Health Care for the Homeless / Farmworker Health Program (HCH/FH) Co-Applicant Board Meeting

May 14, 2015

9:00 AM — 11:00 AM

Ravenswood Family Health Center
1842 Bay Road (Juanita Duncan Conference Room)
East Palo Alto

HEALTH CARE FOR THE HOMELESS/FARMWORKER HEALTH PROGRAM (HCH/FH)
Co-Applicant Board Meeting
Ravenswood Family Health Center
1842 Bay Road (Juanita Duncan Conf. Room), East Palo Alto
May 14, 2015, 9:00 A.M - 11:00 A.M.

AGENDA

A.	**CALL TO ORDER**	Robert Stebbins	
B.	**CLOSED SESSION**		
1.	No Closed Session this meeting		
C.	**PUBLIC COMMENT**		
	Persons wishing to address items on and off the agenda		
D.	**CONSENT AGENDA**		
1.	Meeting minutes from April 9 ,2015		**TAB 1**
2.	Program Calendar		**TAB 2**
E.	**BOARD ORIENTATION**		
1.	No Board Orientation items this meeting.		
F.	**REGULAR AGENDA**		
1.	Board Update of Consumer Input	Jim Beaumont/Others	
	i. ***Fliers on upcoming events***		**TAB 3**
2.	Discussion of Operational Site Visit (consultant)	Pat Fairchild (by phone)	
3.	HCH/FH Co-Applicant QI Policy	Jim Beaumont	**TAB 4**
	i. ***Action Item –Request to Approve HCH/FH Program QI Policy***		
4.	HCH/FH Co-Applicant Credentialing/Privileging Policy	Jim Beaumont	**TAB 5**
	i. ***Action Item –Request to Approve HCH/FH Program Credentialing/Privileging Policy***		
5.	HCH/FH Co-Applicant Needs Assessment Discussion	Jim Beaumont/Linda Nguyen	**TAB 6**
6.	HCH/FH Uniform Data System (UDS) final report review	Jim Beaumont/Linda Nguyen	**TAB 7**
7.	HCH/FH Program Co-Applicant Board Composition	Jim Beaumont	**TAB 8**
	i. ***Action Item –Request to Form Ad Hoc Committee on Board Composition, Recruitment & Selection***		
8.	HCH/FH Program Contracts report (quarterly)	Linda Nguyen	**TAB 9**
9.	HCH/FH Program Director's report	Jim Beaumont	**TAB 10**
10.	HCH/FH Program Budget & Financial report	Jim Beaumont	**TAB 11**
11.	HCH/FH QI Committee Report (verbal report)	Frank Trinh	
12.	HCH/FH Financial Audit Report	Jim Beaumont	**TAB 12**
	i. ***Action Item –Request to Review & Accept the Financial Audit***		
G.	**OTHER ITEMS**		
1.	Future meetings – every 2nd Thursday of the month (unless otherwise stated)		
	i. ***Next Regular Meeting – June 11 , 2015; 9:00 A.M. – 11:00 A.M. at Fair Oaks Health Center- Redwood City***		
H.	**ADJOURNMENT**	Robert Stebbins	

Meetings are accessible to people with disabilities. Individuals who need special assistance or a disability-related modification or accommodation (including auxiliary aids or services) to participate in this meeting, or who have a disability and wish to request an alternate format for the agenda, meeting notice, or other documents that may be distributed at the meeting, should contact the HCH/FH Program Coordinator at least five working days before the meeting at (650) 573-2966 in order to make reasonable arrangements to ensure accessibility to this meeting and the materials related to it. The HCH/FH Co-Applicant Board regular meeting documents are posted at least 72 hours prior to the meeting and are accessible online at: http://www.sanmateomedicalcenter.org/content/Co-ApplicantBoard.htm.

Parking Lot

- Bylaws Review
  (as needed)
- Annual Tactical Plan
  (no current deadline)
- Scope Discussion
  (no deadline set)
- Transportation
  (no deadline set)
- Program Website
  (no deadline set)

TAB 1
April 9, 2015
Meeting Minutes
(Consent Agenda)

Healthcare for the Homeless/Farmworker Health Program (Program)
Co-Applicant Board Meeting Minutes
Thursday, April 9, 2015
Human Services Agency- 400 Harbor Blvd. Building B (Bali Rm) Belmont

Co-Applicant Board Members Present	County Staff Present	Members of the Public
Robert Stebbins, Chair	Linda Nguyen, Program Coordinator	
Daniel Brown	Glenn Levy, Counsel	
Brian Greenberg	Frank Trinh, HCH/FH Medical Director	
Paul Tunison	Jim Beaumont, Program Director	
Steve Carey	Susan Ehrlich, SMMC CEO	
Erick Brown (arrived 9:26am)		
Julia Wilson		
Kathryn Barrientos		
Beth Falls		

Absent: Kerry Lobel, Tayischa Deldridge

ITEM	DISCUSSION/RECOMMENDATION	ACTION
Call To Order	Robert Stebbins called the meeting to order at 9:02 A.M. Everyone present introduced themselves.	
Public Comment	No Public Comment at this meeting.	
Consent Agenda	All items on Consent Agenda (meeting minutes from March 19, 2015 and the Program Calendar) were approved. Please refer to TAB 1, 2	Consent Agenda was MOVED by Beth SECONDED by, Dan and APPROVED by all Board members present.
Board Orientation:	No Board Orientation for this meeting.	

Regular Agenda: HCH/FH Program *Director's Report*	Jim Beaumont (Dir) reported on program: Working on 4 grant conditions with 120 days implementation; find an attached document showing the status of each grant condition. *Request to add date/when completed as category.* Had discussion with our Project Officer on TA assistance on grant conditions and she suggest working with Dr. Mills on QI/QA Plan and that she can also offer TA assistance on Scope to The Board at a later time in June and to send her available dates in June. UDS has been finalized and will have summary at next Board meeting Awaiting report from OSV visit from HRSA. Spoke with our consultant Pat and she will be available to speak to the Board in next May or June meeting to discuss the results of the OSV visit. <u>Seven-day update</u> Sandy has resigned from the Board, as she has accepted a position with San Mateo's County's Counsel. *Please refer to TAB Additional Documents on the April 9 Board meeting packet.*	Jim- To add date/completion as category on Grant Conditions table Board members to send June availability for 2 days for TA assistance on Scope. Jim- prepare summary of UDS report for next meeting. Jim- coordinate with Pat her availability for May/June board mtg
Regular Agenda: HCH/FH Program *Budget & Financial Report*	A brief report was presented indicating: Jim presented the detailed and summary financial reports that were requested from March meeting. Total program costs according to UDS report is $11 million. *Requested additional reports:* 1. *Monthly and Cumulative grant expenditure information*	Jim/LN work on report

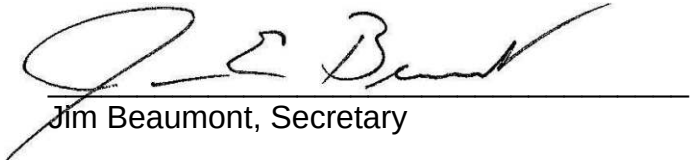
	A. Number of patients served and other metrics *B. Amount of money paid and on what date* *2. Patient income—Monthly* *A. Fee for service—bills for patient services submitted; amount paid* *B. Managed Care—percent of monthly allocation* *3. FQHC supplemental payments amount for SMMC Medi-Cal patients—Quarteryl* Counsel (Glen), offered SMMC CFO to offer budget training to interested Board members. Please refer to TAB Additional documents on the *April 9 Board meeting packet.* Board meeting packet	requests Follow up with CFO on availability for budget training at a Board mtg
QI Committee Report	Dr. Frank Trinh, Medical Director for the HCH/FH Program gave an oral report on QI/QA Plan status: Discussion on revamping the Programs QI Plan on size and scope to make more robust to provide more meaningful data, to understand discrepancies/issues. Frank met with internal IT and there is a firm commitment from them to potentially get universal data, try to align with HRSA outcome measures, as well as need to identify the population on our current EHC (eCW). Will work with IT to get our data to align with SMMC data. Will continue to work with HRSA on their offer for TA with Dr. Mills on our QI Plan. Primary Care reports provided are already very robust, just need to add HCH/FH population to the reports.	Continue to work with IT and SMMC on data needed for QI Plan outcome measures. Work with HRSA for TA on QI Plan Follow up with provider of Primary Care reports

Regular Agenda: Board Update of *Consumer Input*	Discussion on doing more to understand farmworkers needs, as a Board member recently visited (Steve) farm workers living conditions along the Coast to get a better understanding. Steve- volunteered to lead the transportation sub-committee Dan and Eric also volunteered to serve on the Transportation committee Discussion on the numbers and needs of farmworkers, as the numbers are unknown. According to UDS over 2,000 use our clinic system. Voiced the desire to understand the farmworker population with a presentation on needs etc. Current SMC efforts on the Coast- there is a Public Health Nurse that works in Pescadero, Coastside Clinic, Measure A funds to pilot clinic at Peunte (Thursday nights), data is being collected on this. Peunte conducted a survey recently as well. Next Providers Collaborative meeting will be held at Peunte on Tuesday April 21st 10:30-11:30 a.m. for those who may be interested in attending.	Steve, Dan and Eric volunteered for Transportation committee Obtain contact/name for Nurse to schedule tour of farmworkers sites.
Regular Agenda: *Request to Approve HCH/FH Policy & Procedures on Contract/MOU Oversight*	HRSA put us on 120 day grant condition on Policy/Procedures on Contracts/MOU oversight because the document was lacking "specific" language. Project Officer suggested getting TA from OSV staff, but the language (on small/minority business) that was omitted was already in the policy. We are referencing the language and the SMMC Policy specifically so that this is clear. *Please refer to TAB 3 on the April 9, 2015 Board meeting packet*	MOVED by Julia SECONDED by, Kat and APPROVED by all Board members present.
Regular Agenda: *Request to Approve HCH/FH Program Staffing Plan and Initiate*	Discussion on additional staffing needed/suggested from OSV visit and HRSA as very significant. Prepared in documents for two positions (Management Analyst and Clinical Program Coordinator) for now and possibly more in the near future.	MOVED by Bob

staffing actions	There was discussion on whether the program really needed the two positions and if it was an option to hire one for now and consider the other at a later time. Motion to hire 1 MA now and explore the other position (Clinical Program Coordinator) at a later time. *Please refer to TAB 4 on the March 19, 2015 Board meeting packet. Requires two-thirds (2/3) majority vote of the total current Board members for approval.*	SECONDED by, Dan OPPOSE- Paul and Dan ABSTAIN- Brian and APPROVED by remainder of Board members: Beth, Julia, Dan, Kat, Eric, Bob
Regular Agenda: Board discussion- on HCH/FH SMMC Clinic Utilization for 2014	Tabled for next Board meeting	Jim/Linda add to May Board packet for discussion.
Adjournment	Robert adjourned the meeting at __11:09____ a.m.	

Robert Stebbins, Chair

April 9, 2015_____
Date



Jim Beaumont, Secretary

April 9, 2015_____
Date

TAB 2
Program Calendar
(Consent Agenda)

Health Care for the Homeless & Farmworker Health (HCH/FH) Program

2015 Calendar (*Revised May 2015*)

EVENT	DATE	NOTES
• Board Meeting (May 14, 2015 from 9:00 a.m. to 11:00 a.m.) • Initiate Tactical Plan Development • Begin Needs Assessment (plan and create material) • National Farmworker Health Conference in San Antonio, TX (May 5-7) • NHCHC National Conference IN Washington, D.C. (May 7-9)	May	Board meeting at Ravenswood- East Palo Alto
• Board Meeting (June 11, 2015 from 9:00 a.m. to 11:00 a.m.) • Initiate Preparation for Service Area Competition (SAC) Submission • Board Review & Approval of Program Services, Sites and Hours • Administer Needs Assessment Surveys	June	Board meeting at Fair Oaks Health Center- Redwood City
• Board Meeting (July 9, 2015 from 9:00 a.m. to 11:00 a.m.) • Conduct Focus Groups • Board approval of SAC for submission • RFP distributed • Initiate QI Population Reporting	July	Board meeting at Health System- Alameda Campus, San Mateo
• Board Meeting (August 13, 2015 from 9:00 a.m. to 11:00 a.m.) • Analysis of Needs Assessment	August	
• Board Meeting (September 10, 2015 from 9:00 a.m. to 11:00 a.m.) • Review RFP proposals • Tentative TA with HRSA for Scope of Project • Nominations for Chair & Vice-Chair	September	
• Board Meeting (October 8, 2015 from 9:00 a.m. to 11:00 a.m.) • Grant Year Budget Approval • Approval of RFP proposals • Election of Chair & Vice-Chair • Potential Regional Conference	October	
• Board Meeting (November 12, 2015 from 9:00 a.m. to 11:00 a.m.) • Contracting , prepare for BOS	November	
• Board Meeting (December 10, 2015 from 9:00 a.m. to 11:00 a.m.) • Contracts needing approval for BOS submission	December	

TAB 3
Upcoming Events
(Consumer Input)

CONTINENTAL BREAKFAST

LUNCH CATERED BY:
PASTA POMODORO CAFÉ

OPTIONAL CONTINUING EDUCATION CREDITS
FOR NURSES, SOCIAL WORKERS, AND HEALTH EDUCATORS

CEU'S AVAILABLE: PAYABLE AT CONFERENCE ONLY

MAKE CEU CHECK PAYABLE TO:
SAN FRANCISCO PUBLIC HEALTH FOUNDATION

The California State Board of Registered Nursing has approved the San Francisco Dept. of Public Health-Community Health Education Section-Code, as a Provider of Continuing Education for Registered Nurses, Provider #CEP 03548.

The California Board of Behavioral Sciences has approved the San Francisco Dept. of Public Health-Community Health Education Section, Provider #1389, as a provider of Continuing Education for MFCC, MFT and LCSWs.

The Community Health Education Section and the San Francisco Dept. of Public Health has been designated as a multiple event provider of continuing education by the National Commission for Health Education Credentialing, Inc., Provider #CA0039.

SMC Family Health Services/MCAH
Attn. Faye Jennings, Sr. PHN
2000 Alameda de las Pulgas Ste 200
San Mateo, Ca. 94403

18TH ANNUAL SAN FRANCISCO BAY AREA REGIONAL HOMELESS PERINATAL CONFERENCE

SUPPORTING FAMILIES ON THEIR ROAD TO RECOVERY
WEDNESDAY, MAY 20, 2015
8:30 A.M. – 1:30 P.M.

THE CALIFORNIA ENDOWMENT
1111 BROADWAY STREET, 7TH FLOOR
OAKLAND, CA 94612

SPONSORED BY:
ALAMEDA, CITY OF BERKELEY, CONTRA COSTA, SAN FRANCISCO AND SAN MATEO COUNTY HEALTH DEPARTMENTS, MATERNAL, PATERNAL, CHILD AND ADOLESCENT HEALTH SERVICES AND THE SAN FRANCISCO HOMELESS PRENATAL PROGRAM

HOSTED BY:
SAN MATEO COUNTY,SAN FRANCISCO HOMELESS PRENATAL PROGRAM AND SAN FRANCISCO DEPARTMENT OF PUBLIC HEALTH

CONFERENCE OBJECTIVES

1. To increase knowledge regarding the factors that lead to substance abuse and impact the recovery process.
2. To gain awareness of the importance of gender-specific treatment programs for families.
3. To become energized in working with families and strengthen connections to providers in the San Francisco Bay Area.

BART:

Exit @ 12 Street – Exit in front of building
(Strongly recommended)

DIRECTIONS:

From Concord Area: Take I-680 East to CA-24 West toward Oakland. CA-24 becomes I-980 West. Take the 12th St., exit onto Brush St.; turn left on 11th St.; turn left on Broadway.
From Richmond Area: Take I-80 West to I-580 East to I-980 West and follow the bold directions above.
From San Francisco: Take I-80 East across Bay Bridge to I-580 East, to I-980 West and follow the bold directions above.
From San Jose: Take I-880 West to I-980 East, exit at 11th/14th St., continue on Castro St., turn right on 11th St. and left on Broadway.

PARKING:

City Center Garage: 525 14th Street, $2/20 min.; Daily Max $25/day
1000 Broadway Garage (underneath OUSD): Early Bird (before 9am) $9/day; Daily Max $16
Douglas Parking/Clay St. Garage: 1414 Clay St/14th St. $3/hour; $14/day

PROGRAM HIGHLIGHTS

9:00 AM – 1:30 PM
8:30 AM (REGISTRATION)

WELCOME

Diane Beetham, MSN, RN, PHN
Director of Nursing
San Francisco Dept. Public Health Maternal Child and Adolescent Health Section

Faye Jennings, RN, SrPHN,
Perinatal Services Coordinator, San Mateo County Family Health Services/MCAH

FEATURING THE FILM

On Life's Terms:
Mothers in Recovery
By Sheila Ganz
WWW.ONLIFESTERMS.ORG

PANEL DISCUSSION (EXPERTS ON ADDICTION, RECOVERY AND TREATMENT)

LUNCH /COUNTY NETWORKING

(BRING BUSINESS CARDS AND FLYERS ABOUT YOUR PROGRAM)

PROGRESS, CHALLENGES AND ACTION STEPS

FOR CONFERENCE INFORMATION CALL:

SHARON WALCHAK – 415-401-4313

REGISTRATION

Space is limited. Registration form and check must be received by 5:00 pm, Friday, May 15, 2015

FEE: $30.00

Make check payable to:
Inter- City Services, Inc.

MAIL REGISTRATION FORM AND CHECK TO:
SM FAMILY HEALTH SERVICES/MCAH
ATTN. FAYE JENNINGS
2000 ALAMEDA DE LAS PULGAS STE 200
SAN MATEO, CA. 94403

NAME: _____

AGENCY and JOB TITLE:

_____

COUNTY OF EMPLOYMENT: _____

MAILING ADDRESS: _____

_____

CITY/ZIP: _____

PHONE: ( )____ - _____

FAX: ( )_____ - _____

E-MAIL: _____

One of the ways the Department of Housing works towards its mission/goal to ensure that housing permanently exists for people of all income levels and generations in San Mateo County is by funding and partnering with non-profit agencies' programs and projects to keep current homeowners and renters in their current housing. One such program is the Coastside Minor Home Repair Program operated by Senior Coastsiders that holds a one day event to repair/rehab the homes of low-income seniors and adults with disabilities living on the coastside from Montara to Pescadero.

This year, the 25th Annual Senior Coastsiders' Home Rehab Day will be held on Saturday, June 6th. Over the past 24 years, teams of volunteers have renovated/repaired more than 450 homes and 15 non-profit facilities, with work ranging from installing wheelchair ramps, replacing unsafe stairs and porches, fixing plumbing problems and furnaces, painting houses inside and out and cleaning out yards. All skill levels are welcome (i.e. don't think you have to be a handyman, everyone can help their team in some way).

To register as a group or as an individual, go to this link: http://www.seniorcoastsiders.org/#!home-repair-volunteer/c1nys

If you have additional questions, please call Vicki at Senior Coastsiders at 650-726-9056.

Senior Coastsiders

TAB 4
Request to Approve HCH/FH Quality Improvement Policy

SAN MATEO COUNTY
HEALTH SYSTEM

DATE: May 14, 2015

TO: Co-Applicant Board, San Mateo County Health Care for the Homeless/Farmworker Health (HCH/FH) Program

FROM: Jim Beaumont, Director
HCH/FH Program

SUBJECT: REQUEST TO APPROVE QI/QA POLICY

On April 29, 2015, the Program received a Technical Assistance Conference Call with our Project Officer and a HRSA clinical consultant. Based on that call, the feedback and comments from the recent Operational Site Visit and the recommendations of our consultants, the HCH/FH Program QI/QA Policy had been redrafted. The policy is a required submission by May 14, 2015 on our 120-day implementation grant condition on Program Requirement #10 – Quality Improvement.

This request is for the Board to approve the HCH/FH QI/QA Policy. Approval of this item requires a majority vote of the Board members present.

Attachments:
HCH/FH QI/QA Policy

SAN MATEO COUNTY

HEALTHCARE FOR THE HOMELESS/FARMWORKER HEALTH PROGRAM

Program Policy and Procedures

Policy Area: Quality Improvement	**Effective Date: 05/14/2015**
Subject: HCH/FH Policy/Procedures	**Approved Date: Revision Date: 05/14/2015**
Title of Policy: Health Care for Homeless and Farmworkers Health QI Policy/Procedures	**Approved by: Co-Applicant Board**

I. PURPOSE:

The purpose of the Health Care for the Homeless and Farmworker Health Program (HCH/FH)'s Quality Improvement (QI) Program is to evaluate and ensure, on an on-going basis, the effectiveness of health care provided to homeless and farmworker patients and families, success in meeting utilization targets, achievement of clinical and financial performance objectives, and the highest levels of patient satisfaction. The HCH/FH QI Plan will be established and implemented through the QI Policy and Procedure, which will:

- Establish broad performance improvement goals and priorities that are aligned with the goals and objective identified in the Strategic Plan of the HCH/FH Program and meets Section 330-Program requirements.
- Develop and utilize specific mechanisms for the identification, adoption and reporting of performance improvement projects.
- Monitor program performance through appropriate data collection including systematic aggregation and analysis of data from San Mateo Medical Center (SMMC) clinics and program contractors.
- Develop a process by which problems can be assessed and proposed solutions implemented with a method of follow-up that will assure problem resolution.
- Provide information regarding performance improvement activities and education to the HCH/FH Program Co-Applicant Board, San Mateo Medical Center (SMMC) Hospital Board, SMMC Quality Improvement Committee (QIC), program staff, and program contractors.

The HCH/FH QI Program provides the structure, tools, and resources to improve the quality of the HCH/FH Program in three essential areas:

- Patient **Access** to quality care
- Personal and organizational **Excellence**
- **Collaboration** with co-workers and community partners

The HCH/FH QI Plan also provides the outline for monitoring and improving program service delivery in four major areas:

- Quality of **Service-** Patient access and satisfaction
- Quality of **Care**- Clinical indicators and outcome measures
- Quality of **Work**- Staff productivity, satisfaction and retention
- Quality of **Population Health**- Health status indicators for the target population

The HCH/FH QI Policy and Procedures establishes and implements the QI Program and involves the following components:

- Composition and responsibilities of the HCH/FH QI Committee
- Identification of quality indicators
- Selection of quality objectives
- Measurement of progress on quality indicators and objectives
- Risk Management
- System for using data to guide improvements
- Mechanisms for accountability and organizational responsibility
- QI infrastructure support and resources

II. POLICY:

The San Mateo County HCH/FH Program's Co-Applicant Board has instituted a quality improvement program that establishes the structure and process for improving organizational performance. The HCH/FH QI Program will be carried out in accordance with HCH/FH and SMMC policies through:

- Establishing broad performance improvement goals and priorities that are aligned with the mission, vision, values and goals of the program
- Developing and utilizing specific mechanisms for the identification, adoption and reporting of performance improvement projects
- Monitoring program performance through appropriate data collection, aggregation and analysis
- Providing information regarding performance improvement activities and education to the HCH/FH Co-Applicant Board, SMMC Hospital Board, SMMC Quality Improvement Committee (QIC), program staff, and program contractors.

The HCH/FH QI Plan will be submitted by the HCH/FH QI Committee to the HCH/FH Co-Applicant Board. Annual QI plans will include the following components: quality assurance/control activities, quality improvement activities, patient satisfaction measures, and peer monitoring activities. Quarterly reports of performance improvement activities will be provided to the HCH/FH Co-Applicant Board and to the SMMC QIC as appropriate. Subsequent to the quarterly reports, further activities will be determined by the HCH/FH Co-Applicant Board to review and approve indications for evaluation studies, review data looking for trends and significant variance, and make recommendations and/or take action as required. Recommendations and actions involving SMMC clinics will be communicated by the HCH/FH QI Committee to the SMMC QIC. Recommendations and actions involving program contractors will be communicated by the HCH/FH QI Committee directly to the contractors.

III. ORGANIZATION AND REPORTING CHANNELS:

A. The HCH/FH QI Committee is responsible for implementing the HCH/FH QI Program and development of the annual QI Plan.
B. The HCH/FH QI Committee will review and analyze data from SMMC clinics and contractors on a quarterly basis. Data collection and analysis of outcome measures indicated by the UDS (Uniform Data System) report are conducted on a yearly basis.
C. The HCH/FH QI Committee provides reports to the HCH/FH Co-Applicant Board on a quarterly basis and to the SMMC Hospital Board on an annual basis.
D. Quality improvement concerns regarding services performed by SMMC clinic providers and contractors will be reported as part of quality plan reports to the HCH/FH Co-Applicant Board, SMMC Hospital Board, and SMMC QIC. The HCH/FH QI Committee will make recommendations and/or take action as required.
E. The HCH/FH Program provides services embedded in the SMMC clinic structure as well as through contracts with community partners. Quality improvement concerns regarding services performed by SMMC clinic providers and contractors will be processed through the HCH/FH QI Committee and the HCH/FH Co-Applicant Board.

F. HCH/FH QI Committee

The HCH/FH QI Committee provides leadership for organization-wide, ongoing assessment, monitoring and improvement of HCH/FH programs and services in major functional areas and important aspects of care, including clinical primary care, patient and staff education, continuity of care, risk management, patient satisfaction, support services, medical record/information systems, and financial integrity and accountability. The HCH/FH QI Committee is responsible for the planning and implementation of activities to ensure the quality of care delivered by the HCH/FH Program for homeless and farmworker patients and families.

1. The HCH/FH QI Committee will consist of the Medical Director, Program Coordinator, representatives of primary care providers, representatives of all program services contractors and other ad hoc members as needed.
2. The HCH/FH QI Committee will meet at least quarterly (a minimum of four times per year). If a problem, incident or urgent business arises between the dates of regular meetings, the HCH/FH Medical Director or Program Director may call an emergency meeting.

   The HCH/FH Medical Director establishes the agenda for each meeting. The Program Coordinator records and maintains files of minutes of each meeting. Each meeting agenda may include but will not be limited to:

   - Presentation of previous meeting minutes for approval
   - Risk management status review
   - Review of status of UDS quality of care and health disparities clinical measures
   - Review of HCH and FH utilization trends

- Review of audits
- Review of areas of concern/problem reports
- Follow-up of previously identified problems/opportunities for improvement

3. The HCH/FH QI Committee will review data from SMMC clinics and contractors on a quarterly basis and monitor progress on utilization and clinical performance measure. Reports and recommendations may include but are not limited to:

   - Reports on utilization by homeless and farmworker patients and families and sub-populations within these two target populations
   - Findings from applicable internal and external audits
   - Clinical performance measure findings
   - Patient and staff satisfaction survey results
   - Patient and staff concerns or suggestions

   SMMC clinics and contractors report risk management and other significant concerns regarding patient safety, including patient-related incident reports, immediately to the HCH/FH Medical Director.

4. The activities of the HCH/FH QI Committee are legally protected under the California Health and Safety Code Section 1370. The law protects those who participate in quality of care or utilization review. It provides further that "neither the proceedings nor the records of such reviews shall be subject to discovery, nor shall any person in attendance at such reviews be required to testify as to what transpired thereat." All peer review and other confidential reviews and actions will be done during closed session of the QI Committee meeting.

IV. QUALITY IMPROVEMENT ACTIVITIES:

A. Quality Indicators

The HCH/FH QI Committee will carefully select quality and health disparity indicators based on the following priorities:

- Selected practice guidelines - Use of practice guidelines to meet clinical standards for adult, older adult and pediatric health maintenance and for treatment of conditions that disparately affect HCH/FH patients
- Benchmarks for clinical performance measures reported in the annual UDS summary and rollout reports for Section 330 grantees
- Healthy People 2020 and HEDIS measures for chronic disease and preventive care
- New or significantly modified major processes - Impact of processes adopted or modified to improve quality of care
- Requirements of external agencies that have significant consequence in either supporting the HCH/FH Program's attainment of its mission or financial well-being - Requirements from funders, requirements from regulatory agencies, and Bureau of Primary Health Care (BPHC) measures Indicators that have been identified as having

broad impact across organizational functions and that should be considered for immediate action - Clinical and legal compliance issues, training and staff development requirements, and factors that impact community health and relations

B. Selection of Specific Quality Objectives

The HCH/FH QI Committee will develop an annual QI Plan with specific objectives in the areas of access and utilization of care, and clinical performance. The annual work plan is revised on an ongoing-basis and will:

- Outline specific goals and outcome measures for access to care, utilization of services, and clinical performance measures for homeless and farmworker individuals and families
- Propose implementation plan for goals and outcome measures
- Measure and analyze proposed goals and outcome measures
- Revise or add goals and outcome measures as needed with proposed follow-up plan
- Each year, the annual QI Plan will be submitted to the HCH/FH Co-Applicant Board for approval at the June meeting
- Data collection for each annual QI Plan will begin in July of that year

C. Measurement of Quality Indicators and Progress on Objectives

The HCH/FH QI Committee oversees and coordinates collection and analysis of data by SMMC clinics and program contractors to measure quality indicators and progress toward annual objectives.

1. Data Collection Systems: To ensure the availability of accurate and timely data to inform QI activities, the HCH/FH QI Committee coordinates:

    - Development, testing and application of procedures and tools (forms, charts, logs, etc.) for the collection of data for HCH/FH QI purposes
    - Regular training/re-training of staff on data collection, including "just-in-time" training on changes in procedures and to solve problems
    - Design and posting of simple instructions and reminders about data collection
    - Quality control of data collection and follow-up
    - Assurance that data collection complies with SMMC procedures for data storage, maintenance (including backups) and security; covering all formats of data (charts, notes, electronic records, etc.) and exchange of data between SMMC and program contractors

2. Patient Records Reviews: Based on SMMC policies and procedures, the HCH/FH Medical Director establishes procedures for and supervises reviews of representative samples of electronic health records and/or SMMC clinic patient charts to measure progress toward selected clinical performance measures and other quality indicators. Contractors have in place procedures and supervision for records review of homeless and farmworker patients. Reviews of patient records are conducted quarterly. A formal Peer Review Program is conducted by SMMC and all providers of primary

care.

3. Data Analysis: The HCH/FH Medical Director oversees data analysis conducted by the Program Staff . The Program Director prepares aggregated reports of data from SMMC clinics and program contractors to the HCH/FH QI Committee as requested by the Medical Director. Data performance compared to the goals for Quality Measures and emerging trends derived from the reports will guide the HCH/FH QI Committee in identifying problem areas/opportunities for improvement and planning improvement projects

D. System for Using Data to Guide Improvements

Improvement activities will follow the Plan-Do-Study-Act (PDSA) methodology. This methodology requires careful planning at all stages of the cycle.

	STEPS IN THE QI PROCESS	***USEFUL TOOLS***
P	**Plan the improvement** ➢ Plan the implementation of the improvement ➢ Plan continued data collection	☑ Data Collection Methods ☑ Group Decision-Making Tools
D	**Do the improvement to the process** ➢ Make the change ➢ Measure the impact of the change	☑ Flowchart ☑ Data Collection Methods ☑ Run Chart
S	**Study the results** ➢ Examine data to determine whether change led to the expected improvement	☑ Cause and Effect Diagram ☑ Run Charts ☑ Control Charts ☑ Histograms
A	**Act to hold the gain and continue to improve the process** ➢ Develop a strategy for maintaining the improvements ➢ Determine whether or not to continue working on the process	☑ Flowchart ☑ Group Decision-Making Tools

E. Risk Management

The HCH/FH QI Committee will work closely with the SMMC Patient Safety Committee (PSC). The PSC is a chartered subcommittee of SMMC QIC and is responsible for oversight of patient safety at all SMMC patient care facilities. Effective reduction of medical/health care errors and other factors that contribute to unintended adverse patient outcomes in a health care organization requires an environment in which patients, patient families, and organization staff and leaders can identify and manage actual and potential risks to patient safety. This environment encourages recognition and acknowledgment of risks to patient safety and medical/health care errors;

initiation of actions to reduce these risks; internal reporting of what has been found and the actions taken; focus on processes and systems; and minimization of individual blame or retribution for involvement in a medical/health care error. Organizational learning is also encouraged regarding medical/health care errors. Sharing of organizational knowledge is also supported to effect behavioral changes within the organization and in other health care organizations to improve patient safety.

HCH/FH complies with the SMMC Integrated Patient Safety Plan (in WorkSite titled PI.03.01.01-A Integrated Patient Safety Program). In compliance with the Integrated Patient Safety Plan, sentinel events and other significant untoward events, or the risk of such events, will be included in the HCH/FH QI Plan through special reporting. Such events are further defined in the Integrated Patient Safety Plan. These events may also be reportable pursuant to the County's sentinel event reporting ordinance. Actions taken as a result of root causes analyses and focus reviews will be included in the quality improvement program and reported to the HCH/FH Co-Applicant Board, SMMC Hospital Board, and SMMC QIC. Primary care contractors have in place and comply with their individual risk management plans and all related policies and procedures.

F. Patient/Client Complaints

Patient/client grievances and complaints are treated with the highest importance. Complaints and concerns should be resolved at the program level whenever possible. When an issue cannot be resolved, procedures are followed as described in the policy in the Rights and Responsibilities of the Patient chapter in WorkSite titled RI.01.07.01-B Patient Grievance Procedure. Complaints and grievances, which relate to quality of care issues, are referred to the appropriate department or committee for review and action.

G. Credentialing and Privileging

SMMC primary care providers delivering care for homeless and farmworker patients and families are subject to SMMC credentialing and privileging policies and procedures. These policies and procedures ensure the appointment and re-appointment of appropriately licensed and qualified individuals to the medical staff and grant such individuals specific clinical privileges. Primary care contractors have credentialing and privileging policies and procedures in place as well. The HCH/FH Co-Applicant Board will verify annually, or as needed, that SMMC and primary care contractors have credentialing and privileging policies and procedures verifying that all licensed and certified healthcare practitioners delivering care for homeless and farm worker patients and families are in full compliance with the Bureau of Primary Health Care Policy Information Notices 2001-16 and 2002-22.

H. Patient Satisfaction Surveys

The HCH/FH Program will conduct a patient satisfaction survey biennially with homeless and farmworker patients of SMMC clinics and program contractors. The HCH/FH QI Committee will review survey results and use the findings to assist in identifying important issues for

patients that may need to be addressed. The survey format may also be used for focused surveys regarding a specific area of patient care.

V. MECHANISMS FOR ACCOUNTABILITY AND ORGANIZATIONAL RESPONSIBILITY:

The HCH/FH Co-Applicant Board has the ultimate authority and responsibility for the implementation and maintenance of ongoing QI activities. This responsibility is delegated to the HCH/FH QI Committee. To ensure accountability for HCH/FH QI, organizational responsibilities are defined as follows:

1. The HCH/FH Medical Director is responsible for ensuring that the HCH/FH QI Plan is properly developed, implemented and coordinated. The Medical Director oversees reviews of patient records by licensed health professionals. The Medical Director is involved in the coordination of QI activities with primary care contractors. The Medical Director assists the Program Director with the preparation and presentation of the HCH/FH QI quarterly report to the HCH/FH Co-Applicant Board.

2. The HCH/FH Program Director is responsible for managing the collection, analysis, and reporting of accurate, timely data to inform QI activities. Program Director works with the Medical Director to prepare and present the HCH/FH QI quarterly report to the HCH/FH Co-Applicant Board.

3. Infrastructure Support and Resources for QI: The SMMC Quality Management Department is responsible for supporting SMMC's organization-wide quality management program, including the HCH/FH QI Plan. The department provides program support through assisting in the collection of data for performance improvement purposes, conducting clinical review activities, preparing summary reports, reporting data, maintaining a central location for QI records and organizational review activities while safeguarding confidentiality, maintaining records and databases that support performance improvement activities, and providing training related to dissemination and implementation of QI activities.

Approved _____

_____ _____

Board Chair Program Director

TAB 5
Request to Approve HCH/FH Credentialing and Privileging Policy

SAN MATEO COUNTY
HEALTH SYSTEM

DATE: May 14, 2015

TO: Co-Applicant Board, San Mateo County Health Care for the Homeless/Farmworker Health (HCH/FH) Program

FROM: Jim Beaumont, Director
HCH/FH Program

SUBJECT: REQUEST TO APPROVE CREDENTIALING AND PRIVILEGING POLICY

On April 29, 2015, the Program received a Technical Assistance Conference Call with our Project Officer and a HRSA clinical consultant. Based on that call, the feedback and comments from the recent Operational Site Visit and the recommendations of our consultants, the HCH/FH Program Credentialing and Privileging Policy has been developed. The policy is a required submission by May 14, 2015 on our 120-day implementation grant condition on Program Requirement # -----.

This request is for the Board to approve the HCH/FH Credentialing and Privileging Policy. Approval of this item requires a majority vote of the Board members present.

Attachments:
HCH/FH Credentialing and Privileging Policy

SAN MATEO COUNTY

HEALTHCARE FOR THE HOMELESS/FARMWORKER HEALTH PROGRAM

Program Policy

Policy Area: Program Services Staffing	**Effective Date: 05/14/2015**
Subject: Credentialing & Privileging	**Approved Date: Revision Date: 05/14/2015**
Title of Policy: HCH/FH Program Credentialing & Privileging Policy & Procedure	**Approved by: Co-Applicant Board**

1. **Rationale or background to policy:**

The San Mateo County Health Care for the Homeless/Farmworker Health (HCH/FH) Program supports that regular verification of the credentials of health care practitioners and delineation of their privileges are required for increased patient safety, reduction of medical errors and the provision of high quality health care services. As part of the responsibility to provide all required primary, preventive, enabling health services and additional health services as appropriate and necessary, either directly or through established arrangements and referrals, all services provided to HCH/FH patients must be provided by staff who are properly licensed, credentialed and privileged, as appropriate.

2. **Policy Statement**:

The HCH/FH Co-Applicant Board shall review and endorse the credentialing and privileging actions taken by the San Mateo Medical Center (SMMC) Board of Directors (BOD).

In support of these actions, the HCH/FH Co-Applicant Board shall verify annually, or as needed, that SMMC's Credentialing & Privileging policies and processes are in full compliance with the Health Services and Resources Administration's (HRSA) requirements as referenced in Policy Information Notices (PIN) 2002-22 and 2001-16 and as ever updated by HRSA. Upon review of the SMMC Credentialing and Privileging policies and processes, the HCH/FH Co-Applicant Board shall affirm their compliance with HRSA requirements.

3. Procedures:

The HCH/FH Quality Improvement Committee (QIC) shall review SMMC Credentialing and Privileging policies, procedures and processes annually to determine continuing compliance with HRSA requirements. The QIC will report on their findings and determination at the Co-Applicant Board's regular January meeting each year. The HCH/FH Co-Applicant Board shall review the QIC's determination and take action to affirm SMMC compliance with HRSA requirements.

Should the HCH/FH Co-Applicant Board find during an annual verification, or at any other time, that the SMMC credentialing & privileging policies, procedures and processes are no longer fully in compliance with HRSA requirements, the HCH/FH Co-Applicant Board shall immediately initiate a resolution process as specified in the Co-Applicant Agreement to remediate the situation.

If the QIC determines that there is any material non-compliance with HRSA requirements, they shall immediately notify the HCH/FH Director, SMMC and the Medical Staff Office of SMMC of their finding and of the timing of their report to the HCH/FH Co-Applicant Board. On concurrence with the determination by the HCH/FH Co-Applicant Board, a resolution process as called for in the Co-Applicant Agreement shall be initiated to address the issue. The HCH/FH QIC shall track the progress on the issue and provide monthly reports to the HCH/FH Co-Applicant Board until the issue is resolved. Once resolved, the HCH/FH Co-Applicant Board will review and endorse the final resolution and the current status of the SMMC Credentialing and Privileging policies, procedures and processes.

As long as the SMMC Credentialing and Privileging policies, procedures and processes have been determined to be in compliance with HRSA requirements, all credentialing and privileging actions taken by the SMMC BOD shall be added to the HCH/FH Co-Applicant Board's next regular meeting agenda for review and endorsement.

Approved _____

_____ _____

Board Chair Program Director

TAB 6
HCH/FH Need Assessment Discussion

SAN MATEO COUNTY
HEALTH SYSTEM

DATE: May, 14, 2015

TO: Co-Applicant Board, San Mateo County Health Care for the Homeless/Farmworker Health (HCH/FH) Program

FROM: Linda Nguyen, HCH/FH Program Coordinator

SUBJECT: NEEDS ASSESSMENT

The Program is preparing for the upcoming Needs Assessment to better inform the program by determining priority areas and overarching goals, as well as guide what services to fund for the next contract cycle. We will be conducting focus groups and distributing surveys to clients as well as providers this summer to gather data/needs.

Attached you will find surveys that have been used in the past as well as a distribution list of where surveys were circulated.

Please answer each question as best as you can. Your answers will help to set goals for delivering health care for homeless individuals and agricultural workers in San Mateo County. Your feedback will help San Mateo Medical Center answer health care access questions. **A**ll surveys are **confidential** and there is **no way** that your answer will be identified as yours.

Your year of birth: ☐☐☐☐
Year

Ethnicity:
(Check all that apply.)
☐ African American ☐ Asian / PI ☐ Latino / Hispanic
☐ White ☐ Native American ☐ Other _____ Pls. Indicate (Optional)

Gender: ☐ Female ☐ Male ☐ Other

Health Insurance:
☐ MediCal ☐ MediCare ☐ MCE ☐ Private Insurance
☐ Healthy Families ☐ Healthy Kids ☐ ACE ☐ No Insurance

Source of Income:
(Last Month)
☐ Job ☐ Social Security ☐ No income
☐ Disability Insurance ☐ General Assistance ☐ Other _____ Please Indicate (Optional)

Monthly Income:
(Last month)
☐ 0-$50 ☐ $51-$100 ☐ $101-$500
☐ $501-$1,000 ☐ $1,000-$2,000 ☐ Over $2,000

In the past 2 years, have you or a family member ever worked as an agricultural worker?
☐ Yes ☐ No

Your current living situation:
(Today, where are you living? Check all that apply.)

☐ Living in a place not meant for people to live in for long periods like: dry-docked boat, tree house, tent, under freeway / bridge
☐ Outside
☐ Car / Van / Mobile home without water and sewer hook-up
☐ Garage / Shed / structure without running water & sewer
☐ Hotel / Motel
☐ Apartment / House (even if you slept on a couch or on the floor)
☐ Housing for agricultural workers
☐ Homeless shelter
☐ Transitional housing/Treatment program

Please return this form to Naida Pare-Alanda. Phone (650) 573-2966. Fax (650) 573-2030.
Email: npare@smcgov.org. San Mateo County PONY: HOS316AD

I currently receive my healthcare from:
(Check all that apply.)

- ☐ Veterans Administration
- ☐ San Mateo County Emergency Room
- ☐ San Mateo County Clinics (Please specify clinic name:_____)
- ☐ Other hospital Emergency Room
- ☐ Private clinics / other clinics (like Kaiser, Sequoia, Mills-Peninsula)
- ☐ Public Health Mobile Clinic
- ☐ San Mateo Medical Center Mobile Dental Clinic
- ☐ Elsewhere (Please specify clinic name:_____)

My health care needs are: Place numbers only in the boxes that apply to you, leave the rest blank.

☐ Primary Medical Care ☐ Dental Care ☐ Mental Health

☐ Substance Use ☐ Someone to give me accurate, confidential health information and education

☐ Someone to help me navigate clinic system ☐ Someone to help me get health insurance

(Rank your health care needs. Use 1 thru 5 with 1 as the most important need, 2 the next most important need, 3 as the next most important need, 4 as the next important, and 5 as the least of those listed above.)

Please answer the following questions to the best of your ability. Check only one box for each question. If you do not have an opinion or don't know, please do not check any boxes.

I am satisfied with my current health care provider:
☐ Strongly Agree ☐ Agree ☐ Neutral ☐ Disagree ☐ Strongly Disagree

I know where to get medical care:
☐ Strongly Agree ☐ Agree ☐ Neutral ☐ Disagree ☐ Strongly Disagree

I know where to get dental care:
☐ Strongly Agree ☐ Agree ☐ Neutral ☐ Disagree ☐ Strongly Disagree

I know where to go for mental health and substance abuse services:
☐ Strongly Agree ☐ Agree ☐ Neutral ☐ Disagree ☐ Strongly Disagree

I know where to go for accurate and confidential health information:
☐ Strongly Agree ☐ Agree ☐ Neutral ☐ Disagree ☐ Strongly Disagree

Please return this form to Naida Pare-Alanda. Phone (650) 573-2966. Fax (650) 573-2030.
Email: npare@smcgov.org. San Mateo County PONY: HOS316AD

I avoid seeking healthcare because I get billed for services and can't afford to pay:
☐ Strongly Agree ☐ Agree ☐ Neutral ☐ Disagree ☐ Strongly Disagree

I avoid seeking healthcare because I am not treated respectfully:
☐ Strongly Agree ☐ Agree ☐ Neutral ☐ Disagree ☐ Strongly Disagree

I avoid seeking healthcare because I fear deportation or arrest:
☐ Strongly Agree ☐ Agree ☐ Neutral ☐ Disagree ☐ Strongly Disagree

I am unable to seek healthcare because it takes too long before I can get an appointment:
☐ Strongly Agree ☐ Agree ☐ Neutral ☐ Disagree ☐ Strongly Disagree

I am unable to seek healthcare because I am not able to take time off of work:
☐ Strongly Agree ☐ Agree ☐ Neutral ☐ Disagree ☐ Strongly Disagree

I am unable to seek healthcare because I do not have child care:
☐ Strongly Agree ☐ Agree ☐ Neutral ☐ Disagree ☐ Strongly Disagree

I am worried about the confidentiality of my healthcare:
☐ Strongly Agree ☐ Agree ☐ Neutral ☐ Disagree ☐ Strongly Disagree

I can easily arrange for transportation to get to my health care provider:
☐ Strongly Agree ☐ Agree ☐ Neutral ☐ Disagree ☐ Strongly Disagree

Please return this form to Naida Pare-Alanda. Phone (650) 573-2966. Fax (650) 573-2030.
Email: npare@smcgov.org. San Mateo County PONY: HOS316AD

HCH/MH Program Client Survey 2013
Distribution List

Homeless Veterans Rehabilitation Program:
795 Willow Road, Bldg 347-B
Menlo Park, CA 94025

St. Vincent De Paul Sites:
2600 Middlefield Road
Redwood City, CA 94063

50 N. B Street
San Mateo, CA 94401

344 Grand Avenue
South San Francisco, CA 94063

400 Church Street
Half Moon Bay, CA 94019

InnVision Shelter Network Sites:
1450 Chapin Avenue, 2nd Floor
Burlingame, CA 94010

1580A Maple Street
Redwood City, CA 94063

260 Van Buren Road
Menlo Park, CA 94025

325 Villa Terrace
San Mateo, CA 94401

110 Locust Street
Redwood City, CA 94063

415 E. 2nd Avenue
San Mateo, CA 94401

Home and Hope (IHN):
1720 El Camino Real #7
Burlingame, CA 94010

Catholic Worker Hospitality House Sites:
555 San Bruno Avenue
San Bruno, CA 94066

545 Cassia Street
Redwood City, CA 94063

Samaritan House Sites:
295 N Access Rd
South San Francisco, CA 94128

4031 Pacific Blvd.
San Mateo, CA 94403

Spring Street:
2686 Spring Street
Redwood City, CA 94063

New Creation Home Ministries:
422 Hibiscus Court
East Palo Alto 94303

Project 90 Sites:
15 9th Avenue
San Mateo CA 94401

720 South B St.
San Mateo, CA 94401

314 Baden Avenue
South San Francisco, CA 94080

Daytop Village:
2560 Pulgas Avenue
East Palo Alto CA 94303

Free At Last:
1796 Bay Road
East Palo Alto 94303

Woman's Recovery Association:
1450 Chapin Avenue, 1st Floor
Burlingame, CA 94010

Project We HOPE:
1854 Bay Road
East Palo Alto, CA 94303

HCH/MH Program Client Survey 2013
Distribution List

Coastside Hope:
99 Avenue Alhambra
El Granada, CA 94018

Daly City Community Service Center:
1450 Chapin Avenue, 1st Floor
Burlingame, CA 94010

El Concilio Emergency Services Partnership:
1798-B Bay Road
East Palo Alto, CA 94303

Fair Oaks Community Center:
2600 Middlefield Road
Redwood City, CA 94063

North Peninsula Neighborhood Services Center:
600 Linden Avenue
South San Francisco, CA 94080

Pacifica Resource Center:
1809 Palmetto Avenue
Pacifica, CA 94044

Puente de la Costa Sur:
620 North Street
Pescadero, CA 94060

Ravenswood Family Health Center:
1798-A Bay Road
East Palo Alto, CA 94303

SMC Public Health Mobile Clinic:
225 W. 37th Avenue
San Mateo, CA 94403

SMC BHRS:
2000 Alameda de las Pulgas
San Mateo, CA 94403

Coastside Mental Health Clinic:
225 S. Cabrillo Hwy., Suite 200A
Half Moon Bay, CA 94019

SMC HSA Center on Homelessness:
472 Harbor Blvd., Bldg. C
Belmont, CA 94002

Sonrisas Community Dental Center:
210 San Mateo Road, Suite 104
Half Moon Bay, CA 94019

SMC Public Health Field Nursing:
2000 Alameda de las Pulgas
San Mateo, CA 94403

RotaCare Coastside Clinic:
225 S. Cabrillo Hwy., Suite 100A
Half Moon Bay, CA 94019

El Centro de Libertad:
225 S. Cabrillo Hwy., Suite 100D
Half Moon Bay, CA 94019

Kelly Avenue Catholic Worker House:
160 Kelly Avenue
Half Moon Bay, CA 94019

SMMC Clinic Managers:
222 W. 39th Avenue
San Mateo, CA 94403

Mobile Dental Clinic:
222 W. 39th Avenue
San Mateo, CA 94403
Smmc_hchdental@smcgov.org

HCH/MH Program Client Survey 2013
Distribution List

Potential Community Forums/ Focus Groups:

- Forum with assistance from Our Lady of the Pillar Church
- Ongoing events that homeless or agriculture/nursery workers already attend
- Depends on which area and/or groups we did not get much feedback on from survey (community forum) or an area and/or group that we got feedback from but need more clarity (focus groups)

HCH/MH Program Provider Survey 2013

Please answer each question as best as you can. Your answers will help set goals for delivering health care to homeless individuals and agricultural workers in San Mateo County. Your feedback will assist the Health Care for Homeless and Migrant Health Program at San Mateo Medical Center answer health care delivery and access issues that affect your clients/patients.

HCH/MH Program Provider Survey 2013

1. What are the barriers that prevent your clients/patients from accessing health care? Click all that apply.

- [ ] Transportation
- [ ] Difficulty remembering appointments
- [ ] Inadequate or no health insurance coverage
- [ ] Mental health related issues
- [ ] Substance abuse related issues
- [ ] No childcare
- [ ] Other activities are more important
- [ ] Client/patient does not know where to go to get health care
- [ ] Client/patient is concerned that belongings/pets will be stolen if they go away for an appointment
- [ ] It takes too long to get an appointment
- [ ] Clinic locations are difficult to reach
- [ ] Clinic hours are inconvenient
- [ ] Clinic staff does not understand client's/patient's language
- [ ] Clinic staff are disrespectful
- [ ] Client/patient fears deportation or arrest
- [ ] Client/patient is unable to get time off of work
- [ ] Other (please specify)

2. Please rank the top 5 barriers that your clients/patients face when accessing health care services. You can only select one barrier for each column.

	Most difficult barrier	2nd barrier	3rd barrier	4th barrier	5th barrier
Transportation	◯	◯	◯	◯	◯
Difficulty remembering appointments	◯	◯	◯	◯	◯
Inadequate or no health insurance coverage	◯	◯	◯	◯	◯
Mental health related issues	◯	◯	◯	◯	◯
Substance abuse related issues	◯	◯	◯	◯	◯
No childcare	◯	◯	◯	◯	◯
Other activities are more important	◯	◯	◯	◯	◯
Client/patient does not know where to go to get health care	◯	◯	◯	◯	◯
Client/patient is concerned that belongings/pets will be stolen if they go away for an appointment	◯	◯	◯	◯	◯
It takes too long to get an appointment	◯	◯	◯	◯	◯
Clinic locations are difficult to reach	◯	◯	◯	◯	◯
Clinic hours are inconvenient	◯	◯	◯	◯	◯
Clinic staff does not understand client's/patient's language	◯	◯	◯	◯	◯
Clinic staff are disrespectful	◯	◯	◯	◯	◯
Client/patient fears deportation or arrest	◯	◯	◯	◯	◯
Client/patient is unable to get time off of work	◯	◯	◯	◯	◯

3. What type of health services do your clients/patients need? Is more access needed or sufficient for these services?

	More Access Needed	OK As Is
Primary medical care	◯	◯
Specialty care (e.g. podiatry or cardiology)	◯	◯
Mental health services	◯	◯
Substance abuse services	◯	◯
Dental care	◯	◯
General vision care including glasses	◯	◯
Chronic disease management, such as hypertension or diabetes	◯	◯
Case management/health care navigator	◯	◯
Health education	◯	◯
Alternative care (e.g. accupuncture, chiropractic care, etc.)	◯	◯

Other (please specify)

4. In the next five years, what are the top 3 priority areas that would result in the most improvements in health for your clients/patients?

	Highest/top priority	Number 2 priority	Number 3 priority
More weekend and/or evening hours at local, fixed clinic sites	◯	◯	◯
Transportation assistance (e.g. reduced fares or shuttles to health care appointments or education workshops)	◯	◯	◯
Provide or increase health care services via mobile/portable clinics, community-based satellite clinics or other alternative clinic sites	◯	◯	◯
Health navigation/case management	◯	◯	◯
Assistance with getting and keeping health insurance coverage	◯	◯	◯
Health education/chronic disease management workshops	◯	◯	◯
Cultural sensitivity/competency training for providers	◯	◯	◯

Other (please specify)

5. The type of organization that I work for is best described as a...

- [ ] Core service center
- [ ] Food program
- [ ] "Wet" homeless shelter
- [ ] "Dry" homeless shelter
- [ ] Housing provider or housing support service
- [ ] Health care provider, such as medical and/or dental
- [ ] Mental health service provider
- [ ] Substance abuse treatment program
- [ ] Faith-based organization
- [ ] Other (please specify)

6. My organization mainly serves:

- [ ] Homeless individuals
- [ ] Agricultural workers and their families
- [ ] Both homeless and agricultural workers
- [ ] Other (please specify)

7. My organization service area is:

- [ ] Countywide
- [ ] North County (Daly City, San Bruno, Pacifica, etc.)
- [ ] Mid-County (San Mateo, Burlingame, San Carlos, etc.)
- [ ] South County (Redwood City, East Palo Alto, Menlo Park, etc.)
- [ ] Coastside (Half Moon Bay, Pescadero, La Honda, etc.)

8. Please select the choice that best describes the type of work that you do for your organization.

- ◯ Case manager/outreach worker
- ◯ Front line staff (e.g. intake coordinator, receptionist, Medical Assistant, etc.)
- ◯ Nurse, Nurse Practitioner or Physician Assistant
- ◯ Physician/MD
- ◯ Administrator
- ◯ Licensed behavioral health provider
- ◯ Other behavioral health provider
- ◯ Other (please specify)

Thank you for your participation. If you have any questions, please contact Naida Pare-Alanda (650-573-2966 or npare@smcgov.org).

TAB 7
HCH/FH Uniform Data System (UDS) Report Summary

UDS Data	2010	2011	2012	2013	2014
UNDUP PTS	5,110	4,897	5,779	7,516	**7,707**
• Homeless	4,883	4,109	4,803	6,171	**5,596**
• MSFW	227	837	1,031	1,435	**2,265**
VISITS	20,002	20,854	28,400	39,628	**41,361**
AGE RANGE					
• 0-19 YRS	17%	21%	24%	1,715	**2,113 (27%)**
• 20-64 YRS	79%	76%	72%	5,012	**4,771 (62%)**
• Over 65 YRS	4%	3%	4%	789	**823 (10%)**
SEX					
• Male	58%	55%	52%	3,796	**3,997 (52%)**
• Female	42%	45%	48%	3,720	**3,710 (48%)**

UDS Outcome Measures (HCH/FH Program SAC Goals)	2010	2011	2012	2013	2014
• Childhood IZs Completed by Age 2-3 (80%)	82%	72%	74%	87%	**88%**
• Pap Test in Last 3 Years (60%)	64%	60%	86%	67%	**57%**
• Child & Adolescent BMI & Counseling (70%)	N/A	70%	47%	83%	**80%**
• Adult BMI & Follow-up Plan (60%)	N/A	59%	31%	66%	**44%**
• Tobacco Use Queried (80%)	N/A	74%	80%	96%	**77%**
• Tobacco Cessation Offered (95%)	N/A	97%	90%	90%	
• Treatment for Persistent Asthma (85%)	N/A	83%	88%	100%	**100%**
• Lipid Therapy in CAD Patients (90%)	N/A	N/A	96%	96%	**90%**
• Aspirin Therapy in IVD Patients (90%)	N/A	N/A	99%	96%	**98%**
• Colorectal Screening Performed (40%)	N/A	N/A	40%	54%	**34%**
• Babies with Normal Birth Weight (95%)	93%	96%	87%	94%	**99%**
• Hypertension Controlled <140/90 (70%)	59%	66%	60%	80%	**64%**
• Diabetes Controlled <9 HgbA1C (80%)	61%	73%	71%	74%	**49%**
• First Trimester Prenatal Care (75%)	61%	73%	71%	75%	**84%**

UDS Outcome Measures	HCH/FH Program 2014 (SAC goal)	330-Progs CA 2013	Healthy People 2020 Goals
• Childhood Immunizations Complete by Age 2-3	88% (80% goal)	80%	80%
• Pap Test in Last 3 Years	57% (60% goal)	60%	93%
• Child & Adolescent BMI & Counseling	80% (70% goal)	54%	57.7 (BMI)/15.2% for all patients
• Adult BMI & Follow-up Plan	44% (60% goal)	57%	53.6% (BMI)/31.8% (obese adults)
• Tobacco Use Queried	77% (80% goal)	92%	69%
• Treatment for Persistent Asthma	100% (85% goal)	77%	Diff measures
• Lipid Therapy in CAD Patients	90% (90% goal)	73%	Diff measures
• Aspirin Therapy in Ischemic Heart Disease Patients	98% (90% goal)	74%	Diff measures
• Colorectal Screening Performed	34% (40% goal)	33%	Diff measures
• Babies with Normal Birth Weight	99% (95% goal)	94%	92%
• Hypertension Controlled (<140/90)	64% (70% goal)	65%	61%
• Diabetes Controlled (<9 HgbA1c)	49% (80% goal)	67%	85%
• First Trimester Prenatal Care	84% (75% goal)	78%	78%

Program Name: Health Center 330

Submission Status: Change Requested

UDS Report - 2014

Center / Health Center Profile

Title	Name	Phone	Fax	Email
UDS Contact	Jim Beaumont	(650) 573-2459	Not Available	jbeaumont@smcgov.org
Project Director	Jim Beaumont	(650) 573-2459	(650) 573-2030	jbeaumont@smcgov.org
CEO	Susan Ehrlich	(650) 573-2041	Not Available	sehrlich@co.sanmateo.ca.us
Chairperson	Not Available	Not Available	Not Available	Not Available
Clinical Director	Not Available	Not Available	Not Available	Not Available

UDS Report - 2014

Patients by ZIP Code

ZIP Code (a)	None/Uninsured (b)	Medicaid/CHIP/Other Public (c)	Medicare (d)	Private Insurance (e)	Total Patients (f)
94002	15	64	29	1	109
94005	58	47	1	0	106
94010	32	70	24	0	126
94014	60	82	20	1	163
94015	46	84	17	4	151
94018	8	26	3	0	37
94019	304	607	34	6	951
94025	70	98	20	18	206
94030	15	33	15	0	63
94038	34	55	2	0	91
94044	13	56	12	0	81
94060	331	155	8	17	511
94061	71	159	29	5	264
94062	24	50	12	2	88
94063	429	462	73	14	978
94064	3	11	3	0	17
94065	7	13	3	0	23
94066	82	133	25	2	242
94070	15	52	18	2	87
94080	228	313	75	11	627
94303	210	339	51	10	610
94401	531	649	79	9	1268
94402	48	85	21	0	154
94403	102	240	66	7	415
94404	15	52	33	0	100
Other ZIP Codes	37	95	29	18	179
Unknown Residence	19	37	4	0	60
Grand Total	2807	4067	706	127	7707

UDS Report - 2014

Table 3A: Patients By Age and Gender - Universal

S.No	Age Groups	Male Patients (a)	Female Patients (b)
1.	Under Age 1	144	146
2.	Age 1	67	72
3.	Age 2	80	76
4.	Age 3	56	53
5.	Age 4	76	36
6.	Age 5	60	60
7.	Age 6	45	45
8.	Age 7	55	59
9.	Age 8	49	59
10.	Age 9	39	46
11.	Age 10	43	48
12.	Age 11	43	41
13.	Age 12	40	48
14.	Age 13	41	26
15.	Age 14	37	43
16.	Age 15	39	54
17.	Age 16	39	37
18.	Age 17	38	47
Subtotal Patients (Sum lines 1-18)		**991**	**996**
19.	Age 18	28	43
20.	Age 19	27	28
21.	Age 20	40	31
22.	Age 21	41	41
23.	Age 22	42	38
24.	Age 23	39	46
25.	Age 24	42	40
26.	Ages 25-29	290	291
27.	Ages 30-34	312	258
28.	Ages 35-39	276	267
29.	Ages 40-44	278	228
30.	Ages 45-49	338	232
31.	Ages 50-54	363	268
32.	Ages 55-59	338	219
33.	Ages 60-64	225	188
Subtotal Patients (Sum lines 19-33)		**2,679**	**2,218**

OMB Control Number: 0195-0193

Program Name: Health Center 330

Submission Status: Change Requested

UDS Report - 2014

Table 3A: Patients By Age and Gender - Universal

S.No	Age Groups	Male Patients (a)	Female Patients (b)
34.	Ages 65-69	145	175
35.	Ages 70-74	78	118
36.	Ages 75-79	50	103
37.	Ages 80-84	26	48
38.	Age 85 and over	28	52
Subtotal Patients (Sum lines 34-38)		**327**	**496**
39.	**Total Patients (Sum lines 1-38)**	**3,997**	**3,710**

OMB Control Number: 0195-0193

Program Name: Health Center 330

Submission Status: Change Requested

UDS Report - 2014

Table 3A: Patients By Age and Gender - Migrant Health Center

S.No	Age Groups	Male Patients (a)	Female Patients (b)
1.	Under Age 1	115	115
2.	Age 1	32	34
3.	Age 2	43	37
4.	Age 3	33	29
5.	Age 4	38	15
6.	Age 5	33	36
7.	Age 6	27	26
8.	Age 7	29	34
9.	Age 8	33	34
10.	Age 9	25	30
11.	Age 10	26	28
12.	Age 11	27	26
13.	Age 12	30	28
14.	Age 13	19	20
15.	Age 14	25	30
16.	Age 15	26	34
17.	Age 16	21	23
18.	Age 17	18	25
Subtotal Patients (Sum lines 1-18)		**600**	**604**
19.	Age 18	15	25
20.	Age 19	5	5
21.	Age 20	8	8
22.	Age 21	14	14
23.	Age 22	11	12
24.	Age 23	10	13
25.	Age 24	9	12
26.	Ages 25-29	56	56
27.	Ages 30-34	58	69
28.	Ages 35-39	54	99
29.	Ages 40-44	65	78
30.	Ages 45-49	48	60
31.	Ages 50-54	40	51
32.	Ages 55-59	39	39
33.	Ages 60-64	23	20
Subtotal Patients (Sum lines 19-33)		**455**	**561**

OMB Control Number: 0195-0193

Program Name: Health Center 330

Submission Status: Change Requested

UDS Report - 2014

Table 3A: Patients By Age and Gender - Migrant Health Center

S.No	Age Groups	Male Patients (a)	Female Patients (b)
34.	Ages 65-69	16	9
35.	Ages 70-74	7	3
36.	Ages 75-79	2	4
37.	Ages 80-84	0	2
38.	Age 85 and over	2	0
Subtotal Patients (Sum lines 34-38)		**27**	**18**
39.	**Total Patients (Sum lines 1-38)**	**1,082**	**1,183**

OMB Control Number: 0195-0193

UDS Report - 2014

Table 3A: Patients By Age and Gender - Health Care For The Homeless

S.No	Age Groups	Male Patients (a)	Female Patients (b)
1.	Under Age 1	36	34
2.	Age 1	35	43
3.	Age 2	40	42
4.	Age 3	27	27
5.	Age 4	42	23
6.	Age 5	28	26
7.	Age 6	19	20
8.	Age 7	29	27
9.	Age 8	16	25
10.	Age 9	15	17
11.	Age 10	19	22
12.	Age 11	17	17
13.	Age 12	11	21
14.	Age 13	23	6
15.	Age 14	14	14
16.	Age 15	15	22
17.	Age 16	19	15
18.	Age 17	23	22
Subtotal Patients (Sum lines 1-18)		**428**	**423**
19.	Age 18	13	18
20.	Age 19	23	23
21.	Age 20	32	25
22.	Age 21	28	30
23.	Age 22	31	26
24.	Age 23	30	33
25.	Age 24	33	30
26.	Ages 25-29	236	236
27.	Ages 30-34	259	192
28.	Ages 35-39	225	173
29.	Ages 40-44	215	161
30.	Ages 45-49	293	178
31.	Ages 50-54	329	226
32.	Ages 55-59	307	183
33.	Ages 60-64	207	169
Subtotal Patients (Sum lines 19-33)		**2,261**	**1,703**

OMB Control Number: 0195-0193

Program Name: Health Center 330

Submission Status: Change Requested

UDS Report - 2014

Table 3A: Patients By Age and Gender - Health Care For The Homeless

S.No	Age Groups	Male Patients (a)	Female Patients (b)
34.	Ages 65-69	129	168
35.	Ages 70-74	71	115
36.	Ages 75-79	48	100
37.	Ages 80-84	26	46
38.	Age 85 and over	26	52
Subtotal Patients (Sum lines 34-38)		**300**	**481**
39.	**Total Patients (Sum lines 1-38)**	**2,989**	**2,607**

OMB Control Number: 0195-0193

Program Name: Health Center 330

Submission Status: Change Requested

UDS Report - 2014

Table 3B - Patients By Hispanic Or Latino Ethnicity / Race / Language - Universal

S.No	Patients by Race	Patients by Hispanic or Latino Ethnicity			
		Hispanic/Latino (a)	Non Hispanic/Latino (b)	Unreported/Refused to Report (c)	Total (d)
1.	Asian	8	501		509
2a.	Native Hawaiian	19	0		19
2b.	Other Pacific Islander	8	161		169
2.	**Total Hawaiian/Pacific Islander (Sum lines 2a+2b)**	**27**	**161**		**188**
3.	Black/African American	19	662		681
4.	American Indian/Alaska native	87	37		124
5.	White	2,413	1,885		4,298
6.	More than one race	1,465	332		1,797
7.	Unreported/Refused to report	31	31	48	110
8.	**Total Patients (Sum lines 1+2+3 through 7)**	**4,050**	**3,609**	**48**	**7,707**

S.No	Patients by Language	Number of Patients (a)
12.	Patients Best Served in a Language other than English	3,275

OMB Control Number: 0195-0193

Program Name: Health Center 330

Submission Status: Change Requested

UDS Report - 2014

Table 3B - Patients By Hispanic Or Latino Ethnicity / Race / Language - Migrant Health Center

S.No	Patients by Race	Patients by Hispanic or Latino Ethnicity			
		Hispanic/Latino (a)	Non Hispanic/Latino (b)	Unreported/Refused to Report (c)	Total (d)
1.	Asian	0	67		67
2a.	Native Hawaiian	3	0		3
2b.	Other Pacific Islander	0	19		19
2.	**Total Hawaiian/Pacific Islander (Sum lines 2a+2b)**	**3**	**19**		**22**
3.	Black/African American	1	21		22
4.	American Indian/Alaska native	15	10		25
5.	White	1,418	125		1,543
6.	More than one race	498	47		545
7.	Unreported/Refused to report	19	11	11	41
8.	**Total Patients (Sum lines 1+2+3 through 7)**	**1,954**	**300**	**11**	**2,265**

S.No	Patients by Language	Number of Patients (a)
12.	Patients Best Served in a Language other than English	1,774

OMB Control Number: 0195-0193

UDS Report - 2014

Table 3B - Patients By Hispanic Or Latino Ethnicity / Race / Language - Health Care For The Homeless

S.No	Patients by Race	Patients by Hispanic or Latino Ethnicity			
		Hispanic/Latino (a)	Non Hispanic/Latino (b)	Unreported/Refused to Report (c)	Total (d)
1.	Asian	8	437		445
2a.	Native Hawaiian	16	0		16
2b.	Other Pacific Islander	8	146		154
2.	**Total Hawaiian/Pacific Islander (Sum lines 2a+2b)**	**24**	**146**		**170**
3.	Black/African American	18	650		668
4.	American Indian/Alaska native	73	27		100
5.	White	1,059	1,788		2,847
6.	More than one race	1,000	295		1,295
7.	Unreported/Refused to report	12	21	38	71
8.	**Total Patients (Sum lines 1+2+3 through 7)**	**2,194**	**3,364**	**38**	**5,596**

S.No	Patients by Language	Number of Patients (a)
12.	Patients Best Served in a Language other than English	1,591

OMB Control Number: 0195-0193

UDS Report - 2014

Table 4 - Selected Patient Characteristics - Universal

S.No	Characteristic	Number of Patients (a)
Income as Percent of Poverty Level		
1.	100% and below	5,452
2.	101 - 150%	605
3.	151 - 200%	234
4.	Over 200%	90
5.	Unknown	1,326
6.	**Total (Sum lines 1-5)**	**7,707**

Principal Third Party Medical Insurance Source		0-17 Years Old (a)	18 and Older (b)
7.	None/Uninsured	420	2,387
8a.	Regular Medicaid (Title XIX)	1,553	2,514
8b.	CHIP Medicaid	0	0
8.	**Total Medicaid (Sum lines 8a+8b)**	**1,553**	**2,514**
9.	Medicare (Title XVIII)	0	706
10a.	Other Public Insurance non-CHIP (Specify: -)	0	0
10b.	Other Public Insurance CHIP	0	0
10.	**Total Public Insurance (Sum lines 10a+10b)**	**0**	**0**
11.	Private Insurance	14	113
12.	**Total (Sum lines 7+8+9+10+11)**	**1,987**	**5,720**

Managed Care Utilization

S.No	Payor Category	Medicaid (a)	Medicare (b)	Other Public Including Non-Medicaid CHIP (c)	Private (d)	Total (e)
13a.	Capitated Member months	24,057	2,982	-	-	27,039
13b.	Fee-for-service Member months	-	-	-	-	-
13c.	**Total Member Months (Sum lines 13a+13b)**	**24,057**	**2,982**			**27,039**

OMB Control Number: 0195-0193

UDS Report - 2014

Table 4 - Selected Patient Characteristics - Universal

S.No	Characteristics - Special Populations	Number of Patients (a)
14.	Migratory (330g Health Centers Only)	329
15.	Seasonal (330g Health Centers Only)	1,936
16.	**Total Agricultural Workers or Dependents (All Health Centers Report This Line)**	**2,265**
17.	Homeless Shelter (330h Health Centers Only)	1,562
18.	Transitional (330h Health Centers Only)	1,083
19.	Doubling Up (330h Health Centers Only)	1,867
20.	Street (330h Health Centers Only)	488
21.	Other (330h Health Centers Only)	596
22.	Unknown (330h Health Centers Only)	0
23.	**Total Homeless (All Health Centers Report This Line)**	**5,596**
24.	**Total School Based Health Center Patients (All Health Centers Report This Line)**	**47**
25.	**Total Veterans (All Health Centers Report This Line)**	**62**
26.	**Total Public Housing Patients (All Health Centers Report This Line)**	**-**

OMB Control Number: 0195-0193

UDS Report - 2014

Table 4 - Selected Patient Characteristics - Migrant Health Center

S.No	Characteristic	Number of Patients (a)
Income as Percent of Poverty Level		
1.	100% and below	727
2.	101 - 150%	299
3.	151 - 200%	129
4.	Over 200%	50
5.	Unknown	1,060
6.	**Total (Sum lines 1-5)**	**2,265**

Principal Third Party Medical Insurance Source		0-17 Years Old (a)	18 and Older (b)
7.	None/Uninsured	195	671
8a.	Regular Medicaid (Title XIX)	999	322
8b.	CHIP Medicaid	0	-
8.	**Total Medicaid (Sum lines 8a+8b)**	**999**	**322**
9.	Medicare (Title XVIII)	0	49
10a.	Other Public Insurance non-CHIP (Specify: -)	0	0
10b.	Other Public Insurance CHIP	0	0
10.	**Total Public Insurance (Sum lines 10a+10b)**	**0**	**0**
11.	Private Insurance	10	19
12.	**Total (Sum lines 7+8+9+10+11)**	**1,204**	**1,061**

Managed Care Utilization

S.No	Payor Category	Medicaid (a)	Medicare (b)	Other Public Including Non-Medicaid CHIP (c)	Private (d)	Total (e)
13a.	Capitated Member months	-	-	-	-	-
13b.	Fee-for-service Member months	-	-	-	-	-
13c.	**Total Member Months (Sum lines 13a+13b)**					

S.No	Characteristics - Special Populations	Number of Patients (a)
14.	Migratory (330g Health Centers Only)	329
15.	Seasonal (330g Health Centers Only)	1,936
16.	**Total Agricultural Workers or Dependents (All Health Centers Report This Line)**	**2,265**
17.	Homeless Shelter (330h Health Centers Only)	
18.	Transitional (330h Health Centers Only)	
19.	Doubling Up (330h Health Centers Only)	
20.	Street (330h Health Centers Only)	
21.	Other (330h Health Centers Only)	

S.No	Characteristics - Special Populations	Number of Patients (a)
22.	Unknown (330h Health Centers Only)	
23.	**Total Homeless (All Health Centers Report This Line)**	**-**
24.	**Total School Based Health Center Patients (All Health Centers Report This Line)**	**20**
25.	**Total Veterans (All Health Centers Report This Line)**	**16**
26.	**Total Public Housing Patients (All Health Centers Report This Line)**	**-**

OMB Control Number: 0195-0193

UDS Report - 2014

Table 4 - Selected Patient Characteristics - Health Care For The Homeless

S.No	Characteristic	Number of Patients (a)
Income as Percent of Poverty Level		
1.	100% and below	4,834
2.	101 - 150%	333
3.	151 - 200%	113
4.	Over 200%	43
5.	Unknown	273
6.	**Total (Sum lines 1-5)**	**5,596**

Principal Third Party Medical Insurance Source		0-17 Years Old (a)	18 and Older (b)
7.	None/Uninsured	236	1,753
8a.	Regular Medicaid (Title XIX)	611	2,235
8b.	CHIP Medicaid	0	0
8.	**Total Medicaid (Sum lines 8a+8b)**	**611**	**2,235**
9.	Medicare (Title XVIII)	0	663
10a.	Other Public Insurance non-CHIP (Specify: -)	0	0
10b.	Other Public Insurance CHIP	0	0
10.	**Total Public Insurance (Sum lines 10a+10b)**	**0**	**0**
11.	Private Insurance	4	94
12.	**Total (Sum lines 7+8+9+10+11)**	**851**	**4,745**

Managed Care Utilization

S.No	Payor Category	Medicaid (a)	Medicare (b)	Other Public Including Non-Medicaid CHIP (c)	Private (d)	Total (e)
13a.	Capitated Member months	-	-	-	-	-
13b.	Fee-for-service Member months	-	-	-	-	-
13c.	**Total Member Months (Sum lines 13a+13b)**					

S.No	Characteristics - Special Populations	Number of Patients (a)
14.	Migratory (330g Health Centers Only)	
15.	Seasonal (330g Health Centers Only)	
16.	**Total Agricultural Workers or Dependents (All Health Centers Report This Line)**	**-**
17.	Homeless Shelter (330h Health Centers Only)	1,562
18.	Transitional (330h Health Centers Only)	1,083
19.	Doubling Up (330h Health Centers Only)	1,867
20.	Street (330h Health Centers Only)	488
21.	Other (330h Health Centers Only)	596

S.No	Characteristics - Special Populations	Number of Patients (a)
22.	Unknown (330h Health Centers Only)	0
23.	**Total Homeless (All Health Centers Report This Line)**	**5,596**
24.	**Total School Based Health Center Patients (All Health Centers Report This Line)**	**27**
25.	**Total Veterans (All Health Centers Report This Line)**	**-**
26.	**Total Public Housing Patients (All Health Centers Report This Line)**	**-**

OMB Control Number: 0195-0193

Program Name: Health Center 330

Submission Status: Change Requested

UDS Report - 2014

Table 5 - Staffing And Utilization - Universal

S.No	Personnel by Major Service Category	FTEs (a)	Clinic Visits (b)	Patients (c)
Medical Care Services				
1.	Family Physicians	0.90	3,145	
2.	General Practitioners	0.20	697	
3.	Internists	1.40	3,839	
4.	Obstetrician/Gynecologists	0.30	783	
5.	Pediatricians	1.80	5,332	
7.	Other Specialty Physicians	1.10	3,612	
8.	**Total Physicians (Sum lines 1-7)**	**5.70**	**17,408**	
9a.	Nurse Practitioners	1.80	5,295	
9b.	Physician Assistants	0.10	397	
10.	Certified Nurse Midwives	0.00	4	
10a.	**Total NP, PA, and CNMs (Sum lines 9a - 10)**	**1.90**	**5,696**	
11.	Nurses	3.80	6,438	
12.	Other Medical Personnel	-		
13.	Laboratory Personnel	-		
14.	X-Ray Personnel	-		
15.	**Total Medical (Sum lines 8+10a through 14)**	**11.40**	**29,542**	**7,072**
Dental Services				
16.	Dentists	1.00	3,708	
17.	Dental Hygienists	-	75	
18.	Dental Assistants, Aides, Techs	-		
19.	**Total Dental Services (Sum lines 16-18)**	**1.00**	**3,783**	**1,318**
Mental Health Services				
20a.	Psychiatrists	0.20	559	
20a1.	Licensed Clinical Psychologists	0.50	617	
20a2.	Licensed Clinical Social Workers	-	39	
20b.	Other Licensed Mental Health Providers	-	-	
20c.	Other Mental Health Staff	-	-	
20.	**Total Mental Health (Sum lines 20a-20c)**	**0.70**	**1,215**	**352**

OMB Control Number: 0195-0193

Program Name: Health Center 330

Submission Status: Change Requested

UDS Report - 2014

Table 5 - Staffing And Utilization - Universal

S.No	Personnel by Major Service Category	FTEs (a)	Clinic Visits (b)	Patients (c)
Substance Abuse Services				
21.	Substance Abuse Services	-	-	-
Other Professional Services				
22.	Other Professional Services (Specify: Podiatry)	0.20	501	248
Vision Services				
22a.	Ophthalmologists	0.10	260	
22b.	Optometrists	0.20	646	
22c.	Other Vision Care Staff	0.30		
22d.	**Total Vision Services (Sum lines 22a-22c)**	**0.60**	**906**	**534**
Pharmacy Personnel				
23.	Pharmacy Personnel	-		
Enabling Services				
24.	Case Managers	-	4,429	
25.	Patient/Community Education Specialists	-	985	
26.	Outreach Workers	-		
27.	Transportation Staff	-		
27a.	Eligibility Assistance Workers	-		
27b.	Interpretation Staff	-		
28.	Other Enabling Services (Specify: -)	-		
29.	**Total Enabling Services (Sum lines 24-28)**		**5,414**	**3,537**

OMB Control Number: 0195-0193

Program Name: Health Center 330

Submission Status: Change Requested

UDS Report - 2014

Table 5 - Staffing And Utilization - Universal

S.No	Personnel by Major Service Category	FTEs (a)	Clinic Visits (b)	Patients (c)
Other Programs/Services				
29a.	Other Programs and services (Specify: -)	-		
Administration and Facility				
30a.	Management and Support Staff	2.10		
30b.	Fiscal and Billing Staff	0.00		
30c.	IT Staff	0.00		
31.	Facility Staff	0.00		
32.	Patient Support Staff	0.00		
33.	**Total Facility and Non-Clinical Support Staff (Lines 30a - 32)**	**2.10**		
Grand Total				
34.	**Grand Total (Sum lines 15+19+20+21+22+22d+23+29+29a+33)**	**16.00**	**41,361**	

OMB Control Number: 0195-0193

Program Name: Health Center 330

Submission Status: Change Requested

UDS Report - 2014

Table 5 - Staffing And Utilization - Migrant Health Center

S.No	Personnel by Major Service Category	FTEs (a)	Clinic Visits (b)	Patients (c)
Medical Care Services				
1.	Family Physicians		497	
2.	General Practitioners		82	
3.	Internists		566	
4.	Obstetrician/Gynecologists		227	
5.	Pediatricians		3,792	
7.	Other Specialty Physicians		590	
8.	**Total Physicians (Sum lines 1-7)**		**5,754**	
9a.	Nurse Practitioners		1,487	
9b.	Physician Assistants		16	
10.	Certified Nurse Midwives		-	
10a.	**Total NP, PA, and CNMs (Sum lines 9a - 10)**		**1,503**	
11.	Nurses		991	
12.	Other Medical Personnel			
13.	Laboratory Personnel			
14.	X-Ray Personnel			
15.	**Total Medical (Sum lines 8+10a through 14)**		**8,248**	**1,947**
Dental Services				
16.	Dentists		852	
17.	Dental Hygienists		-	
18.	Dental Assistants, Aides, Techs			
19.	**Total Dental Services (Sum lines 16-18)**		**852**	**350**
Mental Health Services				
20a.	Psychiatrists		13	
20a1.	Licensed Clinical Psychologists		25	
20a2.	Licensed Clinical Social Workers		-	
20b.	Other Licensed Mental Health Providers		-	
20c.	Other Mental Health Staff		-	
20.	**Total Mental Health (Sum lines 20a-20c)**		**38**	**14**

OMB Control Number: 0195-0193

UDS Report - 2014

Table 5 - Staffing And Utilization - Migrant Health Center

S.No	Personnel by Major Service Category	FTEs (a)	Clinic Visits (b)	Patients (c)
Substance Abuse Services				
21.	Substance Abuse Services		-	-
Other Professional Services				
22.	Other Professional Services (Specify: Podiatry)		104	49
Vision Services				
22a.	Ophthalmologists		36	
22b.	Optometrists		75	
22c.	Other Vision Care Staff			
22d.	**Total Vision Services (Sum lines 22a-22c)**		**111**	**59**
Pharmacy Personnel				
23.	Pharmacy Personnel			
Enabling Services				
24.	Case Managers		287	
25.	Patient/Community Education Specialists		-	
26.	Outreach Workers			
27.	Transportation Staff			
27a.	Eligibility Assistance Workers			
27b.	Interpretation Staff			
28.	Other Enabling Services (Specify: -)			
29.	**Total Enabling Services (Sum lines 24-28)**		**287**	**200**

OMB Control Number: 0195-0193

Program Name: Health Center 330

Submission Status: Change Requested

UDS Report - 2014

Table 5 - Staffing And Utilization - Migrant Health Center

S.No	Personnel by Major Service Category	FTEs (a)	Clinic Visits (b)	Patients (c)
Other Programs/Services				
29a.	Other Programs and services (Specify: -)			
Administration and Facility				
30a.	Management and Support Staff			
30b.	Fiscal and Billing Staff			
30c.	IT Staff			
31.	Facility Staff			
32.	Patient Support Staff			
33.	**Total Facility and Non-Clinical Support Staff (Lines 30a - 32)**			
Grand Total				
34.	**Grand Total (Sum lines 15+19+20+21+22+22d+23+29+29a+33)**		**9,640**	

OMB Control Number: 0195-0193

UDS Report - 2014

Table 5 - Staffing And Utilization - Health Care For The Homeless

S.No	Personnel by Major Service Category	FTEs (a)	Clinic Visits (b)	Patients (c)
Medical Care Services				
1.	Family Physicians		2,702	
2.	General Practitioners		639	
3.	Internists		3,334	
4.	Obstetrician/Gynecologists		592	
5.	Pediatricians		1,778	
7.	Other Specialty Physicians		3,125	
8.	**Total Physicians (Sum lines 1-7)**		**12,170**	
9a.	Nurse Practitioners		3,973	
9b.	Physician Assistants		384	
10.	Certified Nurse Midwives		4	
10a.	**Total NP, PA, and CNMs (Sum lines 9a - 10)**		**4,361**	
11.	Nurses		5,605	
12.	Other Medical Personnel			
13.	Laboratory Personnel			
14.	X-Ray Personnel			
15.	**Total Medical (Sum lines 8+10a through 14)**		**22,136**	**5,250**
Dental Services				
16.	Dentists		2,947	
17.	Dental Hygienists		75	
18.	Dental Assistants, Aides, Techs			
19.	**Total Dental Services (Sum lines 16-18)**		**3,022**	**1,099**
Mental Health Services				
20a.	Psychiatrists		549	
20a1.	Licensed Clinical Psychologists		600	
20a2.	Licensed Clinical Social Workers		39	
20b.	Other Licensed Mental Health Providers		-	
20c.	Other Mental Health Staff		-	
20.	**Total Mental Health (Sum lines 20a-20c)**		**1,188**	**341**

OMB Control Number: 0195-0193

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Table 5 - Staffing And Utilization - Health Care For The Homeless

S.No	Personnel by Major Service Category	FTEs (a)	Clinic Visits (b)	Patients (c)
Substance Abuse Services				
21.	Substance Abuse Services		-	-
Other Professional Services				
22.	Other Professional Services (Specify: Podiatry)		405	203
Vision Services				
22a.	Ophthalmologists		226	
22b.	Optometrists		578	
22c.	Other Vision Care Staff			
22d.	**Total Vision Services (Sum lines 22a-22c)**		**804**	**482**
Pharmacy Personnel				
23.	Pharmacy Personnel			
Enabling Services				
24.	Case Managers		3,521	
25.	Patient/Community Education Specialists		985	
26.	Outreach Workers			
27.	Transportation Staff			
27a.	Eligibility Assistance Workers			
27b.	Interpretation Staff			
28.	Other Enabling Services (Specify: -)			
29.	**Total Enabling Services (Sum lines 24-28)**		**4,506**	**2,286**

OMB Control Number: 0195-0193

Program Name: Health Center 330

Submission Status: Change Requested

UDS Report - 2014

Table 5 - Staffing And Utilization - Health Care For The Homeless

S.No	Personnel by Major Service Category	FTEs (a)	Clinic Visits (b)	Patients (c)
Other Programs/Services				
29a.	Other Programs and services (Specify: -)			
Administration and Facility				
30a.	Management and Support Staff			
30b.	Fiscal and Billing Staff			
30c.	IT Staff			
31.	Facility Staff			
32.	Patient Support Staff			
33.	**Total Facility and Non-Clinical Support Staff (Lines 30a - 32)**			
Grand Total				
34.	**Grand Total (Sum lines 15+19+20+21+22+22d+23+29+29a+33)**		**32,061**	

OMB Control Number: 0195-0193

Program Name: Health Center 330

Submission Status: Change Requested

UDS Report - 2014

Table 5A - Tenure for Health Center Staff

S.No	Health Center Staff	Full and Part Time		Locum, On-Call, etc	
		Persons (a)	Total Months (b)	Persons (c)	Total Months (d)
1.	Family Physicians	-	-	-	-
2.	General Practitioners	-	-	-	-
3.	Internists	-	-	-	-
4.	Obstetrician/Gynecologists	-	-	-	-
5.	Pediatricians	-	-	-	-
7.	Other Specialty Physicians	-	-	-	-
9a.	Nurse Practitioners	-	-	-	-
9b.	Physician Assistants	-	-	-	-
10.	Certified Nurse Midwives	-	-	-	-
11.	Nurses	-	-	-	-
16.	Dentists	-	-	-	-
17.	Dental Hygienists	-	-	-	-
20a.	Psychiatrists	-	-	-	-
20a1.	Licensed Clinical Psychologists	-	-	-	-
20a2.	Licensed Clinical Social Workers	-	-	-	-
20b.	Other Licensed Mental Health Providers	-	-	-	-
22a.	Ophthalmologist	-	-	-	-
22b.	Optometrist	-	-	-	-
30a1.	Chief Executive Officer	1	54	-	-
30a2.	Chief Medical Officer	1	14	-	-
30a3.	Chief Financial Officer	-	-	-	-
30a4.	Chief Information Officer	-	-	-	-

OMB Control Number: 0195-0193

UDS Report - 2014

Table 6A - Selected Diagnoses And Services Rendered - Universal

S.No	Diagnostic Category	Applicable ICD-9-CM Code	Number of Visits by Diagnosis Regardless of Primacy (a)	Number of Patients with Diagnosis Regardless of Primacy (b)
Selected Infectious and Parasitic Diseases				
1-2.	Symptomatic HIV, Asymptomatic HIV	042, 079.53, V08	599	106
1-2a.	Newly Diagnosed HIV			1
3.	Tuberculosis	010.xx - 018.xx	320	216
4.	Syphilis and other sexually transmitted infections	090.xx - 099.xx	90	43
4a.	Hepatitis B	070.20, 070.22, 070.30, 070.32	35	15
4b.	Hepatitis C	070.41, 070.44, 070.51, 070.54, 070.70, 070.71	418	156
Selected Diseases of the Respiratory System				
5.	Asthma	493.xx	1,272	588
6.	Chronic bronchitis and Emphysema	490.xx - 492.xx	105	87
Selected Other Medical Conditions				
7.	Abnormal Breast Findings, Female	174.xx; 198.81; 233.0x; 238.3; 793.8x	365	123
8.	Abnormal Cervical Findings	180.xx; 198.82; 233.1x; 795.0x	67	43
9.	Diabetes Mellitus	250.xx; 648.0x; 775.1x	3,893	854
10.	Heart Disease (selected)	391.xx - 392.0x 410.xx - 429.xx	1,806	421
11.	Hypertension	401.xx - 405.xx;	4,819	1,473
12.	Contact Dermatitis and other Eczema	692.xx	274	209
13.	Dehydration	276.5x	20	20
14.	Exposure to Heat or Cold	991.xx - 992.xx	2	2
14a.	Overweight and Obesity	ICD-9: 278.0 - 278.02 or V85.xx excluding V85.0,V85.1, V85.51, V85.52	2,285	1,452
Selected Childhood Conditions				
15.	Otitis Media and Eustachian Tube Disorders	381.xx - 382.xx	476	243
16.	Selected Perinatal Medical Conditions	770.xx;771.xx;773.xx; 774.xx - 779.xx (Excluding 779.3x)	124	61
17.	Lack of expected normal physiologic development (such as delayed milestone, failure to gain weight, failure to thrive). Does not include sexual or mental development nutritional deficiencies in children only	260.xx - 269.xx; 779.3x; 783.3x - 783.4x;	1,316	574

Sources of codes:
International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM), Volumes 1 and 2, 2010/2012. American Medical Association.
Current Procedural Terminology, (CPT) 2010/2012. American Medical Association.
Current Dental Terminology, (CDT) 2010/2011. American Dental Association.
Note: x in a code denotes any number including the absence of a number in that place.

OMB Control Number: 0195-0193

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Table 6A - Selected Diagnoses And Services Rendered - Universal

S.No	Diagnostic Category	Applicable ICD-9-CM Code	Number of Visits by Diagnosis Regardless of Primacy (a)	Number of Patients with Diagnosis Regardless of Primacy (b)
Selected Mental Health and Substance Abuse Conditions				
18.	Alcohol Related Disorders	291.xx, 303.xx; 305.0x; 357.5x	635	278
19.	Other Substance Related Disorders (Excluding Tobacco Use Disorders)	292.1x - 292.8x; 304.xx, 305.2x - 305.9x; 357.6x, 648.3x	1,075	683
19a.	Tobacco use disorder	305.1	704	392
20a.	Depression and Other Mood Disorders	296.xx, 300.4, 301.13, 311.xx	2,116	678
20b.	Anxiety Disorders Including PTSD	300.0x, 300.2x, 300.3, 308.3, 309.81	935	327
20c.	Attention Deficit and Disruptive Behavior Disorders	312.8x, 312.9x, 313.81, 314.xx	128	62
20d.	Other Mental Disorders,Excluding Drug or Alcohol Dependence (includes mental retardation)	290.xx, 293.xx – 302.xx (excluding 296.xx, 300.0x, 300.2x, 300.3, 300.4, 301.13); 306.xx - 319.xx (excluding 308.3, 309.81, 311.xx, 312.8x, 312.9x, 313.81, 314.xx)	1,031	497

S.No	Service Category	Applicable ICD-9-CM or CPT-4 Code(s)	Number of Visits (a)	Number of Patients (b)
Selected Diagnostic Tests/Screening/Preventive Services				
21.	HIV Test	CPT-4: 86689; 86701 - 86703; 87390 - 87391	799	777
21a.	Hepatitis B Test	CPT-4: 86704, 86706, 87515-17	232	223
21b.	Hepatitis C Test	CPT-4: 86803-04, 87520-22	408	404
22.	Mammogram	CPT-4: 77052, 77057 OR ICD-9: V76.11; V76.12	417	354
23.	Pap Test	CPT-4: 88141-88155; 88164-88167, 88174-88175 OR ICD-9: V72.3; V72.31; V72.32; V76.2	572	524
24.	Selected Immunizations: Hepatitis A, Hemophilus Influenza B (HiB), Pneumococcal, Diptheria, Tetanus, Pertussis (DTaP) (DTP) (DT), Mumps, Measles, Rubella, Poliovirus, Varicella, Hepatitis B Child)	CPT-4: 90633-90634, 90645 – 90648; 90670; 90696 – 90702; 90704 – 90716; 90718 - 90723; 90743 – 90744; 90748	2,060	1,531
24a.	Seasonal Flu vaccine	CPT-4: 90654 - 90662, 90672-90673, 90685-90688	2,157	1,884

Sources of codes:
International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM), Volumes 1 and 2, 2010/2012. American Medical Association.
Current Procedural Terminology, (CPT) 2010/2012. American Medical Association.
Current Dental Terminology, (CDT) 2010/2011. American Dental Association.
Note: x in a code denotes any number including the absence of a number in that place.

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Table 6A - Selected Diagnoses And Services Rendered - Universal

S.No	Diagnostic Category	Applicable ICD-9-CM Code	Number of Visits by Diagnosis Regardless of Primacy (a)	Number of Patients with Diagnosis Regardless of Primacy (b)
25.	Contraceptive Management	ICD-9: V25.xx	886	454
26.	Health Supervision of Infant or Child (ages 0 through 11)	CPT-4: 99391 - 99393; 99381 - 99383;	1,845	1,172
26a.	Childhood lead test screening (9 to 72 months)	CPT-4: 83655	331	315
26b.	Screening, Brief Intervention, and Referral to Treatment (SBIRT)	CPT-4: 99408-99409	0	0
26c.	Smoke and tobacco use cessation counseling	CPT-4: 99406 and 99407; S9075	580	497
26d.	Comprehensive and intermediate eye exams	CPT-4: 92002, 92004, 92012, 92014	895	534

S.No	Service Category	Applicable ADA Code	Number of Visits (a)	Number of Patients (b)
Selected Dental Services				
27.	I. Emergency Services	ADA: D9110	28	24
28.	II. Oral Exams	ADA: D0120, D0140, D0145, D0150, D0160, D0170, D0180	809	714
29.	Prophylaxis - Adult or Child	ADA: D1110, D1120	487	331
30.	Sealants	ADA: D1351	56	52
31.	Fluoride Treatment - adult or child	ADA: D1206, D1208	350	301
32.	III. Restorative Services	ADA: D21xx - D29xx	883	314
33.	IV. Oral Surgery (Extractions and other Surgical Procedures)	ADA: D7111, D7140, D7210, D7220, D7230, D7240, D7241, D7250, D7260, D7261, D7270, D7272, D7280	462	320
34.	V. Rehabilitative services (Endo, Perio, Prostho, Ortho)	ADA: D3xxx, D4xxx, D5xxx, D6xxx, D8xxx	822	309

Sources of codes:
International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM), Volumes 1 and 2, 2010/2012. American Medical Association.
Current Procedural Terminology, (CPT) 2010/2012. American Medical Association.
Current Dental Terminology, (CDT) 2010/2011. American Dental Association.
Note: x in a code denotes any number including the absence of a number in that place.

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Table 6A - Selected Diagnoses And Services Rendered - Migrant Health Center

S.No	Diagnostic Category	Applicable ICD-9-CM Code	Visits with Noted Diagnosis Regardless of Primacy (a)	Number of Patients with Diagnosis Regardless of Primacy (b)
Selected Infectious and Parasitic Diseases				
1-2.	Symptomatic HIV, Asymptomatic HIV	042, 079.53, V08	38	6
1-2a.	Newly Diagnosed HIV			0
3.	Tuberculosis	010.xx - 018.xx	28	14
4.	Syphilis and other sexually transmitted infections	090.xx - 099.xx	3	2
4a.	Hepatitis B	070.20, 070.22, 070.30, 070.32	0	0
4b.	Hepatitis C	070.41, 070.44, 070.51, 070.54, 070.70, 070.71	17	5
Selected Diseases of the Respiratory System				
5.	Asthma	493.xx	441	206
6.	Chronic bronchitis and Emphysema	490.xx - 492.xx	13	12
Selected Other Medical Conditions				
7.	Abnormal Breast Findings, Female	174.xx; 198.81; 233.0x; 238.3; 793.8x	40	21
8.	Abnormal Cervical Findings	180.xx; 198.82; 233.1x; 795.0x	10	7
9.	Diabetes Mellitus	250.xx; 648.0x; 775.1x	679	148
10.	Heart Disease (selected)	391.xx - 392.0x 410.xx - 429.xx	193	54
11.	Hypertension	401.xx - 405.xx;	418	147
12.	Contact Dermatitis and other Eczema	692.xx	41	35
13.	Dehydration	276.5x	10	10
14.	Exposure to Heat or Cold	991.xx - 992.xx	0	0
14a.	Overweight and Obesity	ICD-9: 278.0 - 278.02 or V85.xx excluding V85.0,V85.1, V85.51, V85.52	867	537
Selected Childhood Conditions				
15.	Otitis Media and Eustachian Tube Disorders	381.xx - 382.xx	245	123
16.	Selected Perinatal Medical Conditions	770.xx;771.xx;773.xx; 774.xx - 779.xx (Excluding 779.3x)	103	48
17.	Lack of expected normal physiologic development (such as delayed milestone, failure to gain weight, failure to thrive). Does not include sexual or mental development nutritional deficiencies in children only	260.xx - 269.xx; 779.3x; 783.3x - 783.4x;	418	214

Sources of codes:
International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM), Volumes 1 and 2, 2010/2012. American Medical Association.
Current Procedural Terminology, (CPT) 2010/2012. American Medical Association.
Current Dental Terminology, (CDT) 2010/2011. American Dental Association.
Note: x in a code denotes any number including the absence of a number in that place.

OMB Control Number: 0195-0193

Program Name: Health Center 330

Submission Status: Change Requested

UDS Report - 2014

Table 6A - Selected Diagnoses And Services Rendered - Migrant Health Center

S.No	Diagnostic Category	Applicable ICD-9-CM Code	Visits with Noted Diagnosis Regardless of Primacy (a)	Number of Patients with Diagnosis Regardless of Primacy (b)
Selected Mental Health and Substance Abuse Conditions				
18.	Alcohol Related Disorders	291.xx, 303.xx; 305.0x; 357.5x	24	17
19.	Other Substance Related Disorders (Excluding Tobacco Use Disorders)	292.1x - 292.8x; 304.xx, 305.2x - 305.9x; 357.6x, 648.3x	30	14
19a.	Tobacco use disorder	305.1	45	25
20a.	Depression and Other Mood Disorders	296.xx, 300.4, 301.13, 311.xx	166	69
20b.	Anxiety Disorders Including PTSD	300.0x, 300.2x, 300.3, 308.3, 309.81	62	38
20c.	Attention Deficit and Disruptive Behavior Disorders	312.8x, 312.9x, 313.81, 314.xx	51	24
20d.	Other Mental Disorders,Excluding Drug or Alcohol Dependence (includes mental retardation)	290.xx, 293.xx – 302.xx (excluding 296.xx, 300.0x, 300.2x, 300.3, 300.4, 301.13); 306.xx - 319.xx (excluding 308.3, 309.81, 311.xx, 312.8x, 312.9x, 313.81, 314.xx)	154	100

S.No	Service Category	Applicable ICD-9-CM or CPT-4 Code(s)	Number of Visits (a)	Number of Patients (b)
Selected Diagnostic Tests/Screening/Preventive Services				
21.	HIV Test	CPT-4: 86689; 86701 - 86703; 87390 - 87391	239	230
21a.	Hepatitis B Test	CPT-4: 86704, 86706, 87515-17	39	39
21b.	Hepatitis C Test	CPT-4: 86803-04, 87520-22	100	100
22.	Mammogram	CPT-4: 77052, 77057 OR ICD-9: V76.11; V76.12	42	37
23.	Pap Test	CPT-4: 88141-88155; 88164-88167, 88174-88175 OR ICD-9: V72.3; V72.31; V72.32; V76.2	167	159
24.	Selected Immunizations: Hepatitis A, Hemophilus Influenza B (HiB), Pneumococcal, Diptheria, Tetanus, Pertussis (DTaP) (DTP) (DT), Mumps, Measles, Rubella, Poliovirus, Varicella, Hepatitis B Child)	CPT-4: 90633-90634, 90645 – 90648; 90670; 90696 – 90702; 90704 – 90716; 90718 - 90723; 90743 – 90744; 90748	1,038	685
24a.	Seasonal Flu vaccine	CPT-4: 90654 - 90662, 90672-90673, 90685-90688	995	829

Sources of codes:
International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM), Volumes 1 and 2, 2010/2012. American Medical Association.
Current Procedural Terminology, (CPT) 2010/2012. American Medical Association.
Current Dental Terminology, (CDT) 2010/2011. American Dental Association.
Note: x in a code denotes any number including the absence of a number in that place.

OMB Control Number: 0195-0193

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Table 6A - Selected Diagnoses And Services Rendered - Migrant Health Center

S.No	Diagnostic Category	Applicable ICD-9-CM Code	Visits with Noted Diagnosis Regardless of Primacy (a)	Number of Patients with Diagnosis Regardless of Primacy (b)
25.	Contraceptive Management	ICD-9: V25.xx	403	195
26.	Health Supervision of Infant or Child (ages 0 through 11)	CPT-4: 99391 - 99393; 99381 - 99383;	1,280	774
26a.	Childhood lead test screening (9 to 72 months)	CPT-4: 83655	191	182
26b.	Screening, Brief Intervention, and Referral to Treatment (SBIRT)	CPT-4: 99408-99409	0	0
26c.	Smoke and tobacco use cessation counseling	CPT-4: 99406 and 99407; S9075	25	25
26d.	Comprehensive and intermediate eye exams	CPT-4: 92002, 92004, 92012, 92014	106	59

S.No	Service Category	Applicable ADA Code	Number of Visits (a)	Number of Patients (b)
Selected Dental Services				
27.	I. Emergency Services	ADA: D9110	1	1
28.	II. Oral Exams	ADA: D0120, D0140, D0145, D0150, D0160, D0170, D0180	198	177
29.	Prophylaxis - Adult or Child	ADA: D1110, D1120	147	129
30.	Sealants	ADA: D1351	29	27
31.	Fluoride Treatment - adult or child	ADA: D1206, D1208	237	193
32.	III. Restorative Services	ADA: D21xx - D29xx	141	74
33.	IV. Oral Surgery (Extractions and other Surgical Procedures)	ADA: D7111, D7140, D7210, D7220, D7230, D7240, D7241, D7250, D7260, D7261, D7270, D7272, D7280	47	38
34.	V. Rehabilitative services (Endo, Perio, Prostho, Ortho)	ADA: D3xxx, D4xxx, D5xxx, D6xxx, D8xxx	75	44

Sources of codes:
International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM), Volumes 1 and 2, 2010/2012. American Medical Association.
Current Procedural Terminology, (CPT) 2010/2012. American Medical Association.
Current Dental Terminology, (CDT) 2010/2011. American Dental Association.
Note: x in a code denotes any number including the absence of a number in that place.

OMB Control Number: 0195-0193

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Table 6A - Selected Diagnoses And Services Rendered - Health Care For The Homeless

S.No	Diagnostic Category	Applicable ICD-9-CM Code	Visits with Noted Diagnosis Regardless of Primacy (a)	Number of Patients with Diagnosis Regardless of Primacy (b)
Selected Infectious and Parasitic Diseases				
1-2.	Symptomatic HIV, Asymptomatic HIV	042, 079.53, V08	561	100
1-2a.	Newly Diagnosed HIV			1
3.	Tuberculosis	010.xx - 018.xx	292	202
4.	Syphilis and other sexually transmitted infections	090.xx - 099.xx	87	41
4a.	Hepatitis B	070.20, 070.22, 070.30, 070.32	35	15
4b.	Hepatitis C	070.41, 070.44, 070.51, 070.54, 070.70, 070.71	401	151
Selected Diseases of the Respiratory System				
5.	Asthma	493.xx	831	382
6.	Chronic bronchitis and Emphysema	490.xx - 492.xx	92	75
Selected Other Medical Conditions				
7.	Abnormal Breast Findings, Female	174.xx; 198.81; 233.0x; 238.3; 793.8x	325	102
8.	Abnormal Cervical Findings	180.xx; 198.82; 233.1x; 795.0x	57	36
9.	Diabetes Mellitus	250.xx; 648.0x; 775.1x	3,214	706
10.	Heart Disease (selected)	391.xx - 392.0x 410.xx - 429.xx	1,613	367
11.	Hypertension	401.xx - 405.xx;	4,401	1,326
12.	Contact Dermatitis and other Eczema	692.xx	233	174
13.	Dehydration	276.5x	10	10
14.	Exposure to Heat or Cold	991.xx - 992.xx	2	2
14a.	Overweight and Obesity	ICD-9: 278.0 - 278.02 or V85.xx excluding V85.0,V85.1, V85.51, V85.52	1,418	915
Selected Childhood Conditions				
15.	Otitis Media and Eustachian Tube Disorders	381.xx - 382.xx	231	120
16.	Selected Perinatal Medical Conditions	770.xx;771.xx;773.xx; 774.xx - 779.xx (Excluding 779.3x)	21	13
17.	Lack of expected normal physiologic development (such as delayed milestone, failure to gain weight, failure to thrive). Does not include sexual or mental development nutritional deficiencies in children only	260.xx - 269.xx; 779.3x; 783.3x - 783.4x;	898	360

Sources of codes:
International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM), Volumes 1 and 2, 2010/2012. American Medical Association.
Current Procedural Terminology, (CPT) 2010/2012. American Medical Association.
Current Dental Terminology, (CDT) 2010/2011. American Dental Association.
Note: x in a code denotes any number including the absence of a number in that place.

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Table 6A - Selected Diagnoses And Services Rendered - Health Care For The Homeless

S.No	Diagnostic Category	Applicable ICD-9-CM Code	Visits with Noted Diagnosis Regardless of Primacy (a)	Number of Patients with Diagnosis Regardless of Primacy (b)
Selected Mental Health and Substance Abuse Conditions				
18.	Alcohol Related Disorders	291.xx, 303.xx; 305.0x; 357.5x	611	261
19.	Other Substance Related Disorders (Excluding Tobacco Use Disorders)	292.1x - 292.8x; 304.xx, 305.2x - 305.9x; 357.6x, 648.3x	1,045	669
19a.	Tobacco use disorder	305.1	659	367
20a.	Depression and Other Mood Disorders	296.xx, 300.4, 301.13, 311.xx	1,950	609
20b.	Anxiety Disorders Including PTSD	300.0x, 300.2x, 300.3, 308.3, 309.81	873	289
20c.	Attention Deficit and Disruptive Behavior Disorders	312.8x, 312.9x, 313.81, 314.xx	77	38
20d.	Other Mental Disorders,Excluding Drug or Alcohol Dependence (includes mental retardation)	290.xx, 293.xx – 302.xx (excluding 296.xx, 300.0x, 300.2x, 300.3, 300.4, 301.13); 306.xx - 319.xx (excluding 308.3, 309.81, 311.xx, 312.8x, 312.9x, 313.81, 314.xx)	877	397

S.No	Service Category	Applicable ICD-9-CM or CPT-4 Code(s)	Number of Visits (a)	Number of Patients (b)
Selected Diagnostic Tests/Screening/Preventive Services				
21.	HIV Test	CPT-4: 86689; 86701 - 86703; 87390 - 87391	560	547
21a.	Hepatitis B Test	CPT-4: 86704, 86706, 87515-17	193	184
21b.	Hepatitis C Test	CPT-4: 86803-04, 87520-22	308	304
22.	Mammogram	CPT-4: 77052, 77057 OR ICD-9: V76.11; V76.12	375	317
23.	Pap Test	CPT-4: 88141-88155; 88164-88167, 88174-88175 OR ICD-9: V72.3; V72.31; V72.32; V76.2	405	365
24.	Selected Immunizations: Hepatitis A, Hemophilus Influenza B (HiB), Pneumococcal, Diptheria, Tetanus, Pertussis (DTaP) (DTP) (DT), Mumps, Measles, Rubella, Poliovirus, Varicella, Hepatitis B Child)	CPT-4: 90633-90634, 90645 – 90648; 90670; 90696 – 90702; 90704 – 90716; 90718 - 90723; 90743 – 90744; 90748	1,025	846
24a.	Seasonal Flu vaccine	CPT-4: 90654 - 90662, 90672-90673, 90685-90688	1,162	1,055

Sources of codes:
International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM), Volumes 1 and 2, 2010/2012. American Medical Association.
Current Procedural Terminology, (CPT) 2010/2012. American Medical Association.
Current Dental Terminology, (CDT) 2010/2011. American Dental Association.
Note: x in a code denotes any number including the absence of a number in that place.

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Table 6A - Selected Diagnoses And Services Rendered - Health Care For The Homeless

S.No	Diagnostic Category	Applicable ICD-9-CM Code	Visits with Noted Diagnosis Regardless of Primacy (a)	Number of Patients with Diagnosis Regardless of Primacy (b)
25.	Contraceptive Management	ICD-9: V25.xx	485	259
26.	Health Supervision of Infant or Child (ages 0 through 11)	CPT-4: 99391 - 99393; 99381 - 99383;	565	398
26a.	Childhood lead test screening (9 to 72 months)	CPT-4: 83655	140	133
26b.	Screening, Brief Intervention, and Referral to Treatment (SBIRT)	CPT-4: 99408-99409	0	0
26c.	Smoke and tobacco use cessation counseling	CPT-4: 99406 and 99407; S9075	555	472
26d.	Comprehensive and intermediate eye exams	CPT-4: 92002, 92004, 92012, 92014	789	482

S.No	Service Category	Applicable ADA Code	Number of Visits (a)	Number of Patients (b)
Selected Dental Services				
27.	I. Emergency Services	ADA: D9110	27	23
28.	II. Oral Exams	ADA: D0120, D0140, D0145, D0150, D0160, D0170, D0180	611	537
29.	Prophylaxis - Adult or Child	ADA: D1110, D1120	340	202
30.	Sealants	ADA: D1351	27	25
31.	Fluoride Treatment - adult or child	ADA: D1206, D1208	113	108
32.	III. Restorative Services	ADA: D21xx - D29xx	742	240
33.	IV. Oral Surgery (Extractions and other Surgical Procedures)	ADA: D7111, D7140, D7210, D7220, D7230, D7240, D7241, D7250, D7260, D7261, D7270, D7272, D7280	415	282
34.	V. Rehabilitative services (Endo, Perio, Prostho, Ortho)	ADA: D3xxx, D4xxx, D5xxx, D6xxx, D8xxx	747	265

Sources of codes:
International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM), Volumes 1 and 2, 2010/2012. American Medical Association.
Current Procedural Terminology, (CPT) 2010/2012. American Medical Association.
Current Dental Terminology, (CDT) 2010/2011. American Dental Association.
Note: x in a code denotes any number including the absence of a number in that place.

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Table 6B - Quality Of Care Indicators

Section A - Age Categories for Prenatal Patients

	Demographic Characteristics of Prenatal Care Patients	
S.No	**Age**	**Number of Patients (a)**
1.	Less than 15 Years	0
2.	Ages 15 - 19	23
3.	Ages 20 - 24	28
4.	Ages 25 - 44	104
5.	Ages 45 and Over	0
6.	**Total Patients (Sum lines 1-5)**	**155**

Section B - Trimester of Entry into Prenatal Care

S.No	Trimester of First Known Visit for Women Receiving Prenatal Care During Reporting Year	Women Having First Visit with Health Center (a)	Women Having First Visit with Another Provider (b)
7.	First Trimester	120	9
8.	Second Trimester	17	4
9.	Third Trimester	5	0

Section C - Childhood Immunization

S.No	Childhood Immunization	Total Number of Patients with 3rd Birthday During Measurement Year (a)	Number Charts Sampled or EHR Total (b)	Number of Patients Immunized (c)
10.	Children who have received age appropriate vaccines prior to reaching their 3rd birthday during measurement year (on or prior to 31 December)	131	70	62

Section D - Cervical Cancer Screening

S.No	Pap Tests	Total Number of Female Patients 24-64 Years of Age (a)	Number Charts Sampled or EHR Total (b)	Number of Patients Tested (c)
11.	Female patients aged 24-64 who received one or more Pap tests to screen for cervical cancer	1,824	70	40

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Table 6B - Quality Of Care Indicators

Section E - Weight Assessment and Counseling for Children and Adolescents

S.No	Child and Adolescent Weight Assessment and Counseling	Total Patients Aged 3-17 on December 31 (a)	Number Charts Sampled or EHR Total (b)	Number of Patients with Counseling and BMI Documented (c)
12.	Children and adolescents aged 3 until 17 during measurement year (on or prior to 31 December) with a BMI percentile, and counseling on nutrition and physical activity documented for the current year.	1,322	70	56

Section F - Adult Weight Screening and Follow-Up

S.No	Adult Weight Screening and Follow-Up	Total Patients 18 and Older (a)	Number Charts Sampled or EHR Total (b)	Number of Patients with BMI Charted and Follow-Up Plan Documented as Appropriate (c)
13.	Patients aged 18 and older with (1) BMI charted and (2) follow -up plan documented if patients are overweight or underweight	4,935	70	31

Section G - Tobacco Use Screening and Cessation Intervention

S.No	Tobacco Use Screening and Cessation Intervention	Total Patients Aged 18 and Older (a)	Number Charts Sampled or EHR Total (b)	Number of Patients Assessed for Tobacco Use and Provided Intervention if a Tobacco User (c)
14a.	Patients aged 18 and older who (1) were screened for tobacco use one or more times in the measurement year or the prior year AND (2) for those found to be a tobacco user, received cessation counseling intervention or medication	5,075	70	54

Section H - Asthma Pharmacological Therapy

S.No	Asthma Treatment Plan	Total Patients Aged 5-40 with Persistent Asthma (a)	Number Charts Sampled or EHR Total (b)	Number of Patients with Acceptable Plan (c)
16.	Patients aged 5 through 40 diagnosed with persistent asthma who have an acceptable pharmacological treatment plan	259	70	70

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Table 6B - Quality Of Care Indicators

Section I - Coronary Artery Disease (CAD): Lipid Therapy

S.No	Lipid Therapy	Total Patients 18 and Older with CAD Diagnosis (a)	Number Charts Sampled or EHR Total (b)	Number of Patients Prescribed A Lipid Lowering Therapy (c)
17.	Patients aged 18 and older with a diagnosis of CAD prescribed a lipid lowering therapy	308	70	63

Section J - Ischemic Vascular Disease (IVD): Aspirin or Antithrombotic Therapy

S.No	Aspirin or Other Antithrombotic Therapy	Total Patients 18 and Older with IVD Diagnosis or AMI, CABG, or PTCA Procedure (a)	Charts Sampled or EHR Total (b)	Number of Patients with Aspirin or other Antithrombotic Therapy (c)
18.	Patients aged 18 and older with a diagnosis of IVD or AMI,CABG, or PTCA procedure with aspirin or another antithrombotic therapy	210	70	69

Section K - Colorectal Cancer Screening

S.No	Colorectal Cancer Screening	Total Patients 51 through 74 Years of Age (a)	Charts Sampled or EHR Total (b)	Number of Patients with Appropriate Screening for Colorectal Cancer (c)
19.	Patients age 51 through 74 years of age during measurement year (on or prior to 31 December) with appropriate screening for colorectal cancer	1,810	70	24

Section L - Newly Identified HIV Cases and Follow-Up

S.No	New HIV Cases with Timely Follow-up	Total Patients First Diagnosed with HIV (a)	Charts Sampled or EHR Total (b)	Number of Patients Seen Within 90 Days of First Diagnosis of HIV (c)
20.	Patients whose first ever HIV diagnosis was made by health center staff between October 1 and September 30 and who were seen for follow up treatment within 90 days of that first ever diagnosis	1	1	1

Section M - Patients Screened for Depression and Follow-Up

S.No	Patients Screened for Depression and Follow-Up	Total Patients Aged 12 and Older (a)	Charts Sampled or EHR Total (b)	Number of Patients Screened for Depression and Follow-Up Plan Documented as Appropriate (c)
21.	Patients aged 12 and over who were (1) screened for depression with a standardized tool and if screening was positive (2) had a follow-up plan documented if patients were considered depressed	6,209	70	6

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Table 7 - Health Outcomes and Disparities

S.No	Prenatal Services	Total (i)
0	HIV Positive Pregnant Women	0
2	Deliveries Performed by Health Center's Provider	0

Section A: Deliveries and Birth Weight by Race and Hispanic/Latino Ethnicity

S.No	Race & Ethnicity	Prenatal Care Patients who Delivered During the Year (1a)	Live Births: < 1500 grams (1b)	Live Births : 1500 - 2499 grams (1c)	Live Births : > = 2500 grams (1d)
Hispanic/Latino					
1a.	Asian	0	0	0	0
1b1.	Native Hawaiian	1	0	0	1
1b2.	Other Pacific Islander	0	0	0	0
1c.	Black/African American	0	0	0	0
1d.	American Indian/Alaska Native	3	0	0	3
1e.	White	53	1	3	49
1f.	More Than One Race	24	0	5	19
1g.	Unreported/Refused to Report Race	-	0	0	0
Subtotal Hispanic/Latino (Sum lines 1a-1g)		**81**	**1**	**8**	**72**
Non-Hispanic/Latino					
2a.	Asian	0	0	0	0
2b1.	Native Hawaiian	0	0	0	0
2b2.	Other Pacific Islander	3	0	0	3
2c.	Black/African American	12	0	4	8
2d.	American Indian/Alaska Native	0	0	0	0
2e.	White	14	0	0	14
2f.	More Than One Race	4	0	0	4
2g.	Unreported/Refused to Report Race	2	0	0	2
Subtotal Non-Hispanic/Latino (Sum lines 2a-2g)		**35**	**0**	**4**	**31**
Unreported/Refused to Report Ethnicity					
h.	Unreported /Refused to Report Race & Ethnicity	-	0	-	-
i.	**Total (Sum lines 1a-h)**	**116**	**1**	**12**	**103**

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Table 7 - Health Outcomes and Disparities

Section B: Hypertension by Race and Hispanic/Latino Ethnicity				
S.No	**Race & Ethnicity**	**Total Hypertensive Patients (2a)**	**Charts Sampled or EHR Total (2b)**	**Patients with HTN Controlled (2c)**
Hispanic/Latino				
1a.	Asian	3	0	0
1b1.	Native Hawaiian	2	0	0
1b2.	Other Pacific Islander	6	0	0
1c.	Black/African American	3	0	0
1d.	American Indian/Alaska Native	14	1	0
1e.	White	351	17	9
1f.	More Than One Race	180	7	5
1g.	Unreported/Refused to Report Race	1	0	0
Subtotal Hispanic/Latino (Sum lines 1a-1g)		**560**	**25**	**14**
Non-Hispanic/Latino				
2a.	Asian	191	7	5
2b1.	Native Hawaiian	0	0	0
2b2.	Other Pacific Islander	46	2	1
2c.	Black/African American	171	12	6
2d.	American Indian/Alaska Native	7	0	0
2e.	White	373	18	14
2f.	More Than One Race	92	5	4
2g.	Unreported/Refused to Report Race	5	0	0
Subtotal Non-Hispanic/Latino (Sum lines 2a-2g)		**885**	**44**	**30**
Unreported/Refused to Report Ethnicity				
h.	Unreported /Refused to Report Race & Ethnicity	12	1	1
i.	**Total (Sum lines 1a-h)**	**1,457**	**70**	**45**

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Table 7 - Health Outcomes and Disparities

Section C: Diabetes by Race and Hispanic/Latino Ethnicity						
S.No	**Race & Ethnicity**	**Total Patients with Diabetes (3a)**	**Charts sampled or EHR Total (3b)**	**Patients with Hba1c < 8% (3d1)**	**Patients with 8%<= Hba1c <= 9% (3e)**	**Patients with Hba1c > 9% or No Test During Year (3f)**
Hispanic/Latino						
1a.	Asian	2	1	0	0	1
1b1.	Native Hawaiian	1	0	0	0	0
1b2.	Other Pacific Islander	4	0	0	0	0
1c.	Black/African American	1	0	0	0	0
1d.	American Indian/Alaska Native	8	1	1	0	0
1e.	White	220	17	7	0	10
1f.	More Than One Race	103	12	6	1	5
1g.	Unreported/Refused to Report Race	0	0	0	0	0
Subtotal Hispanic/Latino (Sum lines 1a-1g)		**339**	**31**	**14**	**1**	**16**
Non-Hispanic/Latino						
2a.	Asian	95	6	1	2	3
2b1.	Native Hawaiian	0	0	0	0	0
2b2.	Other Pacific Islander	31	1	1	0	0
2c.	Black/African American	64	9	5	0	4
2d.	American Indian/Alaska Native	5	1	0	1	0
2e.	White	152	17	4	1	12
2f.	More Than One Race	49	4	3	0	1
2g.	Unreported/Refused to Report Race	1	0	0	0	0
Subtotal Non-Hispanic/Latino (Sum lines 2a-2g)		**397**	**38**	**14**	**4**	**20**
Unreported/Refused to Report Ethnicity						
h.	Unreported /Refused to Report Race & Ethnicity	6	1	1	0	0
i.	**Total (Sum lines 1a-h)**	**742**	**70**	**29**	**5**	**36**

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Table 8A - Financial Costs

S.No		Accrued Cost (a) $	Allocation of Facility and Non-Clinical Support Services (b) $	Total Cost after Allocation of Facility and Non-Clinical Support Services (c) $
Financial Costs for Medical Care				
1.	Medical Staff	3,123,107	2,429,586	5,552,693
2.	Lab and X-ray	655,851	503,107	1,158,958
3.	Medical/Other Direct	1,530,647	1,166,976	2,697,623
4.	**Total Medical Care Services (Sum lines 1-3)**	**5,309,605**	**4,099,669**	**9,409,274**
Financial Costs for Other Clinical Services				
5.	Dental	307,463	236,263	543,726
6.	Mental Health	212,557	162,055	374,612
7.	Substance Abuse	-	-	
8a.	Pharmacy not including pharmaceuticals	437,434	334,565	771,999
8b.	Pharmaceuticals	216,742		216,742
9.	Other Professional (Specify: Podiatry)	61,710	48,676	110,386
9a.	Vision	36,275	27,656	63,931
10.	**Total Other Clinical Services (Sum lines 5-9a)**	**1,272,181**	**809,215**	**2,081,396**
Financial Costs of Enabling and Other Program Related Services				
11a.	Case Management	167,694		167,694
11b.	Transportation	-		
11c.	Outreach	-		
11d.	Patient and Community Education	-		
11e.	Eligibility Assistance	89,286		89,286
11f.	Interpretation Services	-		
11g.	Other Enabling Services (Specify: -)	-		
11.	**Total Enabling Services Cost (Sum lines 11a-11g)**	**256,980**	**-**	**256,980**
12.	Other Related Services (Specify: -)	-	-	
13.	**Total Enabling and Other Services (Sum lines 11-12)**	**256,980**		**256,980**
Facility and Non-Clinical Support Services and Totals				
14.	Facility	31,847		
15.	Non-Clinical Support Services	4,877,037		
16.	**Total Facility and Non-Clinical Support Services (Sum lines 14 and 15)**	**4,908,884**		
17.	**Total Accrued Costs (Sum lines 4+10+13+16)**	**11,747,650**		**11,747,650**
18.	Value of Donated Facilities, Services and Supplies (Specify: -)			0
19.	**Total with Donations (Sum lines 17-18)**			**11,747,650**

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Table 9D: Patient Related Revenue (Scope of Project Only)

S.No	Payor Category	Full Charges this Period (a) $	Amount Collected this Period (b) $	Retroactive Settlements, Receipts, and Paybacks (c)				Allowances (d) $	Sliding Discounts (e) $	Bad Debt Write Off (f) $
				Collection of Reconciliation/ Wrap around Current Year (c1) $	Collection of Reconciliation/ Wrap around Previous Years (c2) $	Collection of Other Retroactive Payments including Risk Pool/ Incentive/ Withhold (c3) $	Penalty/ Payback (c4) $			
1.	Medicaid Non-Managed Care	4,174,973	2,190,924	1,694,429	236,831	-	-	2,001,641		
2a.	Medicaid Managed Care (Capitated)	8,069,116	2,508,531	1,343,853	105,078	-	-	5,560,585		
2b.	Medicaid Managed Care (Fee-for-Service)	1,533	339	-	-	-	-	987		
3.	**Total Medicaid (Sum lines 1+2a+2b)**	**12,245,622**	**4,699,794**	**3,038,282**	**341,909**			**7,563,213**		
4.	Medicare Non-Managed Care	1,770,952	548,081	53,050	12,516	-	-	1,368,710		
5a.	Medicare Managed Care (Capitated)	-	-	-	-	-	-	-		
5b.	Medicare Managed Care (Fee-for-Service)	1,667,306	755,862	193,230	100,473	-	-	914,649		
6.	**Total Medicare (Sum lines 4+5a+5b)**	**3,438,258**	**1,303,943**	**246,280**	**112,989**			**2,283,359**		
7.	Other Public including Non-Medicaid CHIP (Non Managed Care)	1,004,111	181,269	21,033	1	-	-	823,557		
8a.	Other Public including Non-Medicaid CHIP (Managed Care Capitated)	-	-	-	-	-	-	-		
8b.	Other Public including Non-Medicaid CHIP (Managed Care Fee-for-Service)	-	-	-	-	-	-	-		
9.	**Total Other Public (Sum lines 7+8a+8b)**	**1,004,111**	**181,269**	**21,033**	**1**			**823,557**		
10.	Private Non-Managed Care	47,151	14,174			-	-	23,891		
11a.	Private Managed Care (Capitated)	-	-			-	-	-		
11b.	Private Managed Care (Fee-for-Service)	-	-			-	-	-		
12.	**Total Private (Sum lines 10+11a+11b)**	**47,151**	**14,174**					**23,891**		
13.	Self Pay	2,987,863	687,892						-	136,039
14.	**Total (Sum lines 3+6+9+12+13)**	**19,723,005**	**6,887,072**	**3,305,595**	**454,899**	**-**	**-**	**10,694,020**		**136,039**

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Table 9E: Other Revenues

S.No	Source	Amount (a) $
BPHC Grants (Enter Amount Drawn Down - Consistent with PMS-272)		
1a.	Migrant Health Center	285,849
1b.	Community Health Center	-
1c.	Health Care for the Homeless	1,564,305
1e.	Public Housing Primary Care	-
1g.	**Total Health Center Cluster (Sum lines 1a-1e)**	**1,850,154**
1j.	Capital Improvement Program Grants (excluding ARRA)	4,067
1k.	Affordable Care Act (ACA) Capital Development Grants, including School Based Health Center Capital Grants	-
1.	**Total BPHC Grants (Sum lines 1g+1j+1k)**	**1,854,221**
Other Federal Grants		
2.	Ryan White Part C HIV Early Intervention	-
3.	Other Federal Grants Specify:-	-
3a.	Medicare and Medicaid EHR Incentive Payments for Eligible Providers	-
4a.	American Recovery and Reinvestment Act (ARRA) Capital Improvement Project (CIP) and Facility Investment Program (FIP)	-
5.	**Total Other Federal Grants (Sum lines 2-4a)**	
Non-Federal Grants or Contracts		
6.	State Government Grants and Contracts Specify:-	-
6a.	State/Local Indigent Care Programs Specify:-	-
7.	Local Government Grants and Contracts Specify:Local General Fund coverage of what would be required to cover all costs for the county medical center for program patients.	3,006,357
8.	Foundation/Private Grants and Contracts Specify:-	-
9.	**Total Non-Federal Grants and Contracts (Sum lines 6+6a+7+8)**	**3,006,357**
10.	Other Revenue (Non-patient related revenue not reported elsewhere) Specify:-	-
11.	**Total Revenue (Sum lines 1+5+9+10)**	**4,860,578**

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Program Name: Health Center 330

Submission Status: Change Requested

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Electronic Health Record Capabilities and Quality Recognition

1. Does your center currently have an Electronic Health Record (EHR) system installed and in use?	[X] Yes, at all sites and for all providers [_] Yes, but only at some sites or for some providers [_] No
1a. Is your system certified under the Office of the National Coordinator for Health IT(ONC) Health IT Certification Program?	[X] Yes [_] No
Vendor	eClinicalWorks LLC
Product Name	eClinicalWorks
Version Number	V10
Certified Health IT Product List Number	CC-2014-955447-1
1b. Did you switch to your current EHR from a previous system this year?	[_] Yes [X] No
1c. How many sites have the EHR system in use?	N/A
1d. How many providers use the EHR system?	N/A
1e. When do you plan to install the EHR system?	N/A
2. Does your center send prescriptions to the pharmacy electronically? (Do not include faxing)	[X] Yes [_] No [_] Not Sure
3. Does your center use computerized, clinical decision support such as alerts for drug allergies, checks for drug-drug interations, reminders for preventive screening tests, or other similar functions?	[X] Yes [_] No [_] Not Sure
4. Does your center exchange clinical information electronically with other key providers/health care settings such as hospitals, emergency rooms, or subspecialty clinicians?	[X] Yes [_] No [_] Not Sure
5. Does your center engage patients through health IT such as patient portals, kiosks, secure messaging (i.e., secure email) either through the EHR or through other technologies?	[X] Yes [_] No [_] Not Sure
6. Does your center use the EHR or other health IT system to provide patients with electronic summaries of office visits or other clinical information when requested?	[X] Yes [_] No [_] Not Sure
7. How do you collect data for UDS clinical reporting (Tables 6B and 7)?	[_] We use the EHR to extract automated reports [X] We use the EHR but only to access individual patient charts [_] We use the EHR in combination with another data analytic system [_] We do not use the EHR
8. Are your eligible providers participating in the Centers for Medicare and Medicaid Services (CMS) EHR Incentive Program commonly known as "Meaningful Use"?	[X] Yes, all eligible providers at all sites are participating [_] Yes, some eligible providers at some sites are participating [_] No, our eligible providers are not yet participating [_] No, because our providers are not eligible [_] Not Sure
8a. If yes (a or b), at what stage of Meaningful Use are the majority (more than half) of your participating providers (i.e., what is the stage for which they most recently received incentive payments)?	[_] Adoption, Implementation, or Upgrade (AIU) [_] Stage 1 [_] Stage 2 [_] Stage 3 [X] Not Sure
8b. If no (c only), are your eligible providers planning to participate?	N/A
9. Does your center use health IT to coordinate or to provide enabling services such as outreach, language translation, transportation, case management, or other similar services?	[_] Yes [X] No
If yes, then specify the type(s) of service	-
10. Has your health center received or retained patient centered medical home recognition or certification for one or more sites during the measurement year?	[_] Yes [X] No

If yes, which third party organization(s) granted recognition or certification status? (Can identify more than one.)	[_] National Committee for Quality Assurance (NCQA) [_] The Joint Commission (TJC) [_] Accreditation Association for the Ambulatory Health Care (AAAHC) [_] State Based Initiative [_] Private Payer Initiative [_] Other Recognition Body (Specify: -)
11. Has your health center received accreditation?	[X] Yes [_] No
If yes, which third party organization granted accreditation?	[X] The Joint Commission (TJC) [_] Accreditation Association for the Ambulatory Health Care (AAAHC)
Comments	

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Data Audit Report

Table 3A-Patients by Age and Gender

Edit 03950: Numbers Questioned For Patients Aged 15 - 44. - The proportion of Females aged 15-44 (0.49) is outside the typical range when compared to total patients in the same group. Females aged 15-44 (1,449); Males aged 15-44 (1,531). Please correct or explain.

Related Tables: Table 3A(UR)

Jim Beaumont (Health Center) on 2/14/2015 7:02 PM EST: This number is larger driven by the numbers of MSFW females who receive care. The farmworker males are reluctant to leave the fields and loose incone. So we have a largely female MSFW population in these age cohorts. This has been consistent over the past few years since we added the MSFW population to our scope.

Table 4-Selected Patient Characteristics

Edit 03852: Inter-year change in patients - The percentage of Uninsured patients to total patients has significantly decreased when compared to prior year. Current Year ((36.42)%, (2,807)); Prior Year ((58.85)%, (4,423). Please review the insurance reporting to ensure the information reported is patient's primary medical care insurance. Please correct or explain.

Related Tables: Table 4(UR)

Jim Beaumont (Health Center) on 2/14/2015 9:13 PM EST: With the ACA providing for Medicaid for single adults without disabilities, it provided coverage for most of our homeless population, leading to a large decrease in the Uninsured.

Edit 04132: Inter-year Change in Patients - There is a decrease in the number of Homeless patients reported on Line 23 Column a (5,596) from prior year Line 23 Column a (6,171) . Please correct or explain.

Related Tables: Table 4(UR)

Jim Beaumont (Health Center) on 2/14/2015 9:16 PM EST: With agressive re-housing programs, we believe the total number of homeless is declining in our county. In addition, as a very high cost-of-living county, as the economy has improved it has made it even more difficult for someone to even to be homeless here. We are awaiting the reults of this year's One Night Count for verification.

Edit 04163: Inter-year change in patients - The proportion of Private patients to total patients has significantly decreased when compared to prior year. Current Year (0.02); Prior Year (0.03). Please review the insurance reporting to ensure the information reported is patient's primary medical care insurance. Please correct or explain.

Related Tables: Table 4(UR)

Jim Beaumont (Health Center) on 2/14/2015 9:23 PM EST: We expect this is due to the ACA. With expanded medicaid, some who struggled, but managed to purchase private insurance have now been able to qualify for medicaid. Also, with the marketplace for insurance, those with private insurance can find various plans that provide servcies at other locations. Given the very small proportion of our patients with private insurance, we find the chnages are likely due to the above.

Edit 04184: Inter-year Member Months in question - A significant change in managed care participation Capitated Member months Medicare Line 13a Column b (2,982) is reported compared with the prior year () . Please correct or explain.

Related Tables: Table 4(UR)

Jim Beaumont (Health Center) on 2/14/2015 9:26 PM EST: We have verified this year's member month calculation. Given that last year was all Fee-for-service and this year is all capitated, possible for data to have been entered on the wrong line last year.

Edit 04189: Inter-year Member Months in question - A significant change in managed care participation Fee-for-service Member months Medicaid Line 13b Column a () is reported compared with the prior year (3,318) . Please correct or explain.

Related Tables: Table 4(UR)

Jim Beaumont (Health Center) on 2/14/2015 9:27 PM EST: The Health Plan of San Mateo has gone completely away from fee-for-servcie and now has only capitated coverages.

Edit 04200: Inter-year Member Months in question - A significant change in managed care participation Fee-for-service Member months Medicare Line 13b Column b () is reported compared with the prior year (2,295) . Please correct or explain.

Related Tables: Table 4(UR)

Jim Beaumont (Health Center) on 2/14/2015 9:29 PM EST: While there has been a shift to all capiated plans, given that last year had all Medicare reported as fee-for-service and zero capitated, and this year is all capitated and zero fee-for-service, date may have been entered on the wrong line last year.

Table 5A-Tenure for Health Center Staff

Edit 05834: Staff Tenure in Question - It appears that all staff have increased tenure by twelve or more months over the past year. Please correct or explain.

Related Tables: Table 5A

Arthur Stickgold (Reviewer) on 3/13/2015 12:53 PM EST: did not report

Table 5-Staffing and Utilization

Edit 04144: Inter-year Patients questioned - On Health Care for the Homeless - A large change in Mental Health patients from the prior year is reported on Line 20 Column C. (PY =Total Mental Health (Lines 20a-c) Patients Line 20 Column c (252) , CY = Total Mental Health (Lines 20a-c) Patients Line 20 Column c (341)). Please correct or explain.

Related Tables: Table 5(HCH)

Jim Beaumont (Health Center) on 2/14/2015 10:01 PM EST: Given the relatively small numbers, we consider this to be relatively normal variation.

Edit 04150: Inter-year Patients questioned - On Health Care for the Homeless - A large change in Enabling Services patients from the prior year is reported on Line 29 Column C. (PY = Total Enabling Services (Sum lines 24-28) Patients Line 29 Column c (823) , CY = Total Enabling Services (Sum lines 24-28) Patients Line 29 Column c (2,286)). Please correct or explain.

Related Tables: Table 5(HCH)

Arthur Stickgold (Reviewer) on 3/13/2015 12:51 PM EST: see report comment missing staff -- see report comment

Edit 04682: Inter-year Patients questioned - On Migrant Health Center - A large change in Enabling Services patients from the prior year is reported on Line 29 Column C. (PY = Total Enabling Services (Sum lines 24-28) Patients Line 29 Column c (157) , CY = Total Enabling Services (Sum lines 24-28) Patients Line 29 Column c (200)). Please correct or explain.

Related Tables: Table 5(MHC)

Arthur Stickgold (Reviewer) on 3/13/2015 12:51 PM EST: missing staff -- see report comment

Edit 04684: Inter-year Patients questioned - On Migrant Health Center - A large change in Other Professional Services patients from the prior year is reported on Line 22 Column C. (PY = (31) , CY = (49)). Please correct or explain.

Related Tables: Table 5(MHC)

Jim Beaumont (Health Center) on 2/14/2015 10:09 PM EST: random variation driven by the relatively small numbers.

Edit 04688: Inter-year Patients questioned - On Migrant Health Center - A large change in Mental Health patients from the prior year is reported on Line 20 Column C. (PY = Total Mental Health (Lines 20a-c) Patients Line 20 Column c (5) , CY = Total Mental Health (Lines 20a-c) Patients Line 20 Column c (14)). Please correct or explain.

Related Tables: Table 5(MHC)

Jim Beaumont (Health Center) on 2/14/2015 10:09 PM EST: Random variation driven by the relatively small numbers.

Edit 04690: Inter-year Patients questioned - On Migrant Health Center - A large change in Dental patients from the prior year is reported on Line 19 Column C. (PY = Total Dental Services (Sum lines 16-18) Patients Line 19 Column c (250) , CY = Total Dental Services (Sum lines 16-18) Patients Line 19 Column c (350)). Please correct or explain.

Related Tables: Table 5(MHC)

Jim Beaumont (Health Center) on 2/14/2015 10:11 PM EST: WITH OUR INCREASED ENABLING SERVCIES EFFORTS FOR FARMWORKERS, WE HAVE BEEN ABLE TO GAIN MORE ACCESS FOR THEM FOR DENTAL SERVCIES.

Edit 04692: Inter-year Patients questioned - On Migrant Health Center - A large change in Medical patients from the prior year is reported on Line 15 Column C. (PY = Total Medical Patients Patients Line 15 Column c (1,251) , CY = Total Medical Patients Patients Line 15 Column c (1,947)). Please correct or explain.

Related Tables: Table 5(MHC)

Jim Beaumont (Health Center) on 2/14/2015 10:12 PM EST: Our efforts to engage the farmworker population appear to be leading to increased accessing of servcies.

Edit 05139: Inter-year Patients questioned - On Migrant Health Center - A large change in Vision Services patients from the prior year is reported on Line 22d Column c (PY = (66) , CY = (59)). Please correct or explain.

Related Tables: Table 5(MHC)

Jim Beaumont (Health Center) on 2/14/2015 10:15 PM EST: Small sample random variation.

Edit 00052: Dentist Productivity Questioned - A significant change in Productivity of Dentists on Line 16 (3,708) is reported from the prior year (2,983.85). Please check to see that the FTE and visit numbers are entered correctly.

Related Tables: Table 5(UR)

Jim Beaumont (Health Center) on 2/14/2015 7:06 PM EST: We did a complete new calculation for provider productivity acroos the medical center, thereby providing new baselines for FTE calculations. In addition, dental visits from our contracting organization do not generate any FTE as we do not contract on an FTE basis.

Edit 00058: NP Productivity Questioned - A significant change in Productivity of Nurse Practitioners on Line 9a (2,941.67) is reported from the prior year (1,578.71). Please check to see that the FTE and visit numbers are entered correctly.

Related Tables: Table 5(UR)

Jim Beaumont (Health Center) on 2/14/2015 7:07 PM EST: We did a complete new calculation for provider productivity acroos the medical center, thereby providing new baselines for FTE calculations. In addition, dental visits from our contracting organization do not generate any FTE as we do not contract on an FTE basis.

Edit 00158: PA Productivity Questioned - A significant change in Productivity of PAs on Line 9b (3,970) is reported from the prior year (1,790). Please check to see that the FTE and visit numbers are entered correctly.

Related Tables: Table 5(UR)

Jim Beaumont (Health Center) on 2/14/2015 9:40 PM EST: We did a complete new calculation for provider productivity acroos the medical center, thereby providing new baselines for FTE calculations. With so few visits/FTE being reported for PAs, it is difficult to make a conclusive finding. This as calculated based on the PA baseline for visits.

Edit 00219: Substantial inter-year variance in providers - Number of dental providers and hygienists on Lines 16 and 17 Column a differs substantially from prior year. Current Year - (1). Prior Year - (1.4). Please correct or explain.

Related Tables: Table 5(UR)

Jim Beaumont (Health Center) on 2/14/2015 9:41 PM EST: Primary change is in Hygenist, who provide servcies through our contractor and who were erroneously reported last year since we do not contract on an FTE basis.

Edit 04135: Substantial Inter-year variance in Providers - The number of Mid-Level FTEs reported on Line 10a Column a differs from the prior year. Current Year - (1.9) . Prior Year - (3.3) . Confirm that this is consistent with staffing changes and that the FTE is calculated based on paid hours.

Related Tables: Table 5(UR)

Jim Beaumont (Health Center) on 2/14/2015 9:56 PM EST: The nubers correspond to the providers where the homeless and farmworker patients were seen.

Edit 04149: Inter-year Patients questioned - On Universal - A large change in Enabling Services patients from the prior year is reported on Line 29 Column C. (PY = Total Enabling Services (Sum lines 24-28) Patients Line 29 Column c (980) , CY = Total Enabling Services (Sum lines 24-28) Patients Line 29 Column c (3,537)). Please correct or explain.

Related Tables: Table 5(UR)

Arthur Stickgold (Reviewer) on 3/13/2015 12:51 PM EST: see report comment missing staff -- see report comment

Edit 05765: Patient Support Staff Missing - You report zero patient support staff. This category includes your front desk staff and those who make appointments as well as medical records staff, but not EHR staff. Please correct or explain.

Related Tables: Table 5(UR)

Jim Beaumont (Health Center) on 2/14/2015 10:18 PM EST: We do not directly employ any of these staff, and since they do not generate an appropriate visit count to enable establishing a baseline for FTE calculation, they are accounted for as part of overhead/nonclonical support.

Table 6A-Selected Diagnoses and Services Rendered

Edit 04697: Visits per Patient questioned - A high number of Immunizations services, Line 24, per patient is reported on Migrant Health Center. Please correct or explain.

Related Tables: Table 6A(MHC)

Jim Beaumont (Health Center) on 2/14/2015 7:31 PM EST: We saw a large increase in MSFW children during 2014, almost doubling the number from 2013. And almost half of those were under 5 years of age. This increase in poatients generated a largenumber of visits for routine immunizations (DTP, MMR, etc.) leading to the 6a Table iLine 24 increase.

Table 6B-Quality of Care Indicators

Edit 05773: Line 10 Universe in Question - You are reporting (130.97)% of total possible medical patients in the universe for the Childhood Immunization measure (line 10 Column A). This appears high compared to estimated medical patients in the age group being measured. Please review and correct or explain.

Related Tables: Table 6B, Table 3A(UR), Table 5(UR), Table 4(UR)

Arthur Stickgold (Reviewer) on 3/1/2015 2:52 PM EST: 5. Table 6B/3A. Your calculation of an estimated population for immunizations is nicely done.

Edit 05787: CAD/Line 17 - Based on the universe for total patients with Coronary Artery Disease (CAD) on line 17 column A, we estimate a prevalence rate of (5.87)%. This appears high compared to national averages. Please review and correct or explain.

Related Tables: Table 6B, Table 3A(UR), Table 5(UR), Table 4(UR)

Jim Beaumont (Health Center) on 3/8/2015 5:54 PM EST: Our population is slightly aging, which would lead to a greater frequency of CAD. Also, as we work to establish a medical home, more patients are seen routinely, (so they have at least 2 liketime visits and at least one this year). We havwe reviewed our report selection criteria and have validated the use of the correct diagnostic codes.

Edit 05899: Line 21 Universe in Question - You are reporting (108.98)% of total possible medical patients in the universe for Patients Screened for Depression and Follow-Up measure (line 21 Column A). This appears high compared to estimated medical patients in the age group being measured. Please review and correct or explain.

Related Tables: Table 6B, Table 3A(UR), Table 5(UR), Table 4(UR)

Jim Beaumont (Health Center) on 2/14/2015 10:59 PM EST: Becasue thwe Depression measure uses 12/31 for the birthdate cut-off, some of the 11 year olds (on June 30) will have become 12 by 12/31.

Edit 05193: Line 16 Compliance Rate Questioned - A compliance rate of 100% is reported for Line 16. Please review the number of patients reported in Column c in relation to the sample or universe reported in Column b for accuracy. Please correct or explain.

Related Tables: Table 6B

Jim Beaumont (Health Center) on 2/14/2015 7:34 PM EST: The number is correct. The chart reviews for all 70 cases in the sample verified an acceptable pharmacological treatment plan for persistent asthma.

Edit 05866: Line 20 Compliance Rate Questioned - A compliance rate of 100% is reported for Line 20. Please review the number of patients reported in Column c in relation to the sample or universe reported in Column b for accuracy. Please correct or explain.

Related Tables: Table 6B

Jim Beaumont (Health Center) on 2/14/2015 7:36 PM EST: The number is correct. There was only one new diagnosis in the period and their chart documents treatment within 90 days.

Table 7-Health Outcomes and Disparities

Edit 01344: Deliveries Missing - Zero deliveries are reported by health center providers. If health center providers perform deliveries, please report the number of deliveries on Table 7, Line 2. Please correct or explain.

Related Tables: Table 7

Jim Beaumont (Health Center) on 3/8/2015 6:03 PM EST: All deliveries are all done outside of the medical center.

Edit 01345: Deliveries in question - The total value on Table 7 Line i Column 1a is equal to the combined birthweights of Columns 1b, 1c, 1d (116). This is almost impossible because of multiple births. Please correct or explain.

Related Tables: Table 7

Jim Beaumont (Health Center) on 3/8/2015 6:15 PM EST: There are no multiple births found in this years deliveries.

Edit 04706: High LBW (low birthweight) statistic questioned - More than One Race LBW and VLBW proportion of births reported is higher than the typical range. Please correct or explain. CY (0.18); PY National Average (0.07).

Related Tables: Table 7

Jim Beaumont (Health Center) on 3/8/2015 6:18 PM EST: Very small sample size.

Edit 05548: Low Birthweights Questioned - The More Than One Race LBW and VLBW proportion of births reported appears high. Please correct or explain. CY (17.86)% ;PYN (7.24)%

Related Tables: Table 7

Jim Beaumont (Health Center) on 3/8/2015 6:18 PM EST: Very small sample size.

Edit 05551: Low Birthweights Questioned - The Total LBW and VLBW proportion of births reported appears high. Please correct or explain. CY (11.21)% ;PYN (7.29)%

Related Tables: Table 7

Jim Beaumont (Health Center) on 3/8/2015 6:19 PM EST: Likely result of random fluctaution caused by small sample size.

Edit 05552: Low Birthweights Questioned - The Hispanic/Latino LBW and VLBW proportion of births reported appears high. Please correct or explain. CY (11.11)%;PYN (6.24)%

Related Tables: Table 7

Jim Beaumont (Health Center) on 3/8/2015 6:21 PM EST: Likely result from random fluctuation die to small sample size.

Table 8A-Financial Costs

Edit 03729: Costs Higher Than Reasonable for Staff Only - Medical Staff Costs on Table 8a, Line 1 are higher than typical salaries alone for the FTE reported on Table 5 Line 15. Please correct or explain. (Cost/FTE (273,956.75); PY National Average (88,924.67))

Related Tables: Table 8A, Table 5(UR)

Jim Beaumont (Health Center) on 2/14/2015 9:43 PM EST: Being in a high cost-of-living area makes our salaries higher than average. In addition, as a government entitiy, the benefits package is substantial, equaling 62% of salary.

Edit 04117: Cost Per Visit Questioned - Total Medical Care Cost Per Visit is substantially different than the prior year. Current Year (357.09); Prior Year (247.87).

Related Tables: Table 8A, Table 5(UR)

Jim Beaumont (Health Center) on 2/14/2015 9:48 PM EST: Our billing office has been working diligently over the past few years to insure that everything possible gets charged. We woukld expect the increase is partly do to that effort, along with cost inflation requiring higher charges..

Edit 04126: Cost Per Visit Questioned - Mental Health Cost Per Visit is substantially different than the prior year. Current Year (308.32); Prior Year (106.94).

Related Tables: Table 8A, Table 5(UR)

Jim Beaumont (Health Center) on 2/14/2015 9:51 PM EST: We attribute this to a higher proportion of the visits being with psychiatrists.

Edit 04129: Cost Per Visit Questioned - Other Professional Cost Per visits is substantially different than the prior year. Current Year (220.33); Prior Year (169.36).

Related Tables: Table 8A, Table 5(UR)

Jim Beaumont (Health Center) on 2/14/2015 9:53 PM EST: We attribute this to the overall increase in costs for nonclinical support/overhead, along with some inflation.

Edit 04131: Cost Per Visit Questioned - Total Enabling Services Cost Per Visit is substantially different than the prior year. Curent Year (47.47); Previous Year (128.93).

Related Tables: Table 8A, Table 5(UR)

Jim Beaumont (Health Center) on 2/14/2015 9:54 PM EST: As our enabling servcies are all provided by contractors, this represents a greater efficiency on their part.

Edit 04136: Costs and FTE Questioned - Other Professional Services are reported on Table 8A, Line 9 (61,710) and Table 5, Line 22 (0.2) . Review and confirm that FTEs relate to costs or correct.

Related Tables: Table 8A, Table 5(UR)

Jim Beaumont (Health Center) on 2/14/2015 9:59 PM EST: The result of rounding the FTE.

Edit 05937: Cost per Visit Questioned - Vision Cost Per visit is substantially different than the prior year. Current Year (70.56); Prior Year (169.49).

Related Tables: Table 8A, Table 5(UR)

Jim Beaumont (Health Center) on 2/14/2015 10:21 PM EST: We have verified the number of visits and the cost calculations. It appears a greater percentage of the visits were for Optometry servcies, which would be of lower cost than Ophthamology servcies.

Edit 03727: Inter-Year Variance Questioned - Current Year Facility costs vary substantially from last years cost. (Current Year: Facility Accrued Cost Line 14 Column a (31,847) ; Prior Year: Facility Accrued Cost Line 14 Column a (318,198)). Please correct or explain.

Related Tables: Table 8A

Jim Beaumont (Health Center) on 2/14/2015 7:58 PM EST: As a local government entity in mostly government owned buildings, our faclites costs are largely driven by overall county policies on bond pay-back, etc. Based on the facility costs provided, this is calculated to be the HCH/FH share of the cost.

Edit 03772: Overhead Costs Questioned on Line 11 - You report direct costs Total Enabling Services Cost (Sum Lines 11a through 11g) Accrued Cost Line 11 Column a (256,980) but no overhead allocation has been made. Please check to see that the numbers are entered correctly.

Related Tables: Table 8A

Jim Beaumont (Health Center) on 2/14/2015 7:59 PM EST: All of the Enabling Services costs are from contracts for which there is no local overhead.

Edit 03945: Inter-Year variance questioned - Current Year Administration costs, Line 15 Column a (4,877,037) varies substantially from cost on the same line last year (3,655,125) . Please correct or explain.

Related Tables: Table 8A

Arthur Stickgold (Reviewer) on 3/1/2015 3:13 PM EST: 12. Table 8A. Admin. I suspect that all of the required medical other direct costs are buried in administration. They need to be pulled back out and placed on line 3. Or explain what could possibly drive the admin costs that high.

Edit 05767: Charge to Cost Ratio Questioned - Total charge to cost ratio of (1.73) is reported which suggests that charges are more than costs. Please review the information reported across the tables and correct or explain.

Related Tables: Table 8A, Table 9D

Arthur Stickgold (Reviewer) on 3/1/2015 3:00 PM EST: 11. Table 9D/8A. For what it is worth, the 330 rules do not permit fee schedules that are adjusted to cover unpaid charges, especially since you are getting nearly $2 million to cover them and your Medicaid reimbursement is making a phenomenal profit for the organization. But the numbers are correct which is all we are checking on.

Table 9D-Patient Related Revenue (Scope of Project Only)

Edit 04155: Inter-year Capitation PMPM questioned - The average Medicaid capitation PMPM reported on Line 2a (44.05) is significantly different from the prior year (62.73). Please correct or explain.

Related Tables: Table 9D, Table 4(UR)

Jim Beaumont (Health Center) on 2/14/2015 9:19 PM EST: As part of handling expanded medicaid, there has been established a new and separate capitation plan for the newly eligible. We expect this to be the source of the difference.

Edit 05099: PMPM collections in question - Medicaid Capitation PMPM is outside the typical range. Check to see that the revenue and member months are entered correctly or explain.

Related Tables: Table 9D, Table 4(UR)

Jim Beaumont (Health Center) on 2/14/2015 9:36 PM EST: Not sure what the expected range is. With our large shift to capitation, we do not have any historical reference point. This is the data as reported through the fiscal office.

Edit 04064: Average Charges - Average charge per medical + dental + mental health + vision visits varies substantially from the prior year national average. Current Year (695.4); Prior Year National Average (214.28). Please correct or explain.

Related Tables: Table 9D, Table 5(UR)

Arthur Stickgold (Reviewer) on 3/1/2015 3:21 PM EST: 16. Table 9D. You explain higher charges based on the area. Actually your higher charges are the result of charging double your costs.

Edit 04216: Average Collections - A large change from the prior year in collections per medical+dental+mental health visit is reported. Current Year (245.07); Prior year (222.1). Please review the information and correct or explain.

Related Tables: Table 9D, Table 5(UR)

Jim Beaumont (Health Center) on 2/14/2015 10:06 PM EST: We would considetr his a slight change. Likely due to the movement to more capitation.

Edit 01917: FQHC Medicaid Non-Managed Care retros questioned - FQHC Medicaid Non-Managed Care retros (1,931,260) exceed 50% of Medicaid Non-Managed Care Amount Collected This Period Line 1 Column b (2,190,924) . Verify that Columns C1 through C4 are included in Column b and subtracted from Column d. Please correct or explain.

Related Tables: Table 9D

Jim Beaumont (Health Center) on 2/14/2015 8:10 PM EST: The numbers are correct. With a large local push to managed/capitated care, there is much less Medicaid fee-for-service. This likely causes the retros (for past servcies when the proportion of fee-for-service visits was larger) would exceed the current collections.

Edit 01973: FQHC Medicaid Capitation retros exceed 50% total collections - FQHC Medicaid Capitation retros (1,448,931) exceed 50% of Medicaid Managed Care (capitated) Amount Collected This Period Line 2a Column b (2,508,531) . Verify that Verify that Cols C1 through C4 are included in Col B and subtracted from Col D. Please correct or explain.

Related Tables: Table 9D

Jim Beaumont (Health Center) on 2/14/2015 8:13 PM EST: The numbers are correct. We believe this is simply due to the lag created by the substantial number of new capitated patients servcies.

Edit 02021: Large change in accounts receivable for Total Self Pay is reported - A large change in accounts receivable is reported for Total Self Pay on Table 9D Line 13. Please check that this is consistent with your expectations and correct or explain.

Related Tables: Table 9D

Arthur Stickgold (Reviewer) on 3/1/2015 3:23 PM EST: 15. Table 9D. You report zero sliding discounts. Correct.

Edit 05155: Sliding Discounts in Question - Self-pay charges and/or collections are reported without self-pay sliding discounts. This is unusual. Please correct or explain.

Related Tables: Table 9D

Arthur Stickgold (Reviewer) on 3/1/2015 3:25 PM EST: 15. Table 9D. You report zero sliding discounts. Correct.

Table 9E-Other Revenues

Edit 03736: Inter-Year variance questioned - Total income reported on Tables 9D and 9E for this year varies substantially from the prior year. Please note that Table 9E Line 4 is excluded from this calculation. Please correct or explain. Current Year (11,747,650); Prior Year (7,613,156).

Related Tables: Table 9E, Table 9D

Jim Beaumont (Health Center) on 3/16/2015 5:33 PM EST: Reviewer's request to include the County's General Fund contribution to the county medical center to cover 330 patients costs that were otherwise not reimbursed. Dollars do not actually flow through the program, so they had never been reported in the past.

Edit 02178: Inter-Year Variation in Grant Funds - Current year Migrant Health Center (Section 330(g)) funds vary substantially from the prior year. This may occur if BPHC has substantially changed the grant amount or may be due to the timing of draw downs. Please correct or explain. Current Year - Migrant Health Center Amount Line 1a Column a (285,849) . Prior Year - Migrant Health Center Amount Line 1a Column a (204,978)

Related Tables: Table 9E

Jim Beaumont (Health Center) on 2/14/2015 8:27 PM EST: Our available grant funds did increase somewhat in 2014 (around $300,000) including the draw down for our O/E Supplement (around $98,000). The share of the grant for MH was impacted accordingly.

Edit 03467: Inter-Year variation in grant funds - Current year Health Care for the Homeless(Section 330(h)) funds vary substantially from the prior year. This may occur if BPHC has substantially changed the grant amount or may be due to the timing of draw downs. Please correct or explain. Current Year - Health Care for the Homeless Amount Line 1c Column a (1,564,305) . Prior Year - Health Care for the Homeless Amount Line 1c Column a (1,161,544) .

Related Tables: Table 9E

Jim Beaumont (Health Center) on 2/14/2015 8:28 PM EST: Our available grant funds did increase somewhat in 2014 (around $300,000) including the draw down for our O/E Supplement (around $98,000). The share of the grant for HCH was impacted accordingly.

Edit 04208: Check Capital Improvement Program Grants - Check to be sure that you have not included any ARRA - CIP or FIP funds on Table 9E Line 1j. ARRA - CIP and ARRA - FIP funds should be reported on Lines 4a and/or 4b of Table 9E. Please correct or explain.

Related Tables: Table 9E

Jim Beaumont (Health Center) on 2/14/2015 8:29 PM EST: These reported funds were not ARRA CIP or FIP awarded funds.

UDS Report - 2014

Comments

Report Comments
Not Available

TAB 8
Request to Form Ad Hoc Committee on Board Composition, Recruitment and Selection

SAN MATEO COUNTY
HEALTH SYSTEM

DATE: May 14, 2015

TO: Co-Applicant Board, San Mateo County Health Care for the Homeless/Farmworker Health Program

FROM: Jim Beaumont, Director
Health Care for the Homeless/Farmworker Health Program

SUBJECT: REQUEST FOR BOARD TO TAKE ACTION ON RE-ESTABLISHING A BOARD COMMITTEE TO REVIEW AND MAKE RECOMMENDATIONS ON BOARD COMPOSITION, RECRUITMENT, AND SELECTION

In February, 2014, the Board approved the formation of an ad hoc committee on board composition, recruitment and selection. That committee produced a standardized application for board membership, and in its wake, there were four (4) new members appointed to the board.

Since that time, the Board has seen members required to leave due to no longer being eligible for Board membership and due to other commitments. At present, the board has an approved membership of 14, with only 11 positions filled. As the required minimum is the have nine (9) Board members, the membership is again approaching that requirement. In addition, various interactions with HRSA representatives has indicated that the Board would be best served by adding community members with expertise in finances, human resources and other basic operational areas. In addition, the Board has the continuing task to have consumer membership on the Board in the form of both farmworkers and homeless individuals.

As it has been some time since the previous as hoc committee met, we are recommending that the Board establish a new ad hoc committee on Board composition, recruitment and selection.

The committee should have a minimum of three (3) and no more than five (5) members from among the voting membership of the Board. If not designated in the Board's action on this request, the committee shall designate a Board chair to lead the committee's activities. The committee would be charged with the task of reviewing the current bylaws on Board composition, recruitment and selection, gathering and discussing whatever information the committee deems appropriate and necessary to its work, and providing a report back to the

Co-Applicant Board during a regular meeting, no later than the August 2015 meeting. The committee may, at its discretion, return partial or separate reports on the topics under its review. All reports will be written and provided to the HCH/FH staff at least 10 days prior to the meeting at which the report will be presented. The committee's report should provide succinct analysis of the issue and may present specific recommendations for Board action. Members of the committee may also prepare a minority report if there are differing views on the final report and the recommendations to be given to the Board. Program staff will assist the committee in logistical arrangements. The Board may give further instruction to the committee as the Board chooses.

A majority vote of the Board members present on this recommendation will establish the committee as described above, or as the above is otherwise amended by the Board. Board members shall designate their interest in serving on the committee. Should there be more interest among the Board membership than there are available positions on the committee, the Board Chair shall select the committee membership from among the Board members expressing interest.

TAB 9
Contractors Report
(Quarter 1)

SAN MATEO COUNTY
HEALTH SYSTEM

DATE: May, 14, 2015

TO: Co-Applicant Board, San Mateo County Health Care for the Homeless/Farmworker Health (HCH/FH) Program

FROM: Linda Nguyen, HCH/FH Program Coordinator

SUBJECT: Quarter 1 Report (January 1, 2015 through March 31, 2015)

Program Performance

The Health Care for the Homeless/Farmworker Health (HCH/FH) Program has contracts with four community-based providers, plus two County-based programs for the 2015 grant year. Contracts are for primary care services (Ravenswood Family Health Center and Public Health Mobile Clinic), dental care services (Ravenswood Family Health Center), and enabling services such as case management and eligibility assistance (InnVision Shelter Network, Behavioral Health & Recovery Services, Puente de la Costa Sur, and Samaritan House).

The following data table includes performance for the first quarter (25%):

HCH/FH Performance *01/01/2015 – 03/31/2015*	Yearly Target # Undup Pts	Actual # YTD Undup Pts	% YTD	Yearly Target # Visits	Actual YTD Visits	% YTD	HCH/FH Funding
Behavioral Health & Recovery Svs	300	79	26%	900	304	34%	$90,000
InnVision Shelter Network (case mgmt & eligibility)	550	144	26%	1,250	219	18%	$145,000
IVSN (O/E)	50	7	14%				
Public Health Mobile Van	1,250	374	30%	2,500	584	23%	$240,000
Public Health- Expanded Services	626	131	21%	782	145	19%	$178,500
Puente de la Costa Sur (CM & Intensive CM)	150	33	22%	350	111	32%	$60,500
Puente (O/E)	100	58	58%				
Ravenswood (Primary Care)	500	219	44%	1,895	377	20%	$65,000
Ravenswood (Dental)	133	83	62%	600	165	28%	$50,000
Samaritan House	175	48	27%	300	110	37%	$55,000
Total HCH/FH Contracts	3,834	1,097	34%	8,577	2,015	26%	$884,000

[1]Please note that total has not been cross-referenced for duplicate patients; O/E= Outreach & Enrollment

Health Care for the Homeless/Farmworker Health Program

Selected Outcome Measure Review (Contracts); First Quarter (January 2015 through March 2015)

Agency	Outcome Measure	Progress
Behavioral Health & Recovery Services	At least 75% (225) screened will have a behavioral health screening. At least 55% (165) will receive case management services.	During the first quarter: - 79 clients (26%) had a behavioral health screening - 70 (31%) received case management services
InnVision Shelter Network	Minimum of 50% (250) will establish a medical home. At least 30% (150) of homeless individuals served have chronic health conditions.	During the first quarter: - 10% (51) established a medical home - 18% of individuals served have a chronic health condition.
Public Health Mobile Van	At least 20% (250) of patient encounters will be related to a chronic disease. At least 75% of clients: - seen at foot clinic will be referred to Mobile Clinic for a medical visit - contacted at Service Connect will be seen at Mobile Clinic for medical visit	During the first quarter: 14% (36) of encounters were related to chronic health. 100% of patients: - with foot patients referred to PH Mobile Clinic for medical visit - contacted at Service Connect will be seen at Mobile Clinic for medical visit
PH-Mobile Van-Expanded Services	At least 75% (470) of individuals will receive comprehensive health screening. Provide intensive primary care services to minimum of 100 residents with chronic health issues.	During the first quarter: - 31 patients received a comprehensive health screening -28 patients with chronic health issues
Puente de la Costa Sur	At least 85 farmworkers served will receive case management services. At least 100 served will be provided transportation and translation services. At least 70% (105) will participate in at least 1 health education class/ workshop.	During the first quarter: - 33 received case management services - 1 client was provided transportation and translation services. - 3% participated in Health education workshop.

Agency	Outcome Measure	Progress
RFHC – Primary Health Care	At least 60% will receive a comprehensive health screening. At least 250 (50%) will receive a behavioral health screening. At least 50 will be provided Case Mgmt.	During the first quarter: - 72% (216) received comprehensive health screening. - 8 received behavioral health screening. - 238 received case management services.
RFHC – Dental Care	At least 30% (39) will complete their treatment plans. At least 85% will attend their scheduled treatment plan appointments. At least 40% will complete their denture treatment plan.	During the first quarter: - 5% (6) completed dental treatment plan. - 85% attended their scheduled treatment plan - 56% completed denture treatment plan.
Samaritan House-Safe Harbor	All 100% (175) will receive a healthcare assessment. At least 95% (166) will receive ongoing case management & create health care plan. At least 70% (122) will schedule primary care appointments and attend at least one.	During the first quarter: - 48 (27%) received a healthcare assessment. - 48 received case management services. - 20% (35) attended at least one primary care appointment.

[1] Medical home -defined as a minimum of (2) attended primary care appointments;
[2] Chronic health conditions- including but not limited to obesity, hypertension, and asthma.

Contractor successes & emerging trends:

- **BHRS** states that it continues to be easier and quicker to get clients into BHRS services.
    - Staff also reports that some clients are having difficulty with housing, even with subsidized housing payments.

- According to **IVSN** their HCH team has been effective in engaging clients by responding quickly to meet clients immediately where they are in an effort to make it convenient for clients and build trust.
    - Staff continues to experience a Medi-Cal backlog and obtaining an accurate timeline/status of approval.

- **Public Health Mobile Clinic** has found success in the coordination and referral of clients between community partners and Service Connect, being on-site makes access for clients easier.
    - Staff has seen an increase in asthma, bronchitis and COPD.

- **Puente** works closely with an HSA Benefits Analyst assigned to their office, making workflow more streamlined for clients. Puente also works closely with CSM Health Coverage Unit to ensure that fees are waved in a timely fashion. Their onsite pilot Thursday clinic (collaboration with CSM Health System and Coastside Clinic) is also providing more opportunities for clients.
    - Staff states that their clients with mixed family status have to enroll their families in one more health programs, a time consuming process.

- **Ravenswood Primary Care** has been able to provide patients with same day primary care appointments. At least four appointment slots are reserved for homeless patients each week; this has been helpful in providing immediate care, mitigating the challenges of trying to track and get a hold of patients at times.
    - They have experienced a dramatic increase in the number of diabetic patients in critical need of Podiatry (foot care) care. The referral process for San Mateo County Health System's is long, as the wait time for appointments is usually over two weeks. Their new health center due to open in May will provide Podiatry services by January 2016, which should help.

- **Ravenswood Dental Care** experiences success through their "Access Dentist", providing same day dental services for unscheduled homeless patients, as a designated "Access Dentist" reserves their day to provide immediate access to dental care.
    - Patients voice frustration with their dental treatment plan possibly taking months to complete. To prevent frustration they have begun to provide homeless patients with as much dental work as possible when they come in for appointments (known as quadrant dentistry), which has been beneficial in reducing the no show appointment rates.

- **Samaritan House/Safe Harbor** states that services are evolving and clients are getting connected faster, taxi vouchers ensure clients make their appointments.
    - They have experienced issues with client transportation, though taxi vouchers help with the issue.

TAB 10
HCH/FH Program
Director's Report

SAN MATEO COUNTY
HEALTH SYSTEM

DATE: May 14, 2015

TO: Co-Applicant Board, San Mateo County Health Care for the Homeless/Farmworker Health (HCH/FH) Program

FROM: Jim Beaumont, Director
HCH/FH Program

SUBJECT: DIRECTOR'S REPORT

Program activity update since the April 09, 2015 Co-Applicant Board meeting:

1. Grant Conditions

   At this time, the Program has five (5) outstanding grant conditions, all as 120-day implementation conditions. Four of those conditions have submission deadlines of May 14, 2015 and are prepared for submission pending the inclusion of Board policies on today's agenda. The fifth 120-day implementation condition has already been submitted.

2. Financial Audit

   On April 21, 2015 we received notice that our Financial Audit had been accepted by HRSA. The Audit is included on today's agenda for Board review and acceptance.

3. Meeting with SMMC CFO on Financial Information Support

   As recommended at the last meeting, on April 15, 2015 I met with SMMC CFO Dave McGrew. At this point we have provided information on the HRSA Program Requirements and are planning on having Dave address the Board at its June meeting.

4. Management Analyst Position

   Based on the Board's approval, a requisition for a Management Analyst position has been initiated. We will be working with Human Resources and hope to have the position announced in the near future.

5. 2015 UDS Report Changes

   On May 6, 2015, HRSA sponsored a webinar for the 2015 changes in the UDS Report. Specifically, there will now be a requirement to report “Medi-Medi” patients (dual Medicare/MediCal eligible); there is a new Quality of Care in Oral Health for children ages 6 to 9; the Diabetes Outcome Measure has been re-defined for reporting only those with HbA1c > 9% and < 8%; and the planning for transitioning to ICD-10 coding.

6. The National Health Care for the Homeless Council’s National Conference was held in Washington, D.C. on May 6th to 10th. We are planning to have brief presentations at the June meeting from those who attended.

7. Seven-Day Update

TAB 11
HCH/FH Program Budget & Financial Report

SAN MATEO COUNTY
HEALTH SYSTEM

DATE: May 14, 2015

TO: Co-Applicant Board, San Mateo County Health Care for the Homeless/Farmworker Health (HCH/FH) Program

FROM: Jim Beaumont, Director
HCH/FH Program

SUBJECT: HCH/FH PROGRAM BUDGET and FINANCIAL REPORT

Through April 30, 2015, Grant Year (GY) expenditures total $852,221, with Base Grant expenditures at $804,671 and Expanded Services Grant expenditures at $47,550.

Base Grant expenditures are at 44.5% of budget through 50% of the GY. However, expenditures are not linear throughout the year. Over the last half of the grant year is when most travel (National Conference and possibly a Regional Conference) takes place and when most of our consultant expense (preparing the Service Area Competition grant application) will occur. Also, the GY to date includes the three months (October, November & December) with the lowest expected contract expenditures; the per capita contract expenditures historically are higher during the initial months of a contract year. However, a number of our contractors are currently at pace equivalent to the proportion of the year completed (around 25%), which would indicate that they may be challenged to expend their entire contract. Typically, contractors are in the mid-30% at this point in their contract year. This could result in $30 – 50,000 of unspent money on the contracts. We will continue to monitor these expenditure rates closely.

Also, as of June 30, 2015, HCH/FH direct support to SMMC clinics is scheduled to end. This results in an unexpended amount of around $51,000 per month.

Based on current projections, there will be a potential unexpended balance of around $200,000 at the end of the GY.

A replica federal budget report along with the GY Summary report is attached.

Additionally, we are in the process of having a budget tool created to provide the Board with a training and work tool for understanding the program budget and for working to create the final budget. The tool should be available by mid-June.

Attachments:
Replica SF-424 Federal Budget Report
GY Summary Report

TAB 12
HCH/FH Financial Audit Report

SAN MATEO COUNTY
HEALTH SYSTEM

DATE: May 14, 2015

TO: Co-Applicant Board, San Mateo County Health Care for the Homeless/Farmworker Health (HCH/FH) Program

FROM: Jim Beaumont, Director
HCH/FH Program

SUBJECT: REQUEST FOR THE BOARD TO REVIEW AND ACCEPT THE FINANCIAL AUDIT

On April 21, 2015, the Program received notification from HRSA of their acceptance of the financial audit. As part of a government entity, the program audit is considered a part of San Mateo County's overall Federal Single Audit. In accordance with HRSA requirements, the Co-Applicant Agreement and the Board's Bylaws, the Board has the responsibility and authority to review and accept the audit. The Board may also take action as it deems appropriate to address any concerns raised in the audit.

This request is for the Board to review and accept the financial audit. A majority vote of the members present is sufficient for approval of the request.

Attachments:
San Mateo County Federal Single Audit Report
San Mateo County Comprehensive Financial Audit Report
San Mateo County Audit Report to the Board of Supervisors and Grand Jury

COUNTY OF SAN MATEO

Report to Board of Supervisors and Grand Jury

For the Fiscal Year Ended June 30, 2014

MGO Certified Public Accountants.

COUNTY OF SAN MATEO

Report to Board of Supervisors and Grand Jury
For the Fiscal Year Ended June 30, 2014

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MGO Certified Public Accountants.

Walnut Creek
2121 N. California Blvd., Suite 750
Walnut Creek, CA 94596
925.274.0190

Sacramento

Oakland

LA/Century City

Newport Beach

San Diego

Seattle

To the Board of Supervisors and the Grand Jury
of the County of San Mateo
Redwood City, California

In planning and performing our audit of the financial statements of the governmental activities, the business-type activities, the aggregate discretely presented component units, each major fund, and the aggregate remaining fund information of the County of San Mateo (County) as of and for the year ended June 30, 2014, in accordance with auditing standards generally accepted in the United States of America and the standards applicable to financial audits contained in *Government Auditing Standards*, issued by the Comptroller General of the United States, we considered the County's internal control over financial reporting (internal control) as a basis for designing audit procedures that are appropriate in the circumstances for the purpose of expressing our opinions on the financial statements, but not for the purpose of expressing an opinion on the effectiveness of the County's internal control. Accordingly, we do not express an opinion on the effectiveness of the County's internal control. Our report includes a reference to other auditors that audited the financial statements of the Housing Authority of San Mateo, the San Mateo County Employees' Retirement Association, First 5 San Mateo County, and the Health Plan of San Mateo, as described in our report on the County's financial statements dated October 31, 2014. This communication does not include results of the other auditors' testing of internal control over financial reporting or compliance and other matters that are reported on separately by those auditors.

A *deficiency in internal control* exists when the design or operation of a control does not allow management or employees, in the normal course of performing their assigned functions, to prevent, or detect and correct, misstatements on a timely basis. A *material weakness* is a deficiency, or a combination of deficiencies, in internal control, such that there is a reasonable possibility that a material misstatement of the entity's financial statements will not be prevented, or detected and corrected, on a timely basis.

Our consideration of internal control was for the limited purpose described in the first paragraph and was not designed to identify all deficiencies in internal control that might be material weaknesses. Given these limitations during our audit, we did not identify any deficiencies in internal control that we consider to be material weaknesses. However, material weaknesses may exist that have not been identified.

We have also included in this report a status of the prior year recommendations that should be brought to your attention as the oversight board. This letter does not affect our report dated October 31, 2014 on the financial statements of the County.

Professional standards require that we provide you with information about our responsibilities under generally accepted auditing standards, *Government Auditing Standards* and OMB Circular A-133, as well as certain information related to the planned scope and timing of our audit. We have communicated such information to you in our audit services plan provided on July 21, 2014. Professional standards also require that we communicate to you the information related to our audit discussed on pages 3 through 6.

We would like to thank County management and staff for the courtesy and cooperation extended to us during the course of our engagement.

This communication is intended solely for the information and use of the Board of Supervisors, the Grand Jury, management, and others within the County, and is not intended to be, and should not be, used by anyone other than these specified parties.

Macias Gini & O'Connell LLP

Walnut Creek, California
October 31, 2014

REQUIRED COMMUNICATIONS

Significant Audit Findings

I. Qualitative Aspects of Accounting Policies

Management is responsible for the selection and use of appropriate accounting policies. The significant accounting policies used by the County are described in Note 2 to the financial statements. As described in note 13(b), for the year ended June 30, 2014, the San Mateo County Employees' Retirement Association (SamCERA) implemented Governmental Accounting Standards Board (GASB) Statement No. 67, *Financial Reporting for Pension Plans; an amendment of GASB Statement No. 25*. The provisions for GASB Statement No. 67 require changes and additions in the Notes to the Financial Statements, Required Supplemental Information, and Other Supplemental Information. Significant changes include calculation of total and net pension liability for financial reporting, comprehensive footnote disclosure regarding pension liability, sensitivity of net pension liability to the discount rate, additional investment disclosure, expected long-term discount rate, and annual money-weighted rate of return on investment.

We noted no transactions entered into by the County during the year for which there is a lack of authoritative guidance or consensus. All significant transactions have been recognized in the financial statements in the proper period.

Accounting estimates are an integral part of the financial statements prepared by management and are based on management's knowledge and experience about past and current events and assumptions about future events. Certain accounting estimates are particularly sensitive because of their significance to the financial statements and because of the possibility that future events affecting them may differ significantly from those expected.

The most sensitive estimates affecting the County's financial statements were:

- Fair values of investments;
- Allowances for doubtful accounts for accounts receivable;
- Allowances for uncollectible mortgage loans;
- Depreciation estimates for capital assets;
- Accrual and disclosure of compensated absences;
- Actuarial valuations of annual required contributions for the pension and other postemployment benefits (OPEB) plans;
- Accrual and disclosure of self-insured claims liabilities;
- Contractual adjustments and estimated uncollectible patient accounts receivable; and
- Certain receivables and payables related to reimbursement claims for patient services.

Management's estimates were based on the following:

- Fair value of investments are based on quoted market prices from independent published sources;
- Allowances for doubtful accounts for accounts receivable are based on historical collection rates;
- Allowances for uncollectible mortgage loans are based on loan terms and conditions. Some loans may be forgiven if certain terms and conditions of the loans are met;

REQUIRED COMMUNICATIONS (Continued)

I. Qualitative Aspects of Accounting Policies (Continued)

- Depreciation estimates for capital assets are based on estimated useful lives for capital assets;
- Accrual of compensated absences is based on unused vacation, compensatory, and holiday time at year-end;
- The actuarial pension and OPEB data is based on actuarial calculations which incorporate actuarial methods and assumptions adopted by the Board of the San Mateo County Employees' Retirement Association and the County, respectively;
- Accrual of self-insured claims liabilities are based on actuarial studies performed by the County's independent actuaries;
- Estimates of contractual adjustments and uncollectible patient accounts receivables are based on historical collections and reimbursement formulas prescribed by federal and state legislation; and
- The Medical Center provides services to patients covered by various reimbursement programs. The amount of revenue to recognize under these programs is subject to management's best estimates of the revenue that will ultimately be collected based on governmental regulations and contractual terms, including the assessment of risk related to potential retroactive audit adjustments and other uncertainties.

During our audit, we evaluated the key factors and assumptions used to develop these accounting estimates in determining that they are reasonable in relation to the financial reporting units that collectively comprise the County's basic financial statements.

Certain financial statement disclosures are particularly sensitive because of their significance to financial statement users. The most sensitive disclosures affecting the financial statements were pension and other postemployment benefits. The disclosures about pension and other postemployment benefits in Note 13 and Note 14 to the financial statements, respectively, are based on actuarial valuations.

The financial statement disclosures are neutral, consistent, and clear.

II. Difficulties Encountered in Performing the Audit

We encountered no significant difficulties in dealing with management in performing and completing our audit.

III. Corrected and Uncorrected Misstatements

Professional standards require us to accumulate all known and likely misstatements identified during the audit, other than those that are clearly trivial, and communicate them to the appropriate level of management. The attached Summary of Uncorrected Financial Statement Misstatements summarizes uncorrected misstatements of the financial statements. Management has determined that their effects are immaterial, both individually and in the aggregate, to the financial statements taken as a whole. In addition, the Summary of Corrected Financial Statement Misstatement includes a material misstatement detected as a result of audit procedures that was corrected by management.

REQUIRED COMMUNICATIONS (Continued)

IV. Disagreements with Management

For purposes of this report, a disagreement with management is a financial accounting, reporting, or auditing matter, whether or not resolved to our satisfaction, that could be significant to the financial statements or the auditor's report. We are pleased to report that no such disagreements arose during the course of our audit.

V. Management Representations

We have requested certain representations from management that are included in the management representation letter dated October 31, 2014.

VI. Management Consultations with Other Independent Accountants

In some cases, management may decide to consult with other accountants about auditing and accounting matters, similar to obtaining a "second opinion" on certain situations. If a consultation involves application of an accounting principle to the governmental unit's financial statements or a determination of the type of auditor's opinion that may be expressed on those statements, our professional standards require the consulting accountant to check with us to determine that the consultant has all the relevant facts. To our knowledge, there were no such consultations with other accountants.

VII. Other Audit Findings or Issues

We generally discuss a variety of matters, including the application of accounting principles and auditing standards, with management each year prior to retention as the County's auditors. However, these discussions occurred in the normal course of our professional relationship and our responses were not a condition to our retention.

Other Matters

We applied certain limited procedures to the management's discussion and analysis, the infrastructure assets reported using the modified approach, the schedules of funding progress, and the budgetary comparison information – general fund, which are required supplementary information (RSI) that supplements the basic financial statements. Our procedures consisted of inquiries of management regarding the methods of preparing the information and comparing the information for consistency with management's responses to our inquiries, the basic financial statements, and other knowledge we obtained during our audit of the basic financial statements. We did not audit the RSI and do not express an opinion or provide any assurance on the RSI.

We were engaged to report on the combining and individual nonmajor fund financial statements and schedules, which accompany the financial statements but are not RSI. With respect to this supplementary information, we made certain inquiries of management and evaluated the form, content, and methods of preparing the information to determine that the information complies with accounting principles generally accepted in the United States of America, the method of preparing it has not changed from the prior period, and the information is appropriate and complete in relation to our audit of the financial statements. We compared and reconciled the supplementary information to the underlying accounting records used to prepare the financial statements or to the financial statements themselves.

REQUIRED COMMUNICATIONS (Continued)

Other Matters (Continued)

We were not engaged to report on the introductory and statistical sections of the comprehensive annual financial report, which accompany the financial statements but are not RSI. We did not audit or perform other procedures on this other information and we do not express an opinion or provide any assurance on it.

CURRENT YEAR RECOMMENDATION

None noted.

STATUS OF PRIOR YEAR RECOMMENDATIONS

Reference Number	
2013-01; 2012-01; 2012-03	**Financial Accounting and Reporting Process (Accounts Payable and Other Liabilities; Deposits; Capitalized Assets; and Evaluation of Completed Capital Projects)** *Status:* Implemented. Significant progress was made in improving internal control processes through monthly account reconciliations, pre-close team review of technical matters, and post-close financial statement analysis. Furthermore, recruiting for the vacant Controller position is currently in-process and will support sustainability of the internal control environment.
2013-02 **2012-02**	**Changes to the Charge Data Master (CDM)** *Status:* Implemented.
2013-03	**Access to Programs and Data** *Status:* Implemented. San Mateo Medical Center (SMMC) has developed reports for monitoring administrative workstation users. The User Access Management Policy below specifies review of these users' activities. The Medical Center established a User Access Management Policy (policy) that establishes guidelines for issuing accounts, confirming the identity of users, conducting audits, and managing accounts, including employee changes and termination. Furthermore, the Medical Center has created an Unused Accounts within 30 Days report which is emailed to management team each month for action. In addition, SMMC has established an Application Request Committee and revised its application access process.
2013-04	**Unapplied Cash Reconciliation** *Status:* Implemented. The Medical Center hired a project contractor to identify and provide solutions to the issue. Workflows were documented and modified to address the primary issues for unreconciled transactions related to Brius, LLC patient payments and State supplemental payments. Furthermore, the Medical Center improved its communication between General Accounting (including cashier), Reimbursement, and Patient Financial Services (PFS) to resolve reconciliation issues in a timely manner. Moreover, the CFO and Accounting Manager review the unapplied account balance on a daily basis to identify and resolve unusual changes.
2011-03	**Net Patient Revenue Completeness** *Status:* In-process. The implementation of Contract Manager tool has been delayed due to the vacancy of the Reimbursement Manager and PFS Manager. Management will reevaluate the need for Contract Manager tool. The monthly Net AR valuation is currently handled by the Medical Center staff and reviewed by an external consultant. The Medical Center will reevaluate the need for Contract Manager when the two vacancies are filled.

COUNTY OF SAN MATEO

Report to Board of Supervisors and Grand Jury
For the Fiscal Year Ended June 30, 2014

SUMMARY OF CORRECTED FINANCIAL STATEMENT MISSTATEMENT

Index	Opinion Unit	Financial Statement Line Item Description	Debit	Credit
1	Governmental Activities	Net Pension Asset	$ 50,000,000	
	Governmental Activities	Special Item Expense		$ 50,000,000

SUMMARY OF UNCORRECTED FINANCIAL STATEMENT MISSTATEMENTS

Index	Opinion Unit	Financial Statement Line Item Description	Debit	Credit
1	San Mateo Medical Center	Contract provider services	$ 110,119	
	San Mateo Medical Center	Patient accounts receivable, net	86,492	
	San Mateo Medical Center	Other fees and purchased services	60,083	
	San Mateo Medical Center	Accounts payable and other		$ 256,694
2	San Mateo Medical Center	State supplemental programs	$ 121,680	
	San Mateo Medical Center	Due from other governmental agencies		$ 121,680