clients are treated equally according to the policy. Check your grantee agency's policies regarding how to handle this situation.



CASWELL COUNTY HEALTH DEPARTMENT POLICY

I. PROCEDURE TITLE: Chain Of Authority In Absence Of Health Director

A. Background:

1. In the absence of the Health Director, there must always be someone who is available to make decisions until the Health Director can be contacted, returns or a new Health Director can be appointed by the Board of Health.
2. State law requires that the Health Director position be a “full time” job
 - a. And endows the Health Director with specific legal authority.
 - b. However, in the normal course of business it is not unusual for the Health Director to be out of the building, county, or even state for either public or private purposes.
 - c. During the Health Director’s absence, routine business must continue and matters must be dealt with in a timely fashion.
3. In the event of a major public health emergency the Health Director, or designee, must play an active role in the county’s Emergency Operations Center.
4. If the appointed Health Director is unavailable for any reason, the Health Director’s designee must take on this important role.
5. According to NCGS 130A-6, “Whenever authority is granted by this Chapter upon a public official, the authority may be delegated to another person authorized by the public official.”

B. Target

1. CCHD Management Team
2. CCHD Staff
3. Board of Health

C. References

1. Board of Health Operating Procedures & Bylaws
2. NCGS 130A-6

II. PROCEDURE:

A. Contacting The Health Director When He/She Is Out Of The Office

1. The Health Director will make a reasonable attempt to make his/her general whereabouts known when out of the Health Department and how he/she may be reached.
2. The Health Director will notify staff if he/she knows that he/she will not be available.
3. The Health Director will make a reasonable attempt to be available most times by electronic means (e.g. cell phone, pager, etc.).
4. If possible, the Health Director will notify staff of an approximate date/time he/she will return.

B. Chain Of Authority In The Temporary Absence Or Unavailability Of The Health Director.

1. For routine decisions normally made by the Health Director that cannot wait until he/she becomes available, the person with the most senior position within the affected work unit will make decisions for their respective units.
 - a. Personal Health

- 1) Physician Extender II
 - 2) Public Health Nurse III
 - 3) Public Health Nurse II with the most knowledge on the issue
 - 4) Accounting Technician V, Social Worker II, Accounting Technician I, Processing Assistant IV or Office Assistant IV with the most knowledge of the subject.
- b. Home Health
- 1) Public Health Nursing Supervisor I
 - 2) Public Health Nurse III with the most knowledge on the issue
 - 3) Social Worker II, Accounting Technician I, Processing Assistant IV or Office Assistant IV with the most knowledge of the subject.
- c. Environmental Health
- 1) Environmental Health Supervisor I
 - 2) Environmental Health Programs Coordinator
 - 3) Environmental Health Specialist
- d. Finance
- 1) Accounting Technician V
 - 2) Accounting Technician I, Processing Assistant IV or Office Assistant IV with the most knowledge of the subject.
2. If the consequences of a decision impacts more than one work unit, the persons in charge of all affected work units will make a joint decision.
 3. For major decisions or ones that impact the whole Health Department, the available members of the Management Team must meet and make the decision jointly.
 4. It is expected that the person or group making the decision will consult with as many other knowledgeable staff (even in other departments) as is necessary to make the best decision under the circumstances.
 5. It is also expected that the Health Director will be notified as soon as possible of any decisions that are made on his/her behalf.
- C. Chain Of Authority If The Health Director Is Incapacitated, Is Not Present, Or Is Otherwise Unavailable During A Public Health Emergency.
1. The Chain of Authority outlined in Section B above works well during routine, short term absences of the Health Director in normal, every day circumstances.
 - a. However, the Incident Command System requires that a single person, not a committee, be in charge during an emergency.
 - b. This person is typically the Health Director.
 2. At all times the Health Director will designate a qualified Health Department employee to temporarily take over his/her duties in his/her absence during a public health emergency or prolonged absence.
 - a. This person will be made known to all staff and relevant governmental agencies,
 - b. And will be trained in the general duties and responsibilities of the Health Director.
 - c. Attachment A shows the order of succession for the agency's key leadership positions (including the Health Director).
 3. If, for whatever reason, the Health Director is thought to be unable to resume his/her duties in a reasonable length of time, the Board of Health will appoint a new interim Health Director or permanent Health Director as is appropriate under the circumstances.

III. ATTACHMENTS

A. Attachment A: Key Leadership Order of Succession

IV. PROCEDURE HISTORY

A. Original Approval Date

1. 03/16/2007

B. Effective Date

1. 03/16/2007

C. Dates of Review

1. 04/29/2011

7. _____

2. 08/17/2012

8. _____

3. 09/29/2013

9. _____

4. 03/25/2014

10. _____

5. 02/24/2015

11. _____

6. _____

12. _____

D. Dates of Revision

1. 07/09/2010

2. 04/29/2011

3. 02/24/2015

V. APPROVAL

Board of Health, Chairperson

Date

Health Director, Secretary to the Board of Health

Date

Appendix A

Caswell County Health Department Key Leadership Order Of Succession			
Key Position	Current	Successor #1	Successor #2
Health Director	Frederick Moore, MD	Jennifer Eastwood, MPH	Patty Smith-Overman, FNP
Physician Extender II (Clinic Director)	Patty Smith-Overman, FNP	Denise Wilkins, RN	Carol Dodson, RN
Home Health Nursing Supervisor I	Cheryl Huskey, RN	Casey Moore, RN	April McKinney, RN
Environmental Health Supervisor I	Donnie Powell, REHS	Will Shields, REHS	Matt Maness, REHS
Accounting Technician V (Finance Officer)	Sharon Hendricks	Betty Hodges	Stephana Wood
Public Health Nurse III (Communicable Disease)	Denise Wilkins, RN	Pam Powell, RN	Susan Cox, RN
Health Educator I (Public Health Preparedness Coordinator)	Marcy Williams, MPH		

Updated: January 23, 2015

	New Constr Auth & Op Permit (Type I & II)	New Constr Auth & Op Permit (Type III)	New Constr Auth & Op Permit (Type IV)	New Constr Auth & Op Permit (Type V)	Insp of Existing OSW Treat Sys (Type I & II Addition)	Insp of Existing OSW Treat Sys (Type I & II Change Out)	Insp of Existing OSW Treat Sys (5 Yr Type III Insp)	Insp of Existing OSW Treat Sys (3 Yr Type IV Insp)	Insp of Existing OSW Treat Sys (Ann Type V Insp)	Restaurant Plan Review	Tattoo Artist Permit Annual Fee	Temporary Food Stand	Impr Permit / Site Eval (<600 gpd & ≤4 bedrooms)	Impr Permit / Site Eval for each additional bedroom >3	Impr Permit / Site Eval (>600 & <3000 gpd)	Impr Permit / Site Eval (>3000 gpd)
7 - JUL	\$ 150 # 3	\$ 200 # 0	\$ 400 # 0	\$ 800 # 0	\$ 50 # 5	\$ 100 # 3	\$ 100 # 0	\$ 100 # 0	\$ 200 # 2	\$ 200 # 0	\$ 150 # 0	\$ 75 # 0	\$ 150 # 7	\$ 75 # 0	\$ 250 # 0	\$ 400 # 0
8 - AUG	\$ 300 # 2	\$ 0 # 0	\$ 0 # 0	\$ 0 # 0	\$ 250 # 2	\$ 300 # 0	\$ 0 # 0	\$ 0 # 0	\$ 400 # 0	\$ 0 # 0	\$ 0 # 0	\$ 0 # 0	\$ 1,050 # 8	\$ 1 # 1	\$ 0 # 0	\$ 0 # 0
9 - SEP	\$ 150 # 1	\$ 200 # 1	\$ 400 # 1	\$ 800 # 4	\$ 100 # 5	\$ 0 # 5	\$ 0 # 0	\$ 0 # 0	\$ 0 # 0	\$ 0 # 0	\$ 0 # 0	\$ 0 # 0	\$ 1,200 # 6	\$ 75 # 1	\$ 250 # 1	\$ 0 # 0
10 - OCT	\$ 150 # 1	\$ 400 # 2	\$ 800 # 4	\$ 1,600 # 2	\$ 200 # 2	\$ 500 # 2	\$ 0 # 0	\$ 0 # 0	\$ 0 # 0	\$ 0 # 0	\$ 0 # 0	\$ 75 # 1	\$ 900 # 5	\$ 75 # 3	\$ 250 # 0	\$ 0 # 0
11 - NOV	\$ 750 # 5	\$ 400 # 2	\$ 800 # 4	\$ 1,600 # 2	\$ 200 # 2	\$ 200 # 0	\$ 0 # 0	\$ 0 # 0	\$ 0 # 0	\$ 0 # 0	\$ 0 # 0	\$ 75 # 0	\$ 750 # 5	\$ 225 # 1	\$ 0 # 0	\$ 0 # 0
12 - DEC	\$ 0 # 0	\$ 200 # 1	\$ 400 # 2	\$ 800 # 2	\$ 100 # 2	\$ 200 # 2	\$ 0 # 0	\$ 0 # 0	\$ 0 # 0	\$ 0 # 0	\$ 0 # 0	\$ 0 # 0	\$ 300 # 3	\$ 150 # 2	\$ 0 # 0	\$ 0 # 0
1 - JAN	\$ 300 # 2	\$ 0 # 0	\$ 0 # 0	\$ 0 # 0	\$ 250 # 5	\$ 300 # 3	\$ 0 # 0	\$ 0 # 0	\$ 0 # 0	\$ 0 # 0	\$ 0 # 0	\$ 0 # 0	\$ 450 # 4	\$ 75 # 1	\$ 0 # 0	\$ 0 # 0
TOTAL	\$ 2,100 # 14	\$ 800 # 4	\$ 1,600 # 0	\$ 3,200 # 0	\$ 1,200 # 24	\$ 1,500 # 15	\$ 0 # 0	\$ 0 # 0	\$ 0 # 2	\$ 400 # 2	\$ 0 # 0	\$ 75 # 1	\$ 5,700 # 38	\$ 675 # 9	\$ 250 # 1	\$ 0 # 0

	Bad Check	Exp or Repair of OSWW Treat Sys (<600 gpd)	Exp or Repair of OSWW Treat Sys (>600 & <3000 gpd)	Exp or Repair of OSWW Treat Sys (>3000 gpd)	Swimming Pool Annual Permit	Swimming Pool Plan Review	Well Camera Evaluation	Well Permit	Well Repair Permit	Bacteria Water Sample	Chemical Water Sample	Nitrate/Nitrite Sample	Pesticides Water Sample	Petroleum Water Sample	Five Test Water Sample Package	\$5 Credit For Previous Payment (See comments)
7 - JUL	\$25	\$50	\$200	\$800	\$100	\$200	\$200	\$300	\$200	\$50	\$50	\$50	\$50	\$50	\$170	-\$5
	#	1	0	0	0	0	1	9	3	1	1	0	0	1	0	
	\$	50	0	0	0	0	2,700	600	600	50	50	0	0	50	0	0
8 - AUG	\$	1	0	0	0	0	3	1	200	50	0	1	0	0	170	0
	#	50	0	0	0	0	900	200	200	50	0	50	0	0	170	0
9 - SEP	\$	4	0	0	0	0	1	0	0	0	0	0	0	0	0	0
	#	200	0	0	0	0	300	0	0	0	0	0	0	0	0	0
	\$	2	0	0	0	0	8	2	2	1	0	0	0	0	0	0
10 - OCT	\$	100	0	0	0	0	2,400	400	400	50	0	0	0	0	0	0
	#	1	0	0	0	0	4	0	0	0	0	0	0	0	0	0
11 - NOV	\$	50	0	0	0	0	1,200	0	0	0	0	0	0	0	0	0
	#	1	0	0	0	0	1	1	1	2	2	0	0	0	0	0
12 - DEC	\$	50	0	0	0	0	300	200	200	100	100	0	0	0	0	0
	#	2	0	0	0	0	4	3	3	1	0	0	0	0	0	0
1 - JAN	\$	100	0	0	0	0	1,200	600	600	50	0	0	0	0	0	0
	#	12	0	0	0	0	30	10	10	6	3	1	0	1	1	0
TOTAL	\$	\$0	\$0	\$0	\$0	\$0	\$9,000	\$2,000	\$300	\$150	\$50	\$50	\$0	\$50	\$170	\$0
	#	0	0	0	0	0	800	\$2,000	\$300	\$150	\$50	\$50	\$0	\$50	\$170	\$0

	\$10 Credit For Previous Payment (See comments)	\$25 Credit For Previous Payment (See comments)	\$50 Credit For Previous Payment (See comments)	\$100 Credit For Previous Payment (See comments)	BACTERIA WATER (TOTAL COLIFORM P/A)	TOTAL COLIFORM MPN	FECAL COLIFORM	FECAL COLIFORM/STREPTOCOCCUS	ENTEROCOCCUS, MPN	IRON BACTERIA	SULFUR/SULFATE REDUCING	PSEUDOMONAS - MTF OR MPN	HETEROTROPHIC PLATE COUNT	FULL INORGANIC PANEL (CHEMICAL)	METALS PANEL	INDIVIDUAL METALS
7 - JUL	\$	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
8 - AUG	\$	0	0	2	0	0	0	0	0	0	0	0	0	0	0	0
9 - SEP	\$	0	0	-200	0	0	0	0	0	0	0	0	0	0	0	0
10 - OCT	\$	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
11 - NOV	\$	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
12 - DEC	\$	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
1 - JAN	\$	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
TOTAL	\$	0	0	2	0	0	0	0	0	0	0	0	0	0	0	0
	\$	\$0	\$0	-\$200	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0

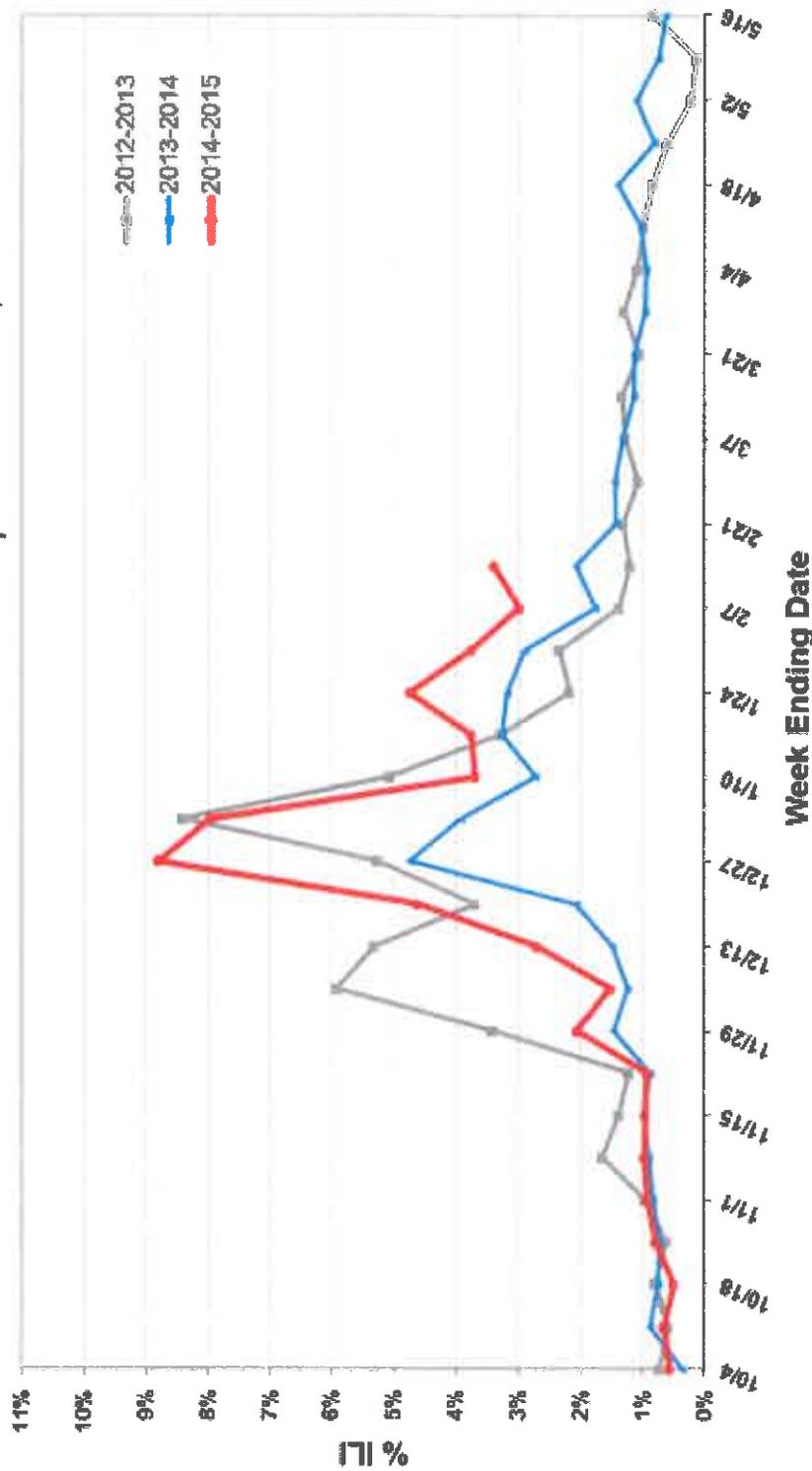
		ANIONS - FL, CL, SULF	DISINFECTION BY-PRODUCTS	FLOURIDE - PHYSICIAN, DENTIST REQUEST	NITRATE/NITRITE	ARSENIC SPECIATION	PESTICIDES WATER SAMPLE	HERBICIDES WATER SAMPLE	PETROLEUM PRODUCTS	VOLATILE ORGANIC CHEMICALS	WELL WATER FULL PANEL	WATER SAMPLING SITE VISIT FEE	SAMPLE PACK (INCLUDES WELL FULL PANEL +PEST+PETRO)	TOTAL
7 - JUL	#													
	\$	0	0	0	0	0	0	0	0	0	0	0	0	\$6,150
8 - AUG	#													
	\$	0	0	0	0	0	0	0	0	0	0	0	0	\$3,095
9 - SEP	#													
	\$	0	0	0	0	0	0	0	0	0	0	0	0	\$2,775
10 - OCT	#													
	\$	0	0	0	0	0	0	0	0	0	0	0	0	\$5,150
11 - NOV	#													
	\$	0	0	0	0	0	0	0	0	0	0	0	0	\$2,925
12 - DEC	#													
	\$	0	0	0	0	0	0	0	0	0	0	0	0	\$2,050
1 - JAN	#								1		4	4		
	\$	0	0	0	0	0	0	0	84	0	336	180	0	\$4,075
TOTAL	#	0	0	0	0	0	0	0	1	0	4	4	0	
	\$	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$84	\$0	\$336	\$180	\$0	\$26,220

**ENVIRONMENTAL HEALTH MONTHLY STATISTICAL REPORT
JANUARY 2015**

ACTIVITY DESCRIPTION	#	COMMENTS
FOOD, LODGING, AND INSTITUTIONAL		
Field Visits	19	
Inspections	14	
Permits Issued-New or Revised Business		
Permits Suspended/Revoked-Business Closed		
Food Service Plan Review		
Consultation Contact	10	
Complaints		
ON SITE WASTE WATER PROGRAM		
Field Visits	56	
Soil/Site Evaluations	7	1 saprolite pit evaluation
Improvement Permits		
Construction Authorizations		
Operation Permits	5	
Denials		
Failing System Evaluations	3	
IP, CA, & OP Permits-Repairs	3	
Existing System Inspections/Authorizations	24	
OSWW Violations Notices		
Consultation Contacts	101	
Migrant Housing Inspections	14	
Pending Applications-Not Addressed		
Complaints	2	
WATER SAMPLES		
Field Visits	29	
Bacteria Samples	17	
Chemical Samples	6	
Petroleum Samples	1	
Pesticide Samples		
Nitrate/Nitrite Samples	6	
Consultation Contacts	31	
Migrant Housing Inspections	14	
WELL PERMITS		
Well Site Field Visits	14	
Number of Permits (New)	4	
Number of Permits(Repair)	2	
Grout Inspections	5	
Well Head Inspections	1	
Well Abandonment Inspections		
Bore Hole Camera Inspections		
Consultation Contacts	16	
Complaints		
SWIMMING POOLS		
Permits/Inspections		
OTHER		
Clerical Time (hours)	51	BETS, OSWP MONTHLY, SL2014-120REPORT
Phone Contacts (Documented)	193	
Digitizing/Scanning (hours)	81	
Continuing Education (Days)		

INFLUENZA SURVEILLANCE, NC 2012-2015

Influenza-Like Illness in ILINet Outpatient Visits,



Note: Week ending displayed is for 2014-2015 influenza season. Flu seasons for previous years may have different week ending dates, but these only vary by a few days.

For more information about comparable national data, visit www.cdc.gov/ncidod/diseases/flu/weekly.htm, and in particular, click on the link "View Chart Data" below "Percentage of Visits for Influenza-Like Illness Reported by the US Outpatient Influenza-Like Illness Surveillance Network (ILINet)".

Relationship between Smoking and Leading Health Problems: 2015 Talking Points

Most adults know that smoking causes lung cancer, but did you know about all the other health problems caused by smoking and secondhand smoke? The U.S. Surgeon General continues to document the diseases attributable to tobacco use, smoking and secondhand smoke. Here are some of the new findings.

Cancer

- One of every three cancer deaths in the US is linked to smoking. This includes lung cancer, which is the deadliest form of cancer, as well as colorectal cancer, which has the second largest number of deaths each year.
- Smoking increases the risk for cancers of the mouth, lips, nose and sinuses, larynx (voice box), pharynx (throat), esophagus (swallowing tube), stomach, pancreas, kidney, bladder, uterus, cervix, ovary (mucinous), and liver.
- Smoking not only causes cancer but also interferes with cancer treatment. Quitting smoking improves the prognosis of cancer patients.

Heart Disease and Stroke

- Smoking is a major cause of cardiovascular disease (CVD) and causes one of every three deaths in the US from CVD. Exposure to secondhand smoke causes heart disease, including heart attacks and strokes in nonsmokers.
- Smokers who quit start to improve their heart health and reduce their risk for CVD immediately. Within a year, the risk of heart attack drops dramatically, and even people who have already had a heart attack can cut their risk of having another if they quit smoking. Within five years of quitting, smokers lower their risk of stroke to about that of a person who has never smoked.

Lung Disease

- Chronic Obstructive Pulmonary Disease (COPD) is the third largest killer, and 8 of 10 COPD cases in the US are attributable to smoking. Asthma is the most common chronic disease of childhood – 1 in 10 high school students in the US has asthma. Exposure to secondhand smoke can trigger an asthma attack in both children and adults.

Diabetes

- Smokers in the US have a 30 to 40 percent higher risk of developing type 2 diabetes than nonsmokers.

Smoking, Fertility and Pregnancy

- Smoking during pregnancy causes premature birth, low birth weight, certain birth defects, and ectopic pregnancy. Babies whose mother smoked during pregnancy are more likely to die from SIDS – Sudden Infant Death Syndrome.

References: U.S. Department of Health and Human Services. *The Health Consequences of Smoking—50 Years of Progress: A Report of the Surgeon General*. Atlanta, GA: 2014. <http://www.surgeongeneral.gov/initiatives/tobacco/>

American Cancer Society, *Cancer Facts & Figures 2014*

**North Carolina Immunization Branch
2014 Annual Immunization Assessment**



Assessment Criteria

Cohort: 10/02/2011 – 10/01/2012

Benchmark Age: 24 months

Selected Benchmarks: DTaP (4), Polio (3), MMR (1), Hib (3), HepB (3), Var (1), PCV (4)

Clients Associated with CASWELL County Health Department

94% of clients met all benchmark criteria

Total Client Count: 18

Statewide Local Health Department Average: **86%**

Clients Residing in CASWELL County

78% of clients met all benchmark criteria

Total Client Count: 197

Statewide County Average: **69%**

Immunization Coverage Goals for FY 2015-2016

LHD: 90% County: 81%

Cohort: 10/02/2012 – 10/01/2013

Evaluation Date: Friday, October 2nd, 2015

Benchmark Age: 24 months

Selected Benchmarks: DTaP (4), Polio (3), MMR (1), Hib (3), HepB (3), Var (1), PCV (4)

Caswell County



Public Health
Prevent. Promote. Protect.

**HOME HEALTH/CAP PROFESSIONAL ADVISORY COMMITTEE
MEETING AGENDA**

February 10, 2015

- I. Call to Order
- II. Approval of Minutes
- III. Old Business
- IV. New Business
 - 1. Progress Report
 - 2. Quality Improvement Report
 - 1. Quarterly Report
 - 2. Update on Home Health QI Project
 - 3. Supervisor's Report
- V. Adjournment



HOME HEALTH/CAP PROFESSIONAL ADVISORY COMMITTEE (PAC)
November 18, 2014 – Meeting Minutes

Member Name	PAC Role	PAC Term Ending Date	Attendance	
			Present	Absent
Sandy Blackwood, PT	Physical Therapist	02/28/2017	X	
Kaye Cobb, RN	Public Health	02/28/2017		X
Jennifer Eastwood, MPH	Ex-officio (Quality Assurance & Improvement)	No term	X	
Sharon Hendricks	Ex-officio	No term	X	
Felicia Echols, RN	CAP-DA Service Provider			X
Cheryl Huskey, RN	Ex-officio	No term	X	
Zettie Jones, Chairperson	Consumer	08/31/2015	X	
Ann Long	Domiciliary	08/31/2015	X	
Casey Moore, RN	Ex-officio (Quality Improvement)	No term	X	X
Fred Moore, MD	Physician	02/28/2017	X	
Loretta Nichols, RN	Registered Nurse	02/28/2017	X	
Michelle Waddell	Department of Social Services		X	

Topic	Discussion	Action Required
Minutes from last meeting	Motion was made to accept minutes from the last meeting. Motion was seconded and approved.	No action required.
Old Business		
Geographic Location for Services	Dr. Moore reminded the Advisory Committee that the Home Health Agency has been going through a tough time financially and that were are trying to make decisions that will help us stay in business and continue to provide services. As discussed during a previous meeting, one action item was to limit our geographic location for services to within Caswell County Borders. Since that discussion, this topic has gone before the Board of	Dr. Moore and staff will continue to monitor the situation and will create a plan for discharging out of county patients when they feel this becomes necessary.

Health and they voted to limit admissions to patients in Caswell County. The agency does still have patients from outside of the county because they were already patients under care. Dr. Moore said at some point we will need to look at discharging them and helping them find other options for care.

New Business

Home Health Cost Report

All home health agencies are required by Medicare to get a cost report and send it to Medicare. Our Home Health Agency (HHA) received its report from last fiscal year (Jul 2013-Jun 2104) last week. Dr. Moore did not feel that there were any no big surprises in th report. Instead, he felt it did re-emphasis some of the areas we need to work on in order to improve our cost. The cost report is a useful tool because it tells the agency what it actually costs to provide each service. As discussed in previous meetings our HHA's cost to provide services costs have increased significantly. Mainly, this is because visits have decreased. Starting 2 years staffing issues began that have caused inefficiencies.

Monthly Visits

The cost accountant also pointed out that the types of visits that are one visit a month (ex. B12 shot, pre-fill meds, psych meds, blood draw, etc) have had an increase in visits. The reimbursement rate for these visits is very low since it is not coupled with another service. The question is whether patients who only need these types of services are truly candidates for home health services. Staff believe these clients are not truly home-bound and can make a visit to their doctor. Dr. Moore realizes that going to the doctor's office is an inconvenience for these patients, but believes it is not impossible. The main issues is that the HHA is losing money on these types of visits. Dr. Moore reports that he and this team are looking at each of these types of visits and plans to stop admitting patients for these types of services soon.

Incontinent & Ostomy Supplies

Dr. Moore further explained that one of the biggest items found in the report, that has not been discussed by this committee, is incontinent and ostomy supplies. Approximately, a third of the current caseload gets no other services than incontinent supplies. In the best of circumstances, this is barely break-even service. For the past couple of years the HHA has been losing money. In addition, some of the staff have gone to talk to another home health agency very much like ours and have gotten good advice from them. They do not provide these services. So, Dr. Moore reported that he is looking at no longer admitting these types of patients and then the next step will be to begin divesting the caseload of the current patients receiving this service. Dr. Moore does not want to leave these patients without means to get these supplies, however. And, there are companies who provide these supplies shipped directly to the patient's home or the care home. Dr. Moore and his team will begin planning to transition patients to those companies and take our HHA out of the role of "middle man" as long as there is no negative impact on the patients. If this happens, Dr. Moore believes we will reduce expenses, remove the agency from the

Staffing Issues

financial risk, and streamline the agency's services. One one committee member pointed out that care homes ordering their own supplies would be a good thing because there is often an overload of supplies in care homes. This would allow them to manage their inventory better.

Kaye Cobb, Home Health's Nursing Director, who has been at the agency for over years is retiring. She is currently taking leave time before her retirement. The current plan is to not fill that vacancy. As previously discussed, the HHA will be cutting the current caseload by a third. The hope is that by reducing the caseload it will free up a nurse to go out and do some public relations with referral sources to help gain more Medicare patients. (Medicare is the only insurance provider that allows the HHA to turn a profit.)

In addition, Sandy Blackwell, the HHA's contract physical therapist, will be leaving. Dr. Moore reported that a physical therapist, who also works at the Brian Center, has been hired to work part-time. Sandy is helping to train her. Because the new therapist is part-time, it may become necessary to change the way we provide physical therapy services and make them more streamlined. The Brian Center also has speech and occupational therapists on staff. The new physical therapist believes that these other therapists may actually consider working part-time as well to provide these services. Dr. Moore believes that by reducing costs and opening up opportunities to provide more services that have higher reimbursement rates we will see an improvement to our bottom line.

New nurses have been hired since the previous PAC meeting. Dr. Moore has been told they are learning quickly and are up to full speed. From a staffing point of view the HHA is doing alright, at the moment.

Billing

Two years ago the HHA contracted HH billing to an outside agency. At the time it was believed that this would be a cost saving measure, but that has proven not to be the case. Dr. Moore explained that in the next few months bringing will be brought back in-house.

Other Changes

In addition, Dr. Moore said that he and his team will be looking at amount of supplies that are keep in-house to identify cost reduction measures and eliminate waste. Meanwhile, the agency plans to increase efficiency by using the Bright Tree software to its highest capability. Specifically, this will be accomplished by utilizing scheduling functions that had not been used to this point.

Conclusion

Dr. Moore said that the next six months in our HHA will be period of major transition. The team plans to continue using Northampton County Health Department's Home Health Agency as a model for CCHD. Dr. Moore reminded the group that the rumor of the HHA closing has been prevalent in the community. He reminded the group that he has not been

told that the Home Health will not be funded. The Commissioners will likely make that decision during the budget process. Dr. Moore hopes that making the changes discussed during this meeting will provide enough impact that the Commissioners will continue funding. However, if the numbers aren't turned around it is a real possibility that they may decide to close the agency.

Dr. Moore explained that one of the Health Department's missions is to help people who otherwise cannot get healthcare. He says that he and his team do not know all the details yet of how adult care homes work, but it is his understanding that that Medicaid pays fees to care homes to provide transportation, etc. When our HHA sends a nurse out to them, the cost gets shifted to us rather than the care home, and we do not get paid by the care home to provide the service. Instead, we've been taking on the cost. While this was not a concern when profits were high, the Cost Accountant indicated that across the board things are getting tighter.

In conclusion, Dr. Moore says there are a lot of changes that will be happening over the next several months. He asked PAC members to let member of the community know that the HHA is trying to make cost saving decisions without jeopardizing the care our patients receive. Some of the things discussed previously may need to be taken on a case-by-case basis. For instance, if a patient is truly homebound and cannot get out to go to the physician's office, then we may need to continue offering the service to that patient. Dr. Moore reiterates that the first step of his team's plan is stop admitting these types of patients. The, the HHA will begin to divesting itself of the patients we currently have under care.

CAP Report

Dr. Moore reported that CAP staff had noticed similar issues with the supplies in that program. The group was reminded that CAP is a Medicaid program that tries to keep people in their home longer by providing some services. Just like with the incontinent and ostomy supplies, the CAP program has been the "middle man." Dr. Moore says that it is his goal to take the HHA and CAP program out of the middle.

Financial Report and Statistics

Dr. Moore reported that the HHA is currently doing a little better than break even. This is better than it has been and Dr. Moore is optimistic that things will start to turn around and that Home Health will continue to provide services to the people of Caswell County.

Dr. Moore provided an overview of statistical information that was provided to PAC members. He summarized by saying that:

- Visits are down up until September, when we hired new nurses. Dr. Moore expects those numbers to rebound, given our current staffing.
- Dr. Moore also pointed out a graph that represents HH & CAP revenue v

QI Report

expenses. Dr. Moore said in July revenue went down to 0. This is due to the county's accounting practices, when money is backed into the previous fiscal year.

The QI Team reviewed the Quarterly QI Report with the team. This report included the following discussion:

- Jennifer Eastwood stated that she had been part of the team who had visited Northampton and had met with their QI Coordinator to see how they do their quarterly and annual reporting as well as other QI activities. There are some things that are required to report to PAC because of Conditions of Participation and accreditation standards. However, she is trying to look for easier ways to report the information is more meaningful to the PAC and not just numbers.
- There was 1 complaint for the quarter (July – Sept) from a care home. The complaint was that after the nurse performed a wound dressing, she did not put the patient's shoes back on and button the his pants. The nurse thought that because the patient had just gotten out of the shower, the home care staff were not done with him and put his shoes on and button his pants after they finished their remaining tasks. Cheryl addressed this issue with the nurse and she was instructed to redress patients to the same level as they were when she got there. She verbalized that she understood that. Cheryl considers the complaint resolved.
- Patient Satisfaction surveys are something that are presented every quarter. This time the information is presented with a little more information. Jennifer said she used a website called Home Health Compare that allows home health agencies to compare statistics from three home health agencies and it gives the NC and Nat averages. At the last meeting there was some concern that the scores were low in a couple of areas. Jennifer pointed out to the committee that when compared to competitors and the NC and National averages, our scores are actually very good. As a sidenote Jennifer indicated that she had been informed that Bayada is now offering full services (skilled nursing and therapy) and therefore, they are now considered our competitor. Cheryl indicated that CareSouth is also a competitor that she sees often.
- Adverse events – Jennifer said that this topic is also being presented in a different way as there is a comparison our current period our last quarter and also to the national reference. Jennifer says this report came from OASIS so it only includes Medicare or maybe some Medicaid patients. Dr. Moore questioned how these numbers were determined. Dr. Moore reminded that we are dealing with small numbers which may make our measures look worse than they actually are. One patient can cause our numbers to jump way out of proportion.
- Jennifer says that during the team meetings they have discovered that not all

Jennifer will investigate this report further and see what exactly the numbers mean.

- referrals are entered into CareAnyware. She says the team is working on a better way to track these to portray a more accurate picture. Based on information available there was one referral from a care home that was not admitted because they were not homebound. There were four referrals not admitted from hospitals. One of the four was because there was a change in a level of care; two patients refused services, and we were unable to locate the fourth patient and therefore couldn't admit him. Three private practice referrals were not admitted. There were a total of 8.
- There were no ethical issues this quarter
 - Infection Control – Jennifer says that usually these are reported in a different way. They are reported to Casey and while Casey was here during this quarter she has since been out on leave. So the report is not available in the format it is usually presented. There were no employee infections this quarter.
 - There were no patient or employees this quarter.
 - TB numbers did not change because 2014 info has not been provided yet.
 - No drills or exercises were performed.
 - Utilization Review was done, but because Casey is out on leave the report was unavailable.
 - Outcomes of care, is also being reported differently. Jennifer said this information use to be reported payor source, but the committee probably does not care how many came from which payor source so this time the numbers are totaled and a comparison of last quarter to this quarter was provided. Jennifer indicated that there seems to be improvement this quarter.
 - Admissions by Top 10 diagnosis statistics were given. Jennifer says that the top two admissions by diagnosis are physical therapy codes and she says this is fairly consistent with previous quarters.
 - OASIS submission errors. The HHA's goal is for there to be errors of less than 10%. There was one error that fell outside of threshold and that was submission date outside of 30 days. Jennifer says that the team believes that streamlining processes will free up time to get those submitted on time and ensure they aren't rejected. The HHA had 99 errors, but 233 that went through successfully. Jennifer said the staff will continue to work to improve and bring the numbers below 10%.
 - Jennifer asked committee members to provide their email address so that reports and minutes can be provided prior to the meeting. Jennifer informed the group that printed copies will be available at the meeting, but by emailing it ahead of time members will have more time to review minutes and reports.

Staffing changes	Dr. Moore wanted to inform the PAC of the chain of authority now that Kaye has retired. Dr. Moore will be stepping into the administrative role until there is a better option. Cheryl is the Nursing Supervisor and will handle clinical/operational aspects of the agency.	No action required
Meeting Adjourned		No action required

Submitted By: Jennifer Eastwood, MPH
November 18, 2014



HOME HEALTH QUALITY IMPROVEMENT PROGRAM QUARTERLY REPORT

Review Period:	Oct-Dec '14	Date Reported:	02/10/2015
Reported To:	<input checked="" type="checkbox"/> Home Health Advisory Committee <input type="checkbox"/> Board of Health <input type="checkbox"/> Home Health Employees		

QUALITY IMPROVEMENT ACTIVITIES

Activity Description	Findings	Corrective Action (if needed)
Complaint	There was one complaint this quarter from that every time the nurse placed the catheter the facility had to call within 3 days to have catheter replaced because it was not working properly.	Nursing Supervisor discussed issue with nurse and also observed nurse performing procedure to assess for competence in correctly performing procedure. Nurse performed procedure correctly but was instructed to slow down. Nursing Supervisor assessed schedule to assign another nurse for catheter changes for this patient.

POLICY REVIEW/REVISION

All policies, procedures, and technical procedures are reviewed annually based on their original approval date. There have been no major revisions to any policies during this quarter.

PATIENT SATISFACTION SURVEYS (Jackson Group – Taken from Home Health Compare)

Indicator	Our agency	Advanced	Bayada	NC Avg	Nat'l Avg
How often the home health team gave care in a professional way?	93%	91%	95%	90%	88%
How well <i>did</i> the home health team communicate with patients?	92%	90%	92%	88%	85%
Did the home health team discuss medicines, pain, and home safety with patients?	85%	87%	92%	85%	84%
How do patients rate the overall care from the home health agency?	90%	88%	94%	86%	84%
Would patients recommend the home health agency to friends and family?	88%	85%	89%	82%	79%

This is using the most current data from Home Health Compare website. Data period is Jul 2013 – Jun 2014

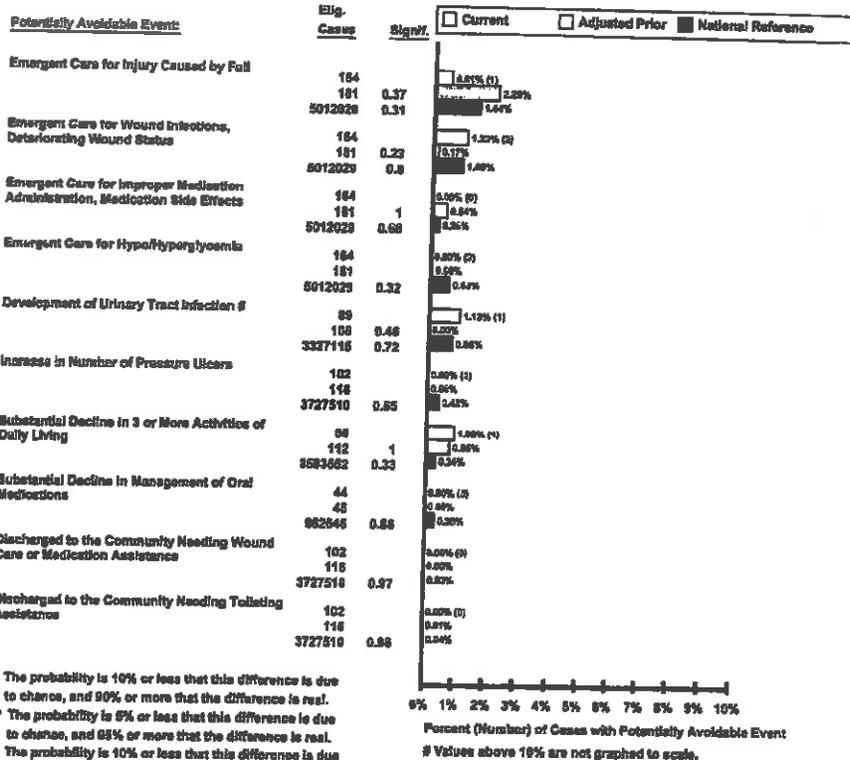
INVESTIGATION OF ADVERSE EVENTS/POTENTIALLY AVOIDABLE EVENTS

Reminder: Adverse Events are situations which Medicare has flagged as potential events in which Home Health interventions may have prevented. Each potential event is investigated to see if any interventions are identifiable as preventative measures which were not taken such as particular teaching subjects or failing to report changes to doctors, etc. The priorities are those of Medicare. Often the numbers are reflective of the same patient reported several different times. (Example: a patient hospitalized for congestive heart failure may have a diagnosis also of respiratory problems or had a urinary traction infection when admitted to Home Health; that patient will show up on the report as three situations) This report was generated through the CASPER Reporting System.

Risk-Adjusted Potentially Avoidable Event Report

Agency Name: CASWELL COUNTY HOME HEALTH AGE
 Agency ID: HM823888
 Location: YANCEYVILLE, NC
 CEN: 347175 Branch: A8
 Medical Number: 3407175
 Date Report Printed: 02/10/2015

Requested Current Period: 01/2014 - 10/2014
 Requested Prior Period: 01/2013 - 12/2013
 Actual Current Period: 01/2014 - 10/2014
 Actual Prior Period: 01/2013 - 12/2013
 # Cases: Curr 172 Prior 185
 Number of Cases In Reference Sample: 5316573

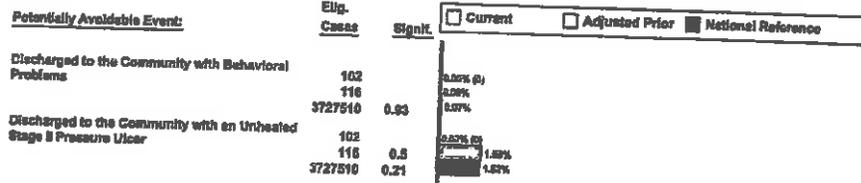


This report has not been approved to meet privacy requirements and can only be used by the home health agency and state agency for defined purposes.

Risk-Adjusted Potentially Avoidable Event Report

Agency Name: CASWELL COUNTY HOME HEALTH AGE
 Agency ID: HH923688
 Location: YANCEYVILLE, NC
 CCH: 347175 Branch: All
 Medicaid Number: 3487175
 Date Report Printed: 02/10/2015

Requested Current Period: 01/2014 - 10/2014
 Requested Prior Period: 01/2013 - 12/2013
 Actual Current Period: 01/2014 - 10/2014
 Actual Prior Period: 01/2013 - 12/2013
 # Cases: Curr 172 Prior 165
 Number of Cases in Reference Sample: 5315575



* The probability is 10% or less that this difference is due to chance, and 90% or more that the difference is real.
 ** The probability is 5% or less that this difference is due to chance, and 95% or more that the difference is real.
 + The probability is 10% or less that this difference is due to chance, and 90% or more that the difference is real.
 ++ The probability is 5% or less that this difference is due to chance, and 95% or more that the difference is real.
 ‡ This outcome has been risk adjusted. However, the predictive model for this outcome is less robust than the other predictive models.
 Note: When a measure value is calculated using less than 10 Episodes of care, the statistical significance level will not be displayed on the report.

Percent (Number) of Cases with Potentially Avoidable Event
 # Values above 10% are not graphed to scale.

This report has not been approved to meet privacy requirements and can only be used by the home health agency and state agency for defined purposes.

UNMET CARE NEEDS/REFERRED BUT NOT ADMITTED

Referral Source	Number Rejected	Reason(s)
Assisted Living Facility	0	
Hospital(s)	2	Patient refused service Unable to locate
Physician Practice	0	
Other Referral Source	1	Patient canceled prior to admission
TOTAL	3	8

SUMMARY OF ETHICAL ISSUES

No ethical issues identified this quarter.

INFECTION/INJURY SUMMARY

Patient Infections

Type of Infection	New	Existed on Admission	Existing	Resolved
Wound Infection	0	0	1	0
UTI Without Catheter		1	1	3
Skin Infection	2	2	0	0
MRSA		2		1
Respiratory	1		1	1
Fungal Infection to Feet	1			
Pneumonia			1	1
HIV		1	1	
TOTAL	4	6	5	6

Employee Infections

Type of Infection	Treatment Initialized	Action Required?	Outcome
MRSA	Antibiotics	Removed from work for 10 days	Resolved with antibiotics. Employee returned to work.
Strep	Antibiotics	Removed from work for 1 days	Resolved with antibiotics. Employee returned to work.

Patient Injuries

Type of Injury	Treatment Initialized	Hospitalized?	Outcome
No patient injuries were reported during this quarter			

Employee Injuries

Type of Injury	Treatment Initialized	Action Required?	Outcome
No employee injuries this quarter			

Tuberculosis

County	Number of Number of cases		
	2011	2012	2013
Caswell	0	1	0
Alamance	2	0	4
Guilford	22	17	19
Rockingham	3	0	0
Orange	3	2	2

Employee Safety Drills or Exercises

No drills or exercises were completed during this quarter

UTILIZATION REVIEW

Method/Info							Results	Action Plan	
Charts for the utilization review audit were selected from the patient roster in the breakdown required by policy.	Total	Male	Female	Age Range	Active	Discharged	A review of the client records revealed no unmet care needs. There were multiple errors in the documentation, however. All of these errors were made by one particular nurse. These errors included, but were not limited to: <ul style="list-style-type: none"> • Omission of supplies • Omission of orders • Corrections in frequency All of the errors were able to be corrected.	Nurse was educated on documentation errors and placed on 100% chart review. At the point and time that her error rates decrease her chart review frequency will also decrease.	
	MCR	16	10	6	62-90	14			2
	MCD	15	7	8	7m-87	13			2
	Other	1				0			1
MCR = Medicare MCD = Medicaid Other = Private Insurance									

OUTCOMES OF CARE SUMMARY

The outcomes summary is an important QI tool because it shows how Caswell County Home Health agency measures up to other Home Health Agencies throughout the United States. Its summary specifically shows how patient status changed. One of the most important aspects of this report is to ensure that the nurses are answering the questions as accurately as possible. The QI Coordinator provides education to nurses during the Nurses Conferences to instruct them regarding these questions and how to appropriately answer them.

	Outcome	Last Quarter	This Quarter
Ambulation/ Locomotion	% Improved	19%	14%
	% Stabilized	76%	85%
	% Declined	4%	1%
Bathing	% Improved	13%	15%
	% Stabilized	84%	79%
	% Declined	6%	6%
Dyspnea (Shortness of Breath)	% Improved	5%	7%
	% Stabilized	93%	85%
	% Declined	4%	8%
Management of Oral Medications	% Improved	3%	6%
	% Stabilized	90%	83%
	% Declined	7%	11%
Pain Interfering with Activity	% Improved	24%	22%
	% Stabilized	66%	68%
	% Declined	8%	10%

Transferring	% Improved	7.5%	11%
	% Stabilized	90%	84%
	% Declined	2.5%	4%
Upper Body Dressing	% Improved	12%	11%
	% Stabilized	86%	83%
	% Declined	2%	6%
Urinary Incontinence	% Improved	5%	0%
	% Stabilized	90%	99%
	% Declined	5%	1%
Acute Care Hospitalization Total Patients		12	16
Discharged to Community – Total Patients		26	15
Emergent Care – Total Patients		36	29

ADMISSIONS BY TOP 10 DIAGNOSIS CODES

Code – Diagnosis	Comments
Abnormality of Gait (781)	5 admissions
Urinary Incontinence (788)	3 admissions
Heart Failure (428)	3 admissions
Cellulitis (682)	2 admissions
Pressure Ulcer (707)	2 admissions
Diabetes Mellitus (250)	2 admissions
Paralysis Agitans (332)	2 admissions
Unspecified Complication of Procedure, Not Elsewhere Classified (998)	2 admissions
Rheumatoid Arthritis (714)	2 admissions
Other Late Effects of Cerebrovascular Disease (438)	2 admissions
Failure to Thrive (783)	1 admissions

Summary - There were 48 total admissions this quarter

OASIS Submission Errors

Goal: Less than 10% errors

Error #	Description	# of Errors	% of Assessments with the Error
+262	Inconsistent M0090 date does not meet CMS timing guidelines. RFAs 04 must be done on an every 60 day cycle; is no earlier than day 56 and no later than day 50 of that cycle.	5	1.76%
+265	New Patient: A new person has been created in the database of the CMS OASIS system at the stat with the information submitted in this record.	1	0.70%
+82	Patient provider updated: This patient was previously cared for by the prior provider identified.	13	4.58%

-3040 Incorrect Format: If the first character is numeric 0-9, then the first 9 characters must be numeric 0-9.	1	0.35%
-3060 Invalid Value: The value submitted for this item is not an acceptable value.	7	2.46%
-3330 Record Submitted Late: The submission date is more than 30 days after M0090 on this new record	40	14.08%
320 HIPPS_VERSION match	26	9.15%
-909 Inconsistent Record Sequence: Under CMS sequencing guidelines, the type assessment in this record does not logically follow the type of assessment in the record received prior to this one.	6	2.11%
-915 Patient Information Mismatch: Submitted value(s) for the item(s) listed do not match the values in the QIES ASAP database. If the record was accepted, the patient information in the database was updated. Verify that the new information is correct.	5	1.76%
TOTAL	105	
TOTAL NUMBER OF ASSESSMENTS SUCCESSFULLY PROCESSED	284	

Corrective Action Plan: There was one error that exceeded the 10% threshold—The submitted assessment was not submitted within CMS timing guidelines. The submission date is more than 30 days from the M0090 (Completion Date). The Home Health Quality Improvement Team continue to work on the processes and identify areas of delays/wastes and look for solutions. This error rate last quarter was 19%, so there has been a decrease in the % of this particular error. All other errors fall within the 10% threshold and require no further action.

WORKFORCE DEVELOPMENT – EDUCATION PROVIDED TO EMPLOYEES

Type	Purpose	Date
KCI Wound Vac	Training new staff on how to use negative pressure wound therapy.	10/2014
OASIS-C1 Training	Train nurses on changes made to OASIS questions. Ensure accuracy of clinical staff answer to those question.	11/13/2014
2015 Insight for Survival	Discussed changes coming to Home Health in 2015. Prepare staff for these changes.	11/17/2014