HEALTH CARE FOR THE HOMELESS/FARMWORKER HEALTH PROGRAM (HCH/FH)
Co-Applicant Board Meeting
San Mateo Medical Center| Classroom 1 San Mateo
April 12, 2018, 9:00 A.M - 11:00 A.M.
AGENDA

A.	**CALL TO ORDER**	Brian Greenberg		**9:00 AM**
B.	**CHANGES TO ORDER OF AGENDA**			**9:05 AM**
C.	**PUBLIC COMMENT**			**9:10 AM**

Persons wishing to address on matters NOT on the posted agenda may do so. Each speaker is limited to three minutes and the total time allocated to Public Comment is fifteen minutes. If there are more than five individuals wishing to speak during Public Comment, the Chairperson may choose to draw only five speaker cards from those submitted and defer the rest of the speakers to a second Public Comment at the end of the Board meeting. In response to comments on a non-agenda item, the Board may briefly respond to statements made or questions posed as allowed by the Brown Act (Government Code Section 54954.2) However, the Boards general policy is to refer items to staff for comprehensive action or report.

D.	**CLOSED SESSION**			**9:12 AM**
	1. Closed Session this meeting			
	i. Action Item- Request to Approve Credentialing/Privileging list of LIPs			
E.	**MEETING MINUTES**	Linda Nguyen	**TAB 1**	**9:15 AM**
	1. Meeting minutes from March 8 , 2018			
F.	**BOARD ORIENTATION**			
	1. Discussion with consultant on OSV	Pat Fairchild		**9:20 AM**
G.	**BUSINESS AGENDA:**			
	1. Sliding Fee Scale Policy			
	i. Action Item- Request to Amend SFS Policy	Jim Beaumont	**TAB 2**	**10:05 AM**
	2. New Board member Request	Brian Greenberg		**10:10 AM**
	i. Action Item- Request to Approve Board member			

Documents for the following item will be available for review at the meeting with time for review prior to consideration and action by the Board.

	3. AIMS Proposal	Jim Beaumont	**TAB 3**	**10:15 AM**
H.	**STRATEGIC/TACTICAL PLAN DISCUSSION**	Jim Beaumont		**10:20 AM**
I.	**REPORTING AGENDA:**			
	1. Consumer Input	Linda/Kat	**TAB 4**	**10:25 AM**
	2. HCH/FH Program QI Report	Frank Trinh	**TAB 5**	**10:35 AM**
	3. HCH/FH Program Director's Report	Jim Beaumont	**TAB 6**	**10:40 AM**
	4. HCH/FH Program Budget/Finance Report	Jim Beaumont	**TAB 7**	**10:45 AM**
	5. Small Funding Requests Report	Elli Lo	**TAB 8**	**10:50 AM**
	6. Final UDS report/submission	Linda/Elli/Jim	**TAB 9**	**10:55 AM**

BOARD COMMUNICATIONS AND ANNOUNCEMENTS

Communications and Announcements are brief items from members of the Board regarding upcoming events in the community and correspondence that they have received. They are informational in nature and no action will be taken on these items at this meeting. A total of five minutes is allotted to this item. If there are additional communications and announcements, the Chairperson may choose to defer them to a second agenda item added at the end of the Board Meeting.

OTHER ITEMS

1. Future meetings – every 2nd Thursday of the month (unless otherwise stated)

Next Regular Meeting May 10, 2018; 9:00 A.M. – 11:00 A.M. SMMC

H.	**ADJOURNMENT**	Brian Greenberg	**11:00 AM**

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.smchealth.org/smmc-hfhfh-board.

TAB 1
Meeting Minutes

Request to Approve

Healthcare for the Homeless/Farmworker Health Program (Program)
Co-Applicant Board Meeting Minutes (March 8, 2018)
SMMC

Co-Applicant Board Members Present	County Staff Present	Members of the Public
Brian Greenberg, Chair	Elli Lo, Management Analyst	Maddy Kane, Puente
Kathryn Barrientos	Linda Nguyen, Program Coordinator	Corina Rodriguez, Puente
Robert Anderson	Frank Trinh, Medical Director	
Allison Ulrich		
Mother Champion		
Tayischa Deldridge		
Steve Carey		
Christian Hansen		
Steven Kraft		
Jim Beaumont, HCH/FH Program Director (Ex-Officio)		

Absent: Dwight Wilson, Gary Campanile

ITEM	DISCUSSION/RECOMMENDATION	ACTION
Call To Order	Brian Greenberg called the meeting to order at 9:01 A.M. Everyone present introduced themselves.	
Regular Agenda Public Comment	No Public Comment at this meeting.	
Closed session **Request to Approve C&P list**	**Action item: *Request to Approve* Credentialing and Privileging List**	Motion to Approve C&P list MOVED by Christian SECONDED by Tay, and APPROVED by all Board members present.
Regular Agenda Consent Agenda	All items on Consent Agenda (meeting minutes from December 14, 2017) were approved. Please refer to TAB 1	Consent Agenda was MOVED by SECONDED by, and APPROVED by all Board members present.
Board orientation	Reminder to take Board Self-Assessment evaluation	Staff re-send Board Evaluation.
Business Agenda: **Travel conference request**	The HCH/FH Program (Program) Co-Applicant Board (Board) approved policy regarding travel reimbursement for Board members who may travel for Board and/or Health Care for the Homeless/Farmworker Health Program (Program) business. So far the program has received a request from one Board member for the upcoming 2018 National Health Care for the Homeless Conference in Minneapolis, Minnesota (May 15-18th); by Dwight Wilson. **Action item: Request to Approve Travel Conference request** *Please refer to TAB 2 on the Board meeting packet*	**Request to Approve Travel Conference request** MOVED by Robert SECONDED by Christian, and APPROVED by all Board members present

Strategic Plan/tactical plan update	Review goals of Strategic plan (7) Discussion on unmet needs for Street homeless, must detox before admitted, too medicated to get access to psych, must be sober enough for psych services **.** Need intensive care beds- treatment readiness to get into "detox	
Reporting Agenda: Consumer Input	Staff shared their experience from the Western Forum for Migrant health held in Seattle, Washington. They shared on 2 workshops of interest: New Findings from the National Agricultural Workers Survey and Updates on Collaborations with HRSA Strategies for Engaging Underserved Communities Website for more information - **http://naws.jbsinternational.com** https://doleta.gov/naws/pages/research/data-tables.cfm A Board member Tay also attended the conference and shared her experience and interest in a workshop regarding self-care. *Please refer to TAB 3 on the Board meeting packet*	
Regular Agenda: HCH/FH Program QI Report	There are no new updates from the San Mateo County HCH/FH Program QI Committee at this time. The next QI Committee meeting will be in March 2018. *Please refer to TAB 4 on the Board meeting packet*	
Regular Agenda: HCH/FH Program **Directors report**	Report included: • With the congressional approval of the budget package on February 8th, full Health Center Funding has been restored for at least the next two years (through September 30, 2019). There also appears to be additional funding around $200-300 million per year for the 330 Programs. No word on HRSA's intent for the additional funding. • We have received a request from Life Moves for the planning and training portions of a Nutrition Program focused on the homeless shelter population. The request is labelled as a "Small Funding Request" and totals $25,000. Program is currently working with the proposal as a small funding request. • Program submitted a complete UDS on February 14, 2018. There is a general update on the report values elsewhere on today's agenda • OSV is July 24-26th *Please refer to TAB 5 on the Board meeting packet.*	Send OSV meeting invite to Board members

Regular Agenda: HCH/FH Program *Budget & Financial Report*	Preliminary grant expenditures for February, 2018, total $335,000. This will increase a little as the County processes month-end transactions, but we have included known contractual expenditures (even if they are not yet reflected as an expenditure by the county), and an estimate of routine county monthly charges. It is too early in the Grant Year to make a meaningful projection on total Grant Year expenditures. However, the initial invoices on our 2018 contracts reflect significant utilization, averaging about 15%. This would be a very good number for the first month of the contract year. *Please refer to TAB 6 on the Board meeting packet.*	
Contractors update- 4th quarter	Staff reported on 4th quarter status of contractors : • The Health Care for the Homeless/Farmworker Health (HCH/FH) Program has contracts with seven community-based providers, plus two County-based programs for the 2017 grant year. Contracts are for primary care services, dental care services, and enabling services such as care coordination and eligibility assistance. • There was a discussion on contractors not spending down their contract and having remaining balance and what actions the Board can take to notify them that funding may be repurposed if the money is not spent down. *Please refer to TAB 7 on the Board meeting packet.*	
UDS report	Program staff submitted the first Uniform Data System (UDS) report on February 14, 2018. The UDS is a standard data set that is reported annually and provides consistent information about health centers. It includes patient demographics, services provided, clinical processes and results, patients' use of services, costs, and revenues that document how San Mateo Health System as well as HCH/FH contractors perform. Over the years there have been fluctuations in both the homeless and farmworker populations. The criteria for the clinical outcome measures have also changed significantly; this is reflected in the UDS trend charts showing data on seven years of UDS reporting (2010-2017). The results from most of the clinical outcome measures have improved from last year, about 9 (out of 14 on table) outcome measures saw an improvement. 2015 was the first year program staff was able to obtain universal reports for some UDS clinical measures by working with our Business Intelligence staff, prior to this program staff had conducted 70 chart reviews for all clinical measures. The use of universal reports can bring about challenges in the accuracy of the results, because validating all the results may be difficult. 2016 UDS measurement year saw a significant change in reporting requirements for clinical outcome measures. In attempt to reduce reporting burden, clinical measures were revised to align with CMS clinical quality measures; because of this visit count criteria went from two to one visit to be counted in the reporting year. *Please refer to TAB 8 on the Board meeting packet.*	
Adjournment	Time _____10:50 am____	Brian Greenberg

TAB 2

Sliding Fee Scale Request to Approve

COUNTY OF SAN MATEO
HEALTH SYSTEM

San Mateo Medical Center
222 W. 39th Avenue
San Mateo, CA 94403
650-573-2222 T
www.sanmateomedicalcenter.org
www.facebook.com/smchealth

DATE: April 12, 2018

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

FROM: Jim Beaumont, Program Director HCH/FH Program

SUBJECT: REQUEST TO APPROVE REVISIONS TO THE SLIDING FEE DISCOUNT SCHEDULE

One of the Federal Program Requirements is having an approved Sliding Fee Discount Program (SFDP). This Board approved policy for the SFDP in October 2014 and was later updated on June 9, 2016 based off of OSV report recommendations. The latest update to the SFDP was in February, 2018 to incorporate the 2018 Federal Poverty Guidelines (FPG).

As we have been working with the Health Coverage Unit on the implementation of the SFDP in advance of our Operational Site Visit, we have identified that the current "discount" in cumbersome and difficult to understand. Currently the SFDS provides for discounts of 98%, 95% and 80% across three income groupings between 100% and 200% of FPG. This requires an individual calculation of potential/actual cost for each service based on the listed charges for that service.

To address this, and in light of the fact that most coverage and insurance programs use flat co-pays to provide discounts across multiple services, we are recommending the Board revise the San Mateo HCH/FH Program Sliding Fee Schedule to utilize flat co-payments to represent the discounts on services. The recommended revised scale is attached to this memo. It provides for co-pays of $20, $25, and $30 across the three income groupings previously having percentage discounts.

This revision will make the SFDP much easier to understand for patients and for staff to administer. In addition, it will clearly make the County's ACE program a better resource for our homeless and farmworker patients.

This Action Request is for the Co-Applicant Board to approve revisions to its approved Sliding Fee Discount Program Policy Schedule to change the discount structure from a percentage to a flat rate.

A majority vote of the members present is necessary and sufficient to approve the request.

Attachments:

- Revised 2018 SFDP Schedule

San Mateo Medical Center
A County System of Healthcare

COUNTY OF SAN MATEO CALIFORNIA

San Mateo County

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

(HRSA 330 Program/FQHC)

Sliding Fee/Discount Schedule

Effective April 12, 2018

Monthly Income Thresholds by Family Size for Sliding Fee/Discount Policy Coverage for Service Charges

Poverty Level[+]	0 - 100%	101% - 138%	139% - 170%	171% - 200%	>200%
Family Size					
1	$1,012	$1,396	$1,720	$2,023	$2,024
2	$1,372	$1,893	$2,332	$2,743	$2,744
3	$1,732	$2,390	$2,944	$3,463	$3,464
4	$2,092	$2,887	$3,556	$4,183	$4,184
5	$2,452	$3,383	$4,168	$4,903	$4,904
6	$2,812	$3,880	$4,780	$5,623	$5,624
7	$3,172	$4,377	$5,392	$6,343	$6,344
8	$3,532	$4,874	$6,004	$7,063	$7,064
For each additional person, add	$360	$497	$612	$720	$721
Patient Cost ==>	**No Charge**	**$20**	**$25**	**$30**	**No Sliding Fee Discount[++]**

[+] Based on 2018 HHS Poverty Guidelines (https://aspe.hhs.gov/poverty-guidelines)

[++] Reduced payments may be available through other state/local funded discount programs.

TAB 3
New Board Member Request

COUNTY OF SAN MATEO
HEALTH SYSTEM

San Mateo Medical Center
222 W. 39th Avenue
San Mateo, CA 94403
650-573-2222 T
www.sanmateomedicalcenter.org
www.facebook.com/smchealth

DATE: April 12, 2018

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

FROM: Board Membership/Recruitment Committee
HCH/FH Program

SUBJECT: BOARD NOMINATION FOR ADONICA SHAW-PORTER

The Co-Applicant Board of the HCH/FH Program may periodically elect new members to the Board as desired and in accordance with Board Bylaws.

The Board Composition Committee has interviewed a candidate it wishes to present to the Board. Summaries of Board Composition Committee evaluation and recommendation for each candidate accompany this TAB.

This request is for the approval of new Board members to enlarge the knowledge and expertise available to the Board for its review and planning duties.

Ms. Shaw Porter is currently employed at San Francisco's first and largest homeless shelter (Raphael House) as a Marketing and Communications Manager. She is a philanthropist, TEDx speaker, social/digital media strategist with experience in public relations, brand management and marketing. She has created and managed digital and social media marketing projects for numerous brands, start-ups, nonprofits, and products in the United States. She specializes in managing social and digital media strategy for brands and large corporations with a global reach.
She is the founder of Impressive Digital Media Management, the founder of San Francisco Association for Scholarship and the Performing Arts, the Executive Director of the Miss San Francisco Scholarship Program through a license with the Miss America Organization, a member of the Pacifica Rotary, a volunteer with the Hunter Point Boys and Girls Club in San Francisco, a Glass Leadership Participant with the Anti-Defamation League (ADL) and a former board member with the Torrance-Southbay YMCA, and former member of the Torrance Del Amo Rotary.
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The Board Composition Committee nominates Adonica Shaw-Porter for a seat on the Co-Applicant Board of the Health Care for the Homeless/Farmworker Health Program.

ATTACHMENT:

- ADONICA SHAW-PORTER APPLICATION
- ADONICA SHAW-PORTER RESUME

San Mateo Medical Center
A County System of Healthcare

COUNTY OF SAN MATEO CALIFORNIA

Board Composition Committee
Nomination to Board

Welcome to the San Mateo County Health Care for the Homeless/Farm Worker Health Co-Applicant Board Application for Board Membership.

1. **What is your name, residence address and contact information (phone and email)?**

My name is Adonica Shaw-Porter. My address is 1528 Terra Nova Blvd Pacifica, Ca 94044. My cell is 310-935-9294 and my email is adonica.shaw@gmail.com

2. **What is your place of employment and title, if applicable?**

Raphael House of San Francisco. We are the first and largest family homeless shelter in San Francisco. I work in the Development Department, and my title is Marketing and Communications Manager,

3. **What experience and/or skills do you have that would make you an effective member of the Board? (Skills & experiences that will be of benefit to the Board.)**

Adonica "Andie" Shaw is a philanthropist, TEDx speaker and a social/digital media strategist with several years client experience in public relations, brand management and marketing. She has created and managed digital and social media marketing projects for numerous brands, start-ups, nonprofits, and products in the United States. She specializes in managing social and digital media strategy for brands and large corporations with a global reach. She currently works as the head of Marketing and Communication for Raphael House of San Francisco, which is the first and largest family homeless shelter in the city.

Prior to her work in the pr and social media industry, she was a weekend weather anchor and reporter for CBS affiliates in California. She was trained by the best; with additional experience from several high level internships and jobs at CNN Los Angeles, NBC and KNBC ent.

She speaks at conferences about strategies for Digital Media and Social Media professionals and how they can leverage their communication internally and with their followers for improved customer relations and profitability. In parallel, she also continues to consult with, coach, and train companies on strategically leveraging social media for their marketing plans and social sentiment objectives.

She has delivered several TEDx talks, and she is the founder of and Impressive Digital Media Management, the founder the San Francisco Association for Scholarship and the Performing Arts, the Executive Director of the Miss San Francisco Scholarship Program through a license with the Miss America Organization, a member of the Pacifica Rotary, a volunteer with the Hunter Point Boys and Girls Club in San Francisco, a Glass Leadership Participant with the Anti-Defamation League (ADL) and a former board member with the Torrance-Southbay YMCA, and former member of the Torrance Del Amo Rotary.

She currently resides in Pacifica, California.

4. **Why do you wish to be a Board member?**

As an advocate for homeless families and a shelter [employee/volunteer], I've seen first-hand how homelessness affects individuals and families emotionally, physically and mentally. I've also seen how the staggering rise in the cost of living in the Bay Area is taking access to health care, housing and livable wages away from some of the hardest working people in San Mateo, San Francisco and Alameda Counties.

I am currently the Marketing and Communications Manager working in Development at Raphael House, the first and largest family shelter in San Francisco. It is 100% privately funded, and provides comprehensive assistance for at-risk families through after school care, job training and mental health resources. Our model is unique, in that we enable families to stay with us for up to a year as we work together to achieve long-term housing and financial stability.

While there are many struggles facing homeless families, health care is critical. Without it, they are statistically more likely to struggle with stability in the long term. A simple injury or illness can quickly lead to an employment problem, with too much missed time or sick leave that is exhausted. This is especially true for physically demanding jobs such as construction, manufacturing and other labor-intensive industries. If employment is lost, it means losing employer-sponsored health insurance for most. The lack of both income and health insurance in the face of injury or illness then becomes a downward spiral. Without funds to pay for health care (treatment, medications, surgery, etc.), healing becomes more difficult, which can lead to the inability to work for extended periods of time, if at all.

According to the NHCHC, because health issues among the homeless are complex and serious, and lead to suboptimal treatment, *"those experiencing homelessness are three to four times more likely to die prematurely, with an average life expectancy as low as 41 years*."

In my view, it is imperative that our communities and public agencies look for ways to provide more health-related services and programs for the homeless to help extend and improve their lives. And given the rate at which people are becoming homeless in the Bay Area, the issue is becoming more and more prevalent, at a time when there is a lack of structured, well-functioning programs in place to help.

I consider an opportunity to serve on the board my chance to engage more fully in tackling this issue within San Mateo County. I've owned several businesses and served on several boards in the past, including the YMCA and Junior League. As a result of my current non-profit work, in addition to my family's private non-profit, I am experienced in, and committed to, actively contributing to the overall direction of the program, service and program development and long-term management and planning. My colleagues would say that I have a knack for developing and nurturing relationships across the community, generating fundraising and management ideas, and moving those ideas to closure.

I strongly believe that my passion, professional experience, and ability to bring several skill sets to the board in business, public relations, marketing, social media and community affairs make me a solid candidate for this board seat. I personally do not believe that we can afford to wait for our country to enact that one particular thing that would end homelessness. The epidemic is unfortunately the culmination of failed policies across the board. But what we can do is break off pieces to tackle in our own neighborhoods and chip away at some of

the contributing factors. And with your acceptance of my application, I hope to be one of those individuals who can be a part of that change in San Mateo County.

5. **Are you homeless, formerly homeless, a farmworker, retired farmworker, or a dependent of a farmworker? (Not a requirement)**

No.

Adonica Shaw

Senior Marketing/ Communications Manager & Fundraiser
Pacifica, CA
adonica.shaw@gmail.com
(310) 935-9294

Adonica Shaw is a senior level Marketing/ Communications Manager and non profit professional with several additional years experience in business development strategy, pr management and integrated campaigns for mobile, and digital marketing. Prior to her work in the pr and social media industry, she was a weekend weather anchor and reporter for CBS affiliates in California, with additional experience from several high level internships and jobs at CNN Los Angeles, NBC and KNBC.

Authorized to work in the US for any employer

Work Experience

Marketing Communications Manager (Development Dept)

Raphael House of San Francisco (Non Profit) - San Francisco, CA
September 2016 to Present

• Responsible for driving donations using marketing materials/ tools for the organization.
• Oversees and manages a marketing committee of volunteers who assist with the marketing efforts of the organization.
• Manages all major event promotion and marketing for RH annual Gala, Fundraisers and shopping events.
• Liaises across teams and departments to produce advertisements, email communications and video content to drive donations, brand awareness and visibility through social and paid social.
• Creates and manages all social and digital content and strategy for all social media accounts.
• Manages all multi-channel marketing campaigns for the agency for (email, direct mail, print, online and /or social media campaigns)
• Writes and edits all blogs, press releases and announcements for corporate site
• Secures and manages all television segments and press placements.
• Manages all press relationships with producers at KPIX, KTVU, ABC, KRON, KTSF. NBC, SF Chronicle, San Francisco Magazine, Gentry, Nob Hill Gazette etc.
• Wrote and edited talking points, scripts, brochures, blogs, marketing materials and speeches on behalf of the executive director and key spokespersons for the organization.
• Oversaw the creation and development of a new website and messaging for the organization.
• Manages all peer to peer campaigns, as well as online fundraising efforts for the organization.
• Manages the creation and development of annual mailings including a bi-annual Newsletter and Annual Report.

Social & Digital Media Manager/ Content Manager

Sunrider International - San Francisco, CA
January 2015 to December 2016

• Liaises with our multimedia team team to product info and video content to drive top of funnel brand awareness and visibility through social and paid social.

• Creates and manages all social and digital content and strategy for all domestic and international social media accounts.
• Manages all multi-channel marketing campaigns for the company for (email, webinars, direct mail, print, online and /or social media campaigns)
• Writes and edits all blogs, press releases and announcements for corporate site
• Wrote and edited talking points, scripts, brochures, blogs, marketing materials and speeches on behalf of owners
• Established global voice and messaging for the Sunrider brand on social media for their global social media accounts
• Responsible for gathering qualitative and quantitative data to monitor brand perception globally
• Uses social listening tools like Salesforce.com and Sprout Social to engage with followers across all company channels, email campaigns, social platforms, and mobile devices.
• Automated and managed all social/digital promotions, and performed all key analysis of all campaigns.
• Managed SEO & SEM for corporate website and marketing campaigns
• Identifies and manages all influencers, and brand ambassadors.
• Manages artistic direction for all product shoots for Instagram and Facebook
• Ideate and create scripts for all product videos and video campaigns for social media.
• Creates all social and digital media tutorials for staff and international social media coordinators.
• Performs all key analysis and data for social and digital campaigns.
• Creates and manages the social media calendar for domestic (US) and international brand activities.
• Manages customer service issues across all (US based) social media platforms.
• Drives A/B and multivariate testing programs to continually improve ad creative and channel performance.
• Partners across departments with analytics team to improve reporting capabilities / marketing dashboards and develops understanding of related metrics (e.g. LTV, churn, etc.)
• Helps to drive the digital strategy for the complete visitor experience across all devices.
• Manages, mentors, and develops global country managers in best practices for social and digital media, and strategies to localize and implement the brand voice and messaging.

Principle/ Marketing Manager & Brand Manager

Image in Motion PR - Los Angeles, CA
November 2012 to December 2016

• Planned, forecasted and reported social media and marketing programs for clients
• Tracked outcomes of social media strategies against a set of defined goals and KPI’s
• Monitored growth, reach, ROI and user LTV from all client campaigns to continually improve performance.
• Initiated all publicity efforts and campaigns, created and distributed company press kit and releases
• Spearheaded social media marketing plans, promotions and giveaways
• Produced weekly social media program status reports detailing key insights,
popular content topics and monitoring results
• Created and maintained a Social Media calendar for campaigns, giveaways and strategic milestones
• Used listening tools like Salesforce.com, Marketo, Google Analytics and Omniture to publish, track and monitor marketing promotions and marketing campaigns.
• Automated and managed all social/digital promotions, and performed all key analysis of all campaigns.
• Managed company sponsorship program and relationships with sponsored athletes

Content Marketing Manager (Contract)

Samba TV - San Francisco, CA
June 2016 to September 2016

• Conceptualized and created B2B marketing content for tech-startup including company blog, newsletter, bylined articles, and social media platforms.
• Created 5–7 blogs each month to drive leads, subscribers, awareness, and/or other important metrics (examples include, case studies, infographics, guides, templates, etc.).
• Worked with Director of Research and co-founders to identify news worthy research and place data with appropriate news outlets such as Wall Street Journal, the AP, MediaMath, Ad Age, Ad Week and Broadcast & Cable.
• Managed and wrote all content for company newsletters. Worked with design team to develop layout, graphics and presentation for monthly newsletters as well.
• Blogged on an ongoing basis to support and promote your offers and to attract site visitors through search, social media, and email subscribers.
• Grew our subscriber base by providing them with regular, helpful content that's aligned with their needs and interests.
• Collaborated with designers, product marketers, sales professionals, and external influencers and industry experts to produce relevant content that meets the needs of both key stakeholders and our audience.
• Optimized content for search engines and lead generation.
• Conducted analytical projects to improve blog strategies/tactics.
• Grew blog subscribers, converting visitors into leads, and expanding our blog's overall reach.
• Managed relationship PR agency and worked with them to place articles and company data and research with Tier 1 publications and outlets.
• Wrote speeches for co-founder.
• Created content regularly to grow the company's footprint (press releases, corporate announcements, and creative content).
• Collaborated with prominent members of the company, including executives, to craft and pitch press releases and thought leadership columns.

Social Media & Web Manager/ Product Manager & Public Relations Manager

Perfect Plus LLC - Telecommute
November 2014 to January 2015

• Created, Implemented and managed all sales on company e-commerce site
• Managed all design and distribution of email promotions for e-commerce site
• Designed and managed all content for social media campaigns for (FB/ TW/ Pinterest)
• Coordinated marketing with QVC & TSC partners to support campaigns, promotions and events.
• Developed and established global voice and messaging for Nick Chavez Beverly Hills on social media
• Advised on emerging web-based and mobile technologies, including their potential use and benefits as well as system integrations for marketing.
• Used marketing publishing tools like Marketo to publish, manage and track promotional marketing campaigns.

Accomplishments
Raised web sales by nearly 167% in six weeks for over 32,000 in sales for the last six weeks of 2014.

Social/Digital Media Manager/ Marketing & Brand Manager

House of Auth - Carson, CA

February 2014 to October 2014

Carson, CA Feb 14 - Present
Social Media Manager and Digital Media Strategist/ Public Relations Manager
• Created and managed all content for social media platforms
• Implemented and managed all advertising budgets for Facebook and Twitter
• Reported social media data for the owners, investors and consultants
• Determined social media and marketing campaign concepts, messaging and copy
• Initiated and managed all publicity efforts and campaigns, reporter/blogger relationships and reviews
• Created and distributed company press kit and releases
• Developed and implemented social sentiment objectives and strategy to manage their online reputation
• Managed social media platforms for athletes, teams, groups that were sponsored by company

Account Executive/ Marketing Manager

Playmaker Images - Los Angeles, CA
March 2011 to June 2013

• Managed and coordinated all marketing and promotional staff and client activities
• Managed social media platforms for athletes, teams, groups that were company clients
• Developed pitches and marketing plans for potential projects and clients
• Created and managed marketing budget, expenses and billing
• Wrote and edited talking points, scripts, brochures, blogs, marketing materials and speeches on behalf of clients
• Prepared internal status reports and data points for executed client campaigns
• Coordinated ad placement for clients through phone and email communication
• Researched trends and developments in clients industry
• Coordinated logistics for client participation in all activities

Reporter/Weather Anchor

Central Coast News CBS/FOX - Salinas, CA
May 2010 to January 2011

One-man-band reporter and weekend weather anchor at Kion CBS and its sister station KCOY
• Posted information on my news stories to news website and social media platforms daily

Education

MFA in Multimedia Communications

Academy of Art University - San Francisco, CA
2009

B.A. in Literary Journalism

University of California - Irvine, CA
2008

Skills

Marketing, Digital Marketing, Content Creation and Management, Community Engagement & Management, UI/UX Design, SEO, Growth Marketing, Facebook, Radian6, Spredfast, Instagram, Wanelo, Ello, Shots, Hashtagify, Bebo, SlideShare, LinkedIn, Periscope, Youtube, Twitter, Pinterest, Google +, Disqus, Medium, Snapchat, Tumblr, Twoo, Vine, Youku, VK, Ren Ren, Sina Weibo, QQ, Line, Whats App, Spinklr, Sprout Social, Secret, Meetup, Creative Suite, Hootsuite, Social Media, Stumble Upon, Facebook and Twitter Analytics, Google Analytics, Social Mention, Social Videos, Video Editing, FinalCut, Edius, Video & Content Ideation, Graphic Design, Copywriting, Marketing Collateral, Campaigns, Marketing program development, Salesforce and Marketo. (9 years)

Links

http://www.adonicashaw.com

http://www.facebook.com/adonicashaw

http://www.twitter.com/adonica_shaw

https://www.linkedin.com/in/adonicashaw

Awards

Speaking Experience - International Social Media 101: The trick to managing global conversations

April 2015

Speaking Abstract Despite the global popularity of Facebook, or even the success of other American companies such as Twitter, LinkedIn, and Google, which have masse appeal in the US, it is safe to say that social media doesn't stop at the American shoreline. And although most companies are finally coming to grips with international SEO, very few tend to setup international social accounts, let alone develop an international social media strategy for them, missing out on strong marketing channels internationally, such as China or Japan.

Speaking Experience - Simply Sentimental - Applying new rules for sentiment analysis

May 2014

Speaking Abstract - Sentiment metrics can be a useful tool in certain marketing and public relations functions, but all too often, data is neither informative, accurate or actionable. Studies show that sentiment analysis tools fall short when it comes to translating sentiment from data. Whether it's context, false negatives, humor or sarcasm, social media managers, public relations professionals and marketeers often find themselves wondering how to apply sentiment to their corporate objectives.

The discourse is muddled with professionals who have strong feelings about whether the data should be used, how it should be used, and when it should be used, if ever. This presentation will examine and propose several practical applications for how the sentiment, good or bad, can be integrated into social media and public relations objectives for continued brand development and improved customer relations.

Speaking Experience - International Social Media 101: The trick to managing global conversations

September 2015

Despite the global popularity of Facebook, Twitter, LinkedIn, and Snapchat, social media manager and global digital directors face a number of different obstacles that are unique to international social media strategy. Common kpi's like the measurement sales, shares or organic reach are simply useless if a company doesn't understand international issues such as accessibility of internet, cultural habits or the breakdown of internet use by different types of devices. And you can forget about running an effective social media campaign without a localized digital campaign. So what do you do? What data do you need to be successful and what is it important? That's what I 'm going to tell you. This presentation will examine and explore an approach to managing international social media platforms with a content and data based strategy for companies that operate multi-nationally.

Panel Experience - Getting Hired in the Social & Digital Media Space

March 2016

Why We GIve

November 2017

Understanding the human behavior side of why we give. Adonica Shaw is a philanthropist, TEDx speaker and a social/digital media strategist with several years client experience in public relations, brand management and marketing. She has created and managed digital and social media marketing projects for numerous brands, start-ups, non-profits, and products in the United States. She specializes in managing social and digital media strategy for brands and large corporations with a global reach. She currently works in Development as the head of Marketing and Communication for Raphael House of San Francisco, which is the first and largest family homeless shelter in the city.

Prior to her work in the pr and social media industry, she was a weekend weather anchor and reporter for CBS affiliates in California. She was trained by the best; with additional experience from several high level internships and jobs at CNN Los Angeles, NBC and KNBC.

https://www.youtube.com/watch?v=UkT47jwMW0Q

Groups

Junior League of San Francisco

2016 to Present

Miss California Organization

June 2014 to Present

Torrance Southbay YMCA Board Member

2015 to May 2016

Torrance Del Amo Rotary Member

2016 to 2016

TAB 4
Consumer Input

Diabetes Alert Day Is March 27

Today, March 27, join the National HCH Council in recognizing Diabetes Alert Day. Diabetes affects over 30 million Americans, and nearly 1 in 4 adults with diabetes are unaware that they have the disease.
People experiencing homelessness face multiple **challenges in managing chronic illnesses such as diabetes. Inadequate access to refrigeration for medication storage and a lack of proper nutrition are some of the obstacles that people without homes encounter when trying to control their diabetes.**

Health Center Site Visits and HRSA's Diabetes Quality Improvement Initiative
As a part of the HRSA Health Center Program Diabetes Quality Improvement Initiative and consistent with the Site Visit Protocol, operational site visits in 2018 will include a review of the Uniform Data System (UDS) diabetes measure and action planning using root cause analysis. Health centers will identify three actions to improve or sustain their performance on the measure and input the action plan in the HRSA Electronic Handbooks (EHBs). Subsequent to the site visit, Project Officers will monitor health centers' progress in implementing their action plans. Make sure your health center registers for Action Plan privileges in the EHBs.

American Diabetes Association® Releases "Economic Costs of Diabetes in the U.S." Report at Annual Call to Congress Event Urging Legislators to Make Diabetes a National Priority

Diabetes is the Most Expensive Condition in the U.S. at $327 Billion in 2017; One of Every Four Health Care Dollars Incurred by Individuals with Diabetes

Today, the American Diabetes Association (ADA) released its new "Economics of Diabetes in the U.S. in 2017" (Economic Costs of Diabetes) report, detailing the fiscal impact of diabetes on American citizens individually and on the nation as a whole. Diabetes is now the most costly chronic illness in the country, with diagnosed diabetes expenses in the U.S. totaling $327 billion in 2017. **The data indicate one of every four health care dollars is incurred by someone with diagnosed diabetes, and one of every seven health care dollars is spent directly treating diabetes and its complications.** The Economic Costs of Diabetes report's release kicked off the ADA's annual Call to Congress advocacy event, with including more than 150 diabetes advocates, researcher and professional football players who held 179 meetings with members of Congress and staff urging them to make diabetes a national priority.
ADA's Chief Scientific, Medical and Mission Officer William T. Cefalu, MD, presented the key findings of the Economic Costs of Diabetes report at a press conference on Capitol Hill this morning.
Most notably, the report revealed that the economic costs of diabetes increased 26 percent from 2012 to 2017, due to both the increased prevalence of the disease and the increased cost per person living with diabetes. These costs include $237 billion in direct medical costs for diagnosed diabetes and $90 billion in reduced productivity. The largest contributors to the cost of diabetes are higher use of prescription medications beyond diabetes medications ($71.2 billion); higher use of hospital inpatient services ($69.7 billion); medications (oral agents and insulin) and supplies to directly treat diabetes ($34.6 billion), and more office visits to physicians and other health providers ($30 billion). **These costs are passed on to all Americans in the form of higher medical costs, higher insurance premiums and taxes, reduced earnings, lost productivity, premature mortality, and intangible costs in the form of reduced quality of life.**
"From our new economics report, it is very clear that diabetes bears a significant impact on our nation, both in its toll on the lives of the millions affected by it, and the economic costs for all," said Dr. Cefalu. "$327 billion in annual costs for diabetes are a substantial burden on our society! Together with advocates from around the country, we met with leaders on Capitol Hill today to urge Congress to make diabetes a national priority. The most important solution we have is continued and increased investment in critical diabetes research, care and prevention to improve diagnosis and treatment, and to help us turn the tide through diabetes prevention. These efforts can help us to improve health outcomes for people with diabetes – and hopefully decrease the cost of diabetes."

http://www.diabetes.org/newsroom/press-releases/2018/economic-cost-study-call-to-congress-2018.html

Readmission Reduction Strategy: Medical Respite Care for Homeless/Housing Insecure Individuals

Sutter Health & Samaritan House: Safe Harbor Shelter

Barbara Williams, MSW - Program Manager-PFS PCOC, Peninsula Family Service
Kat Barrientos, Health Care Case Manager, Safe Harbor-Samaritan House
Yvonne Chan, RN, MSN - Program Manager-PCOC, Mills Peninsula Medical Center

Sutter Health | Peninsula Family Service | Samaritan House | Peninsula Circle of Care

Objectives

1. Understand how a collaboration forged a respite care model to address the unique needs of the homeless/housing insecure patient population post hospitalization.

2. Describe the systems that have been created to deliver a seamless transition between the shelter and the hospital at discharge.

3. Demonstrate how coordinated efforts and supports provided between two hospitals and a shelter can keep clients out of the hospital.

What is Medical Respite?

"Medical respite care is acute and post-acute medical care for homeless persons who are too ill or frail to recover from a physical illness or injury on the streets but are not ill enough to be in a hospital." National Healthcare for the Homeless Council

What Medical Respite Programs Typically Provide

- ✓ Short-term residential care
- ✓ On-site medical and behavioral health services
- ✓ Linkage to regular primary care & mental health/substance abuse services
- ✓ Assistance with benefits, case management and housing

Background

Challenge for Sutter Health hospitals and the homeless patient population

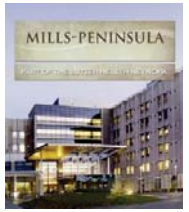
- Napa, San Mateo & Solano Counties are the three counties in SF Bay Area that did not have Medical Respite Programs - 2015 Medical Respite Program Directory. National Health Care for Homeless Council, Inc., 2015.
- Bay Area housing crises
- Limited Skilled Nursing Facilities willing to accept patients with Medi-Cal/Medicaid or NO coverage
- Homeless patients may not meet Skilled Nursing Facility level of care, but need Home Health care follow up at a safe location

SAMARITAN HOUSE

Sutter Health

Partnership Formation: Context

- Sutter Health
  - Mills-Peninsula Medical Center
  - California Pacific Medical Center
- Samaritan House
  - Safe Harbor Shelter
- Peninsula Circle of Care
  - Peninsula Family Service



SAMARITAN HOUSE

Sutter Health

Dashboard

Metrics

February 1, 2017 through January 31, 2018

Total # of Clients Enrolled	40	
# of Female	6	15%
# of Male	34	85%
Age Range		
61 and under	29	72%
62 and over	11	27%
# of Mills Peninsula Medical Center clients	15	37%
# of California Pacific Medical Center clients	25	63%
Exited Program to		
Self-exited/other disposition	6	15%
Housed	4	10%
Shelter Bed	11	27%
Hospital Readmitted	5	12%
No Call/No show (didn't come back)	10	25%
Currently in Program	4	10%
Average Length of Stay (LOS)	5 weeks	

SAMARITAN HOUSE

Sutter Health

Preparing to Launch: Contractual Context

- Develop Formal Contract
- Business Associate Agreement (BAA)
- Negotiate Rates
- Involved the Office of General Counsel
- Writing of program policy and overview

SAMARITAN HOUSE

Sutter Health

Preparing to Launch

On Site Visits to Shelter

- Leadership/ Hospital Disciplines Tour of Safe Harbor Shelter reviewing:
  - Wheelchair / Walker Access
  - Self-Care Needs
  - Environment & Space

Inpatient In-Services

- Meetings between hospital staff/ Case Management leadership and Safe Harbor Health Care Case Manager to review:
  - Acceptance Criteria
  - Referral Process

Partner Relationships

* Larger text size indicates greater involvement in ongoing care while in the program.

Patient Benefits of Medical Respite

- Medical Respite – med supervision, clinic room for home health
- Transitional housing support if client is interested
- 1 medically appropriate hot meal daily
- Able to accept those using oxygen, cPap, wound vac, and/or wheelchair.
- Needs to self-administer Insulin (available refrigeration for storage)
- Transportation vouchers to medical appointments, as appropriate
- Intensive health care case management with non-licensed staff
- Access to Home Health providers

Program Launched

- February 2017
- Communication and Care Planning – Weekly IDT meetings
  - Electronic Health Record for documentation of care plan/progress
- Regular communication between hospital staff and shelter Health Care Case Manager
- Addressing issues as they present themselves
  - Firsts for everyone: providing Home Health services in a Shelter
  - Scheduling follow up medical appointments prior to hospital discharge
  - Providing 1 month medication supply at time of discharge
- Ongoing improvement of workflow

Keys to Our Success

- Communication and teamwork across all disciplines
  - Inpatient case management staff & managers
  - Home Health staff
  - Shelter staff
  - PCOC involvement for support
- Transportation vouchers available for travel to/from medical appointments
- Address issues as they come up

Sutter Health

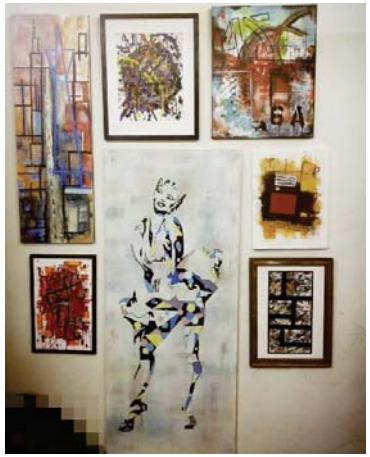
Client Success Story

- Client admitted to hospital, liver disease and near death
- Entered Medical Respite program, stayed clean an sober
- Managed his medications
- Applied for & received State Disability Income (SDI) and saved his monthly award payment
- After Medical Respite stay, transitioned to an emergency bed and then to a transitional bed
- A few months later secured a job and a non-subsidized apartment in San Mateo Co during his stay at the shelter.

Sutter Health

Client Success Story

- An artist
- Comfortable staying in a shelter for the first time
- After Medical Respite stay, he transitioned to an emergency bed
- Stabilized medically and continued to focus on his artworks
- May be featured in upcoming Samaritan House event, featuring an exhibit of his artworks



In Pictures @ Safe Harbor

Safe Harbor Shelter

Location of Medical Respite Program

Actual Shelter Bed

An example of where the clients reside

Day Room

Where clients spend their day and have their meals

Ongoing Evaluation

- How hospitals have benefited from the Medical Respite design
- Why your organization might want to consider building a Medical Respite Program

Contacts:

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Yvonne Chan, Mills Peninsula Medical Center
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TAB 5
QI Report

COUNTY OF SAN MATEO
HEALTH SYSTEM

San Mateo Medical Center
222 W. 39th Avenue
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DATE: April 12, 2018

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

FROM: Frank Trinh, Medical Director HCH/FH Program

SUBJECT: QI COMMITTEE REPORT

The San Mateo County HCH/FH Program QI Committee met in March 2018.

The QI Committee is preparing to implement the Patient Satisfaction Survey in the Summer of 2018. In anticipation for this, the Medical, Dental, Behavioral Health, and Enabling Services Patient Satisfaction Survey forms were reviewed and edited.

The QI Committee is collecting the Primary Care referral lists from Enabling Services agencies contracted with the HCH/FH Program. The Committee has received referral lists from 2 agencies, with the responses from the other agencies pending.

Regarding the Medical Outcome Measures, initial Hypertension control data was reviewed. The initial data is attached to this report. The QI Committee will be further evaluating the Hypertension data at the next Committee meeting in May 2018.

Attached:
Hypertension QI Data Report

Medical Outcome Measure Data Report for Calendar Year 2017: Hypertension

San Mateo County HCH/FH Program QI Committee

March 22, 2018

	# Dx of Hypertension	# Hypertension Controlled	% Hypertension Controlled	# No BP Measured	% No BP Measured
Total Population	1541	981	63.7	87	5.6
Male	861	533	61.9	59	6.9
Female	680	448	65.9	28	4.1
Total Homeless	1442	918	63.7	83	5.8
Doubling Up	766	511	66.7	25	3.3
Shelter	146	77	52.7	19	13.0
Transitional	78	43	55.1	5	6.4
Other	324	221	68.2	19	5.9
Street	128	66	51.6	15	11.7
Homeless Male	818	503	61.5	57	7.0
Homeless Female	624	415	66.5	26	4.2
Total Farmworker	114	68	59.6	6	5.3
Migrant	16	6	37.5	4	25.0
Seasonal	98	62	63.3	2	2.0
Farmworker Male	56	34	60.7	4	7.1
Farmworker Female	58	34	58.6	2	3.4

TAB 6
Director's Report

COUNTY OF SAN MATEO
HEALTH SYSTEM

San Mateo Medical Center
222 W. 39th Avenue
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www.sanmateomedicalcenter.org
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DATE: April 12, 2018

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 CALENDAR

Program activity update since the March 08, 2018 Co-Applicant Board meeting:

1. UDS

Program submitted a final complete UDS on March 09, 2018. This included responses to all of the questions/issues raised by our UDS reviewer. On March 15th we received notice from our reviewer that our UDS had been fully accepted and no further action on our part would be necessary. There is an update on the final report elsewhere on today's agenda.

2. AIMS

Program continues to work with BHRS on the design of a project to address the AIMS funding opportunity. We hope to be able to complete the process and have a final agreement to the Board soon.

3. Quality Award

On March 20th, HRSA announced that they were formally awarding Certificates of Achievement as recognition to the 2017 National Quality Leaders and Health Center Quality Leaders. National Quality Leaders exceed national clinical quality benchmarks, Healthy People 2020 goals, and other critical thresholds above the health center national average in specific categories. Health Center Quality Leaders are among the top 30% of all HRSA-supported health centers that achieved the best overall clinical outcomes, demonstrating high-quality across their clinical operations.

The San Mateo County HCH/FH Program received recognition as a Health Center Quality Leader. This represents our average ranking in the utilized clinical quality measures placed us among the top 30% of all HRSA-supported Health Centers. We have also received a seal that we can display representing this recognition.

San Mateo Medical Center
A County System of Healthcare

4. Staffing

Program has been working with County HR on getting the new staff positions filled. The positions should be announced today, if they haven't already been posted. Based on the agreed upon recruitment strategy, applicants will send their resumes and responses to supplemental question directly to us, and we will screen and bring in for an interview the best applicants. We can make a selection to hire at any point in the process that we believe we have found a candidate worth hiring.

5. Health Plan of San Mateo Respite/Recuperative Care Initiative

Program was informed of an initiative from the HPSM on respite/recuperative care. We met with their staff on March 21st and look forward to working cooperatively with HPSM on this effort.

6. Automation

On March 15th, the Homeless and Farmworker information collected during clinic visit registration began being ported to and displayed in eCW. This is a great culmination of our DISHII grant efforts and something program has been working for over numerous years. This now will display the homeless and farmworker information to the clinical provider at the time of the clinic visit, ensuring that the provider can take this information into consideration for the care and treatment of our clients/patients.

7. Seven Day Update

ATTACHED:

- Program Calendar

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

2018 Calendar (*Revised April 2018*)

EVENT	DATE	NOTES
· Board Meeting (April 12, 2018 from 9:00 a.m. to 11:00 a.m.) · Provider Collaborative meeting · TA visit by consultant	April	@San Mateo Medical Center
· Board Meeting (May 10, 2018 from 9:00 a.m. to 11:00 a.m.) · National Health Care for Homeless Conference, Minneapolis, MN (May 15-18) · QI Committee meeting	May	@San Mateo Medical Center
· Board Meeting (June 14, 2018 from 9:00 a.m. to 11:00 a.m.)	June	@San Mateo Medical Center
· Board Meeting (July 12, 2018 from 9:00 a.m. to 11:00 a.m.) · Site visit with HRSA July 24-26th · QI Committee meeting · Provider Collaborative meeting	July	@San Mateo Medical Center
· Board Meeting (August 9, 2018 from 9:00 a.m. to 11:00 a.m.) · Patient Satisfaction Surveys administered	August	@San Mateo Medical Center
· Board Meeting (September 13, 2018 from 9:00 a.m. to 11:00 a.m.) · QI Committee meeting	September	@San Mateo Medical Center

BOARD ANNUAL CALENDAR	
Project	**Deadline**
UDS submission- Review	April
SMMC annual audit- approve	April/May
Forms 5A and 5B -Review	June/July
Strategic Plan/Tactical Plan-Review	June/July
Budget renewal-Approve	August/sept- Dec/Jan
BPR/SAC-Approve	August
Annual conflict of interest statement - members sign (also on appointment)	October
Annual QI Plan-Approve	Winter
Board Chair/Vice Chair Elections	Winter
Board review annual HR report on OLCPs	WInter
Program Director annual review	Fall /Spring
Sliding Fee Scale (FPL)- review/approve	Spring

TAB 7
Budget &
Finance Report

COUNTY OF SAN MATEO
HEALTH SYSTEM

San Mateo Medical Center
222 W. 39th Avenue
San Mateo, CA 94403
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DATE: April 12, 2018

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

Preliminary grant expenditures through March, 2018, total $471,727. This will increase a little as the County processes month-end transactions, but we have included known contractual expenditures (even if they are not yet reflected as an expenditure by the county), and an estimate of routine county monthly charges.

As we progress farther into the grant year, we are able to make better annual estimates for some of the expenditure categories. Currently, our contracts and MOUs appear to be expending at a rate to reach the mid-to-high 90% utilization. This puts us on track to spend much closer to our total approved grant then we have been able to in the past few years.

Attachment:

- Preliminary GY 2018 Summary Report

GRANT YEAR 2018

Details for budget estimates	Budget [SF-424]	To Date (03/31/18)	Projection for GY (+~44 wks)	Projected for GY 2019
Salaries				
Director				
Program Coordinator				
Medical Director				
Management Analyst				
new position, misc. OT, other, etc.				
	540,000	103,245	540,000	590,000
Benefits				
Director				
Program Coordinator				
Medical Director				
Management Analyst				
new position, misc. OT, other, etc.				
	200,000	43,441	200,000	250,000
Travel				
National Conferences (1500*4)			22,354	20,000
Regional Conferences (1000*5)		1,157	10,000	5,000
Local Travel			1,500	2,000
Taxis		901	7,500	5,000
Van & vehicle usage		1,037	1,000	1,000
	25,000	3,095	42,354	33,000
Supplies				
Office Supplies, misc.	10,500	191	2,500	12,500
Small Funding Requests		25,370	50,000	50,000
	10,500	25,561	52,500	62,500
Contractual				
2016 Contracts		34,825	34,825	
2016 MOUs		14,900	14,900	
Current 2017 contracts	967,030	234,636	950,000	900,000
Current 2017 MOUs	872,000	10,800	850,000	850,000
---unallocated---/other contracts	118,073			
	1,957,103	295,161	1,849,725	1,750,000
Other				
Consultants/grant writer	31,667		30,000	45,000
IT/Telcom	5,928	967	6,000	6,000
New Automation			0	-
Memberships	4,000		4,000	4,000
Training			3,250	4,000
Misc (food, etc.)	5,500	257	5,500	5,500
	47,095	1,224	48,750	64,500
TOTALS - Base Grant	2,779,698	471,727	2,733,329	2,750,000
HCH/FH PROGRAM TOTAL	2,779,698	471,727	2,733,329	2,750,000
PROJECTED AVAILABLE	BASE GRANT		46,369	4

based on est. grant of $2,750,004

TAB 8
Small Funding Request Report

COUNTY OF SAN MATEO
HEALTH SYSTEM

San Mateo Medical Center
222 W. 39th Avenue
San Mateo, CA 94403
650-573-2222 T
www.sanmateomedicalcenter.org
www.facebook.com/smchealth

DATE: April 12, 2018

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

FROM: Elli Lo, Management Analyst and Jim Beaumont, Director HCH/FH Program

SUBJECT: SMALL FUNDING REQUEST BI-ANNUAL REPORT

In accordance with the HCH/FH Program Policy on Small Funding Requests, Program shall provide the Board a summary of the status of the small funding requests from the prior 6-12 months. Small funding requests targeted at one-time small scale projects that that would benefit the health of the homeless and/or farmworker population, or otherwise improve their health status or reduce future health risks. In 2017, Program received a total $56,624 worth of requests from five agencies, approved a total of $40,435 worth of requests for all agencies, and successfully reimbursed a total of $33,632 on Small Funding Requests.

Below is a summary of the approved requests and reports:

Agency	Amount Reimbursed	Purpose	Report
Mental Health Association	$ 2,217	For Homeless individuals in Shelter/Transitional Housing, equipment for RN, medical /dental supplies	• 41 out of 100 Health Care Kits distributed 11/6/17 through 1/25/18 at Spring Street Shelter and MHA's Transitional Housing Program
Ravenswood Family Health Center	$ 1,446	To support the nutritional health and personal hygiene of our HCH patients, as well as create a comfortable rest area for homeless patients waiting to see Tayischa.	• Between 12/2017 to 2/2018, items were distributed to 54% shelter homeless and 46% street homeless
LifeMoves	$ 4,598	Shelter operations items - safety, hygiene, emergency, summer camp	• 75 total unduplicated street homeless individuals received health & hygiene kits (68 existing clients, 7 new clients) • 20 smoking cessation kits were provided • As of February 9, 2018, two clients successfully quit smoking
Puente de la Costa Sur	$ 7,987	Essential items for farmworkers during winter months	• 189 total unduplicated individuals received items; 87% were farmworkers; 23% were new clients • Distributed items at the annual Posada Comunitaria and Zumba classes in Pescadero

Agency	Amount Reimbursed	Purpose	Report
Project WeHOPE	$ 7,383	Homeless clients - Winter Protection and Hygiene	• 107 total unduplicated individuals received items • Distributed via Dignity on Wheels truck to street homeless dwelling in automobiles & RV's and homeless in Project WeHOPE Shelter, East Palo Alto, Redwood City and Half Moon Bay
Total	**$33,632**		

Attached full reports from -

- LifeMoves
- Mental Health Association

HCH Small Funds Grant Report
Supply Distribution
February 9, 2018

In November 2017, Health Care for the Homeless (HCH) awarded LifeMoves a generous grant to purchase supplies to provide to homeless individuals in San Mateo County. On behalf of the homeless individuals and families LifeMoves serves, please accept our sincere appreciation for this generous contribution. LifeMoves is pleased to provide this report on the program's activities and achievements during the grant period.

The LifeMoves team organized all supplies received through this grant opportunity into individual health and hygiene kits. The LifeMoves HCH team distributed these kits to unsheltered homeless individuals in San Mateo County. LifeMoves expected to distribute the kits to 80 unsheltered homeless individuals.

Outcomes: LifeMoves HCH team distributed kits to 75 unduplicated, unsheltered homeless individuals in San Mateo County. We are pleased to share that 68 of the clients were known to LifeMoves and seven clients were not previously known to LifeMoves outreach staff. This was a wonderful opportunity to make contact with new, unsheltered individuals and to engage with these clients to connect individuals to health-related services and provide case management.

The individual health and hygiene kits were a huge success with clients. Not only did LifeMoves have the opportunity to engage new, unsheltered homeless clients, we also learned more about client preferences. November, December and January were cold months this year. For example, the average high temperature along the coast (in Half Moon Bay) was 59 degrees in December. With temperatures in the low 40's at night, people need warm clothes. The type of socks we provided to homeless clients through this grant opportunity were thermal winter socks. The thermal socks are specifically designed to keep feet dry and warm during the winter with double layer insulation, a fully cushioned foot-bed and thick fabric construction. The socks were also anti-microbial and anti-fungal to help prevent bacteria that can lead to infection. Clients greatly appreciated these socks and many clients told outreach staff that they prefer this type of sock in the winter. We plan to incorporate this feedback into future supply orders next winter. Clients also appreciated the paper shower towelettes, the rain ponchos to stay dry, and the hot packs to stay warm.

HCH Small Funds Grant Report
Smoking Cessation
February 9, 2018

LifeMoves hosted a smoking cessation workshop in November. Smoking cessation supplies were provided to the LifeMoves HCH and HOT teams and LifeMoves shelter staff. Also provided to staff were Breathe California of the Bay Area brochures that include tips on how to quit smoking. All 20 Habitrol kits (step one, step two, and step three) purchased through this grant opportunity were distributed to LifeMoves outreach staff.

The LifeMoves HCH team provide smoking cessation kits to unsheltered homeless individuals in San Mateo County. Smoking cessation kits are also available to clients residing in LifeMoves shelters, when necessary. Clients are surveyed when they receive the smoking cessation kit and they are surveyed three months later, when possible.

Outcome: With this grant funding, 20 smoking cessation kits were provided to clients. Each kit included Habitrol step one, Habitrol step two, and Habitrol step three. To date, two clients successfully quit smoking through this funding initiative. Homeless individuals can often be reluctant to quit smoking. We will continue to work with clients to encourage smoke-free living.

Mental Health Association of San Mateo County
Spring Street Shelter
2686 Spring Street
Redwood City, CA 94063

Health Care for the Homeless/Farmworker Program

Report February 5, 2018
Funds received: $2,217.49

Purpose: Health Care Kits for homeless individuals at Spring Street Shelter and MHA's Transitional Housing Program. Health Care Kits included a first aid kit, hand sanitizer, medication organization set, toothbrush, toothpaste, sunscreen and other essential needs. Funds were used to purchase the supplies. We then organized those supplies into basic all-inclusive kits and distributed those kits to all the individuals living in our shelter and all subsequent new residents we received starting 11/6/2017.

Individuals Served: 41 Health Care Kits distributed 11/6/17 through 1/25/18. We retain 59 kits for future distribution that should be fully distributed by summer 2018.

Narrative:
The Spring Street Shelter's objectives for our emergency shelter program include securing safe stable housing for all our residents, helping to manage symptoms and behaviors for individuals with serious mental illness, and improving the lives and well-being for those individuals by addressing health needs including assistance around health care benefits, and assistance with issues around income and entitlement payments. The inclusion of adding Health Care Kits to our already provided services has helped significantly in addressing our residents' health needs. Many of our shelter and transitional housing residents come to Spring Street directly from weeks, months and often years living on the streets, in cars or in other shelters. Much of that time has seen them neglect many of their basic needs, hygiene, healthy diet, and basic first aid for minor problems that can result in major issues.

We have ensured, through the Health Care Kits that all our residents have access to basic hygiene products (toothpaste and toothbrush, hand sanitizer, sun screen) which they may have neglected during their time on the street. Couple that with healthy meals already provided here at Spring Street and residents can achieve a level of healthy stability they sorely have lacked.

We have also issued our residents first aid kits. The kits include bandages of various sizes, medications, scissors, emergency blankets, burn relief, and vinyl gloves among other essentials. The kit comes with instructions for use and our Staff here of shelter workers and our nursing team is available for questions and advice on use of the items in the kit. The First Aid portion of the Health Care Kit is particularly helpful for our residents. If they can safely care for a wound, cut, scrape or burn on their own, it may save them from a minor injury exacerbating into a more serious infection, which may require a higher level of medical intervention in an emergency room or hospital.

We have also included medication organization sets in our Health Care Kits. Many of our residents take multiple medications, both for treatment of their mental illness as well as long or short term medical issues. These sets allow individuals to organize their medications and not miss certain pills or overdo others.

Finally, we have also added 8 ice packs for distribution on an as needed basis for individuals with a swelling injury. To date we have issued 2 of the 8.

TAB 9
UDS Final Submission

COUNTY OF SAN MATEO
HEALTH SYSTEM

San Mateo Medical Center
222 W. 39th Avenue
San Mateo, CA 94403
650-573-2222 T
www.sanmateomedicalcenter.org
www.facebook.com/smchealth

DATE: April 12, 2018

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

FROM: Linda Nguyen, Program Coordinator and Elli Lo, Management Analyst

SUBJECT: UDS FINAL SUBMISSION

Program staff submitted the final Uniform Data System (UDS) report on March 9, 2018. The UDS is a standard data set that is reported annually and provides consistent information about health centers. It includes patient demographics, services provided, clinical processes and results, patients' use of services, costs, and revenues that document how San Mateo Health System as well as HCH/FH contractors perform. Over the years there have been fluctuations in both the homeless and farmworker populations. The criteria for the clinical outcome measures have also changed significantly; this is reflected in the UDS trend charts showing data on eight years of UDS reporting (2010-2017).

Demographics

The shelter population has generally decreased over the years, however, the shelter population had a 39% increase from 1,071 in 2016 to 1,489 in 2017. The street homeless count has a steady increase over the years. The street count increase by 58% from 451 in 2015 to 643 in 2016, and stabilized with a 2% increase to 657 in 2017. This increase may be due to the efforts of the new Street Medicine program that started in January 2016. The other homeless population has been fluctuating over the years and there was a 43% decline from 1,459 in 2016 to 835 in 2017. The doubling up population saw a large spike in 2013, due to a significant increase in the senior clinic (Ron Robinson). There has been an increase from 1,103 in 2016 to 1,601 in 2017. Staff has been working to resolve the doubling up and other homeless data over the years as well as conducting more training to SMMC registration staff.

The farmworker population saw a plateau in 2014 with a steady decrease in following reporting years. There was a 22% decline from 1,497 in 2016 to 1,162 in 2017. This may be due to California's seasonal drought, with loss of employment as well as the challenging political climate.

There was a huge drop of 0 to 19 years old individuals last year, from 1,714 in 2016 to 948 in 2017. For farmworker, there was a 38% decline from 765 in 2016 to 477 in 2017. For homeless, there was a 49% decline from 951 in 2016 to 483 in 2017.

Clinical

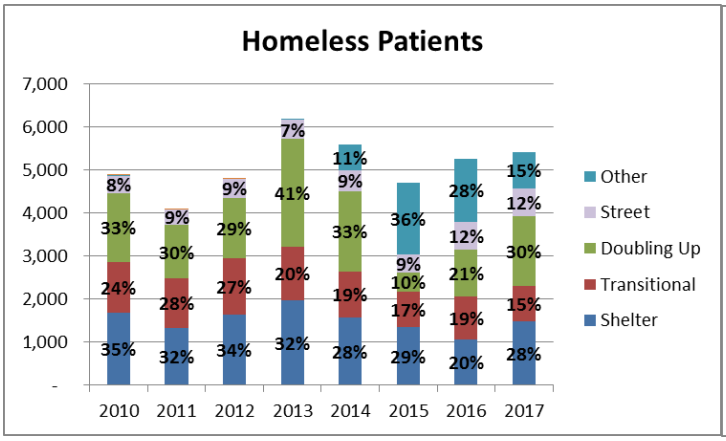
The results from most of the clinical outcome measures have improved from last year, about 9 (out of 14 on table) outcome measures saw an improvement. 2015 was the first year program staff was able to obtain universal reports for some UDS clinical measures by working with our Business Intelligence staff, prior to this program staff had conducted 70 chart reviews for all clinical measures. The use of universal reports can bring about challenges in the accuracy of the results, because validating all the results may be difficult. 2016 UDS measurement year saw a significant change in reporting requirements for clinical outcome measures. In attempt to reduce reporting burden, clinical measures were revised to align with CMS clinical quality measures; because of this visit count criteria went from two to one visit to be counted in the reporting year (denominator).

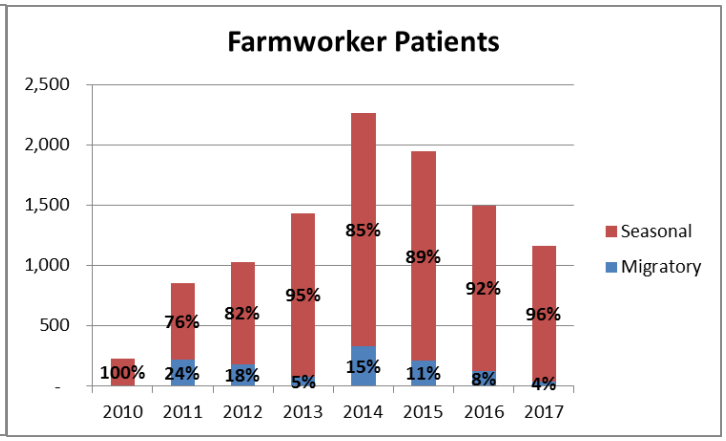
Financial

In 2017, a total of 49 FTEs conducted 39,130 clinic visits for 6,482 unduplicated patients. Patients access multiple services, such as medical (5,734 patients), dental (1,197 patients), mental health (416 patients), podiatry (247 patients), vision (633 patients), enabling (1,311 patients) and supportive services. The total cost of all services provided for homeless and farmworker individuals under HCH/FH is $17,294,055. This is a 12% increase from $15.4 million cost in 2016. For revenue, $5.4 million were patient revenue, including Medicaid and Medicare reimbursement, $1.8 million from HRSA health care for homeless and migrant health center 330 grant, and $10 million from County (ACE) support.

San Mateo Medical Center
A County System of Healthcare

COUNTY OF SAN MATEO CALIFORNIA





ATTACHED:

- Trend chart for 8 years (2010-2017)
- Detailed breakdown of population
- Financial Summary – Staffing, Cost & Revenue
- UDS FINAL SUBMISSION

UDS Data	2010	2011	2012	2013	2014	2015	2016	2017
UNDUP PTS	5,110	4,897	5,779	7,516	7,707	6,556	6,696	**6,482**
• Homeless	4,883	4,109	4,803	6,171	5,596	4,714	5,257	**5,409**
• MSFW	227	837	1,031	1,435	2,265	1,947	1,497	**1,162**
VISITS	20,002	20,854	28,400	39,628	41,361	37,915	39,616	**39,130**
AGE RANGE								
• 0-19 YRS	17%	21%	24%	23%	27%	26%	26%	**15%**
• 20-64 YRS	79%	76%	72%	67%	62%	63%	70%	**76%**
• 65+ YRS	4%	3%	4%	10%	11%	11%	4%	**9%**
SEX								
• Male	58%	55%	52%	51%	52%	52%	50%	**56%**
• Female	42%	45%	48%	49%	48%	48%	50%	**44%**

Homeless Status

	2010	2011	2012	2013	2014	2015	2016	**2017**
Shelter	35%	32%	34%	32%	28%	29%	20%	**28%**
Transitional	24%	28%	27%	20%	19%	17%	19%	**15%**
Doubling Up	33%	30%	29%	41%	33%	10%	21%	**30%**
Street	8%	9%	9%	7%	9%	9%	12%	**12%**
Other	0%	0%	0%	0%	11%	36%	28%	**15%**
Unknown	0%	1%	0%	0%	0%	0%	0%	**0%**

Farmworker Status

	2010	2011	2012	2013	2014	2015	2016	**2017**
Migratory	0%	24%	18%	5%	15%	11%	8%	**4%**
Seasonal	100%	76%	82%	95%	85%	89%	92%	**96%**

UDS Outcome Measures (HCH/FH Program SAC Goals)	2010	2011	2012	2013	2014	2015	2016	2017
• Childhood IZs Completed by Age 2-3 (90%)	82%	72%	74%	87%	88%	86%	80%	**66%**
• Pap Test in Last 3 Years (70%)	64%	60%	86%	67%	57%	64%	60%	**63%**
• Child & Adolescent BMI & Counseling (85%)	N/A	70%	47%	83%	80%	74%	*57%	***59%**
• Adult BMI & Follow-up Plan (75%)	N/A	59%	31%	66%	44%	50%	29%	**43%**
• Tobacco Use Queried (96%)	N/A	74%	80%	96%	77%	* 92%	*86%	***78%**
• Tobacco Cessation Offered (96%)	N/A	97%	90%	90%				
• Treatment for Persistent Asthma (100%)	N/A	83%	88%	100%	100 %	100%	99%	***90%**
• Lipid Therapy in CAD Patients (96%)	N/A	N/A	96%	96%	90%	*80%	*74%	***81%**
• Aspirin Therapy in IVD Patients (96%)	N/A	N/A	99%	96%	98%	*89%	*84%	***86%**
• Colorectal Screening Performed (60%)	N/A	N/A	40%	54%	34%	*49%	*48%	***57%**
• Babies with Normal Birth Weight (95%) (all babies delivered)	93%	96%	87%	94%	99%	92%	97%	**98%**
• Hypertension Controlled <140/90 (80%)	59%	66%	60%	80%	64%	61%	*53%	***63%**
• Diabetes Controlled <9 HgbA1C (75%)	61%	73%	71%	74%	49%	*69%	*54%	***72%**
• First Trimester Prenatal Care (80%)	61%	73%	71%	75%	84%	89%	65%	**49%**

**universal reports were conducted- 2015 as first year; 2016 visit criteria changed- from 2 to 1 visits (denominator)*

UDS Outcome Measures	HCH/FH Program 2017 (SAC/BRP goal)	330-Progs CA 2016	Healthy People 2020 Goals
• Childhood Immunizations Complete by Age 2-3	66% (90% goal)	47.27%	80%
• Pap Test in Last 3 Years	63% (70% goal)	57.7%	93%
• Child & Adolescent BMI & Counseling	*59% (85% goal)	63.98%	57.7 (BMI)/15.2% for all patients
• Adult BMI & Follow-up Plan	43% (75% goal)	64.85%	53.6% (BMI)/31.8% (obese adults)
• Tobacco Use Queried	*78% (96% goal)	85.51%	69%
• Treatment for Persistent Asthma	*90% (100% goal)	89.02%	Diff measures
• Lipid Therapy in CAD Patients	*80% (96% goal)	75.65%	Diff measures
• Aspirin Therapy in Ischemic Heart Disease Patients	*86% (96% goal)	78.59%	Diff measures
• Colorectal Screening Performed	*57% (60% goal)	41.66%	Diff measures
• Babies with Normal Birth Weight (all babies)	98% (95% goal)	93.41%	92%
• Hypertension Controlled (<140/90)	*63% (80% goal)	63.95%	61%
• Diabetes Controlled (<9 HgbA1c)	*72% (75% goal)	67.06%	85%
• First Trimester Prenatal Care	49% (80% goal)	77.51%	78%

**universal reports were conducted- 2015 as first year*

Detailed breakdown of homeless & farmworker populations in UDS 2010-2017

Universal

	2010	2011	2012	2013	2014	2015	2016	2017
Male	2,948	2,671	3,031	3,796	3,997	3,421	3,378	3,621
Female	2,162	2,226	2,748	3,720	3,710	3,135	3,318	2,861
Total	**5,110**	**4,897**	**5,779**	**7,516**	**7,707**	**6,556**	**6,696**	**6,482**

Age	**2010**	**2011**	**2012**	**2013**	**2014**	**2015**	**2016**	**2017**
0-19	881	1,013	1,411	1,715	2,113	1,717	1,714	948
20-64	4,034	3,708	4,143	5,012	4,771	4,140	4,701	4,930
65+	195	176	225	789	823	699	281	604

Homeless

	2010	2011	2012	2013	2014	2015	2016	2017
Shelter	1,694	1,330	1,641	1,981	1,562	1,355	1,071	1,489
Transitional	1,171	1,148	1,305	1,228	1,083	814	981	827
Doubling Up	1,602	1,247	1,406	2,515	1,867	451	1,103	1,601
Street	402	356	447	436	488	408	643	657
Other	2	-	1	11	596	1,686	1,459	835
Unknown	12	28	3	-	-	-	-	-
Total	**4,883**	**4,109**	**4,803**	**6,171**	**5,596**	**4,714**	**5,257**	**5,409**

	2010	2011	2012	2013	2014	2015	2016	2017
Male	2,851	2,380	2,637	3,227	2,989	2,563	2,676	3,117
Female	2,032	1,729	2,166	2,944	2,607	2,151	2,581	2,292

Age	**2010**	**2011**	**2012**	**2013**	**2014**	**2015**	**2016**	**2017**
0-19	754	595	881	1,016	928	696	951	483
20-64	3,936	3,346	3,722	4,401	3,887	3,370	4,066	4,369
65+	193	168	200	754	781	648	240	557

Farmworker

	2010	2011	2012	2013	2014	2015	2016	2017
Migratory	-	220	183	77	329	213	127	42
Seasonal	227	637	848	1,358	1,936	1,734	1,370	1,120
Total	**227**	**857**	**1,031**	**1,435**	**2,265**	**1,947**	**1,497**	**1,162**

	2010	2011	2012	2013	2014	2015	2016	2017
Male	97	325	425	612	1,082	909	745	565
Female	130	512	606	823	1,183	1,038	752	597

Age	**2010**	**2011**	**2012**	**2013**	**2014**	**2015**	**2016**	**2017**
0-19	127	422	540	730	1,254	1,052	765	477
20-64	97	404	461	663	966	836	689	635
65+	3	11	30	42	45	59	43	50

San Mateo County Health Care for Homeless / Farmworker's Health Program
Staffing, Cost & Revenue
Source: 2017 UDS Final Submission

Staff/Visit/Patients

	FTE	Clinic Visits	Patients
Medical	17.30	28,169	5,734
Dental	1.90	3,966	1,197
Mental Health	2.10	2,069	416
Other Professional: Podiatry	0.20	470	247
Vision	0.40	921	633
Pharmacy	7.70		
Enabling Services	0.40	3,535	1,311
Facility & Non-Clinical Support			
Management & Support Staff	3.30		
Patient Support Staff	15.70		
Total	**49.00**	**39,130**	**9,538**

Financial Cost

Financial Cost	Accrued Cost
Medical	$ 7,328,133
Dental	$ 495,007
Mental Health	$ 839,634
Pharmacy + Pharmaceuticals	$ 615,655
Other Professional: Podiatry	$ 68,408
Vision	$ 108,034
Total Clinical	$ 9,454,871
Case Management	$ 568,961
Total Enabling	$ 568,961
Facility & Non-Clinical Support	$ 7,270,223
Total	**$ 17,294,055**

Revenue

Revenue	Amount collected
Patient Revenue	
Medicaid	$ 3,795,917
Medicare	$ 1,532,235
Other Public Non-Managed Care	$ 56,197
Private	$ 6,245
Self-Pay	$ 42,835
Total Patient Revenue	$ 5,433,429
Federal Grant	
HRSA 330 - Farmworker	$ 389,661
HRSA 330 - Homeless	$ 1,465,867
Total Federal Grant	$ 1,855,528
Non-Federal Grant	
Local (ACE)	$ 10,005,098
Total Non-Federal Grant	$ 10,005,098
Total Revenue	**$ 17,294,055**

BHCMIS ID: 091140 - SAN MATEO COUNTY HEALTH SERVICES AGENCY, San Mateo, CA

Date Requested: 03/16/2018 05:00 PM EST
Date of Last Report Refreshed: 03/16/2018 05:00 PM EST

Program Name: Health Center 330

Submission Status: Review In Progress

UDS Report - 2017

Center / Health Center Profile

Do you self-identify as an NMHC? No

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	Jim Beaumont	(650) 573-2459	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

BHCMIS ID: 091140 - SAN MATEO COUNTY HEALTH SERVICES AGENCY, San Mateo, CA

Date Requested: 03/16/2018 05:00 PM EST
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Submission Status: Review In Progress

UDS Report - 2017

Patients by ZIP Code

ZIP Code (a)	None/Uninsured (b)	Medicaid/CHIP/Other Public (c)	Medicare (d)	Private (e)	Total Patients (f)
94002	7	69	32	0	108
94005	170	51	1	0	222
94010	14	61	20	1	96
94014	33	79	28	1	141
94015	36	95	23	2	156
94018	2	12	2	0	16
94019	221	535	42	6	804
94020	17	12	1	0	30
94025	73	100	18	0	191
94030	7	25	18	0	50
94038	9	17	4	0	30
94044	18	48	13	0	79
94060	194	83	4	13	294
94061	64	144	32	0	240
94062	18	71	16	0	105
94063	277	414	74	5	770
94066	66	108	22	1	197
94070	7	28	9	1	45
94080	134	346	75	10	565
94303	293	622	37	9	961
94304	7	6	0	2	15
94401	239	464	63	5	771
94402	15	44	14	0	73
94403	63	136	42	3	244
94404	3	34	10	1	48

ZIP Code (a)	None/Uninsured (b)	Medicaid/CHIP/Other Public (c)	Medicare (d)	Private (e)	Total Patients (f)
95125	11	2	0	1	14
96060	11	6	0	0	17
Other ZIP Codes	56	111	30	3	200
Unknown Residence	0	0	0	0	0
Total	2065	3723	630	64	6482

BHCMIS ID: 091140 - SAN MATEO COUNTY HEALTH SERVICES AGENCY, San Mateo, CA

Date Requested: 03/16/2018 05:00 PM EST
Date of Last Report Refreshed: 03/16/2018 05:00 PM EST

Program Name: Health Center 330

Submission Status: Review In Progress

UDS Report - 2017

Table 3A: Patients By Age And By Sex Assigned At Birth - Universal

S.No	Age Groups	Male Patients (a)	Female Patients (b)
1.	Under Age 1	36	33
2.	Age 1	35	8
3.	Age 2	14	25
4.	Age 3	25	16
5.	Age 4	26	20
6.	Age 5	24	27
7.	Age 6	21	16
8.	Age 7	25	17
9.	Age 8	26	22
10.	Age 9	22	23
11.	Age 10	37	21
12.	Age 11	27	28
13.	Age 12	16	24
14.	Age 13	21	20
15.	Age 14	18	28
16.	Age 15	21	28
17.	Age 16	24	24
18.	Age 17	31	26
Subtotal Patients (Sum lines 1-18)		**449**	**406**
19.	Age 18	21	39
20.	Age 19	13	20
21.	Age 20	21	33
22.	Age 21	28	25
23.	Age 22	38	21
24.	Age 23	41	27
25.	Age 24	41	29
26.	Ages 25-29	295	184
27.	Ages 30-34	320	257
28.	Ages 35-39	333	245
29.	Ages 40-44	274	236
30.	Ages 45-49	312	269
31.	Ages 50-54	398	295

S.No	Age Groups	Male Patients (a)	Female Patients (b)
32.	Ages 55-59	466	285
33.	Ages 60-64	275	182
Subtotal Patients (Sum lines 19-33)		**2,876**	**2,147**

BHCMIS ID: 091140 - SAN MATEO COUNTY HEALTH SERVICES AGENCY, San Mateo, CA

Date Requested: 03/16/2018 05:00 PM EST
Date of Last Report Refreshed: 03/16/2018 05:00 PM EST

Program Name: Health Center 330

Submission Status: Review In Progress

UDS Report - 2017

Table 3A: Patients By Age And By Sex Assigned At Birth - Universal

S.No	Age Groups	Male Patients (a)	Female Patients (b)
34.	Ages 65-69	154	122
35.	Ages 70-74	65	78
36.	Ages 75-79	38	58
37.	Ages 80-84	26	27
38.	Age 85 and over	13	23
Subtotal Patients (Sum lines 34-38)		**296**	**308**
39.	**Total Patients (Sum lines 1-38)**	**3,621**	**2,861**

OMB Control Number: 0195-0193

BHCMIS ID: 091140 - SAN MATEO COUNTY HEALTH SERVICES AGENCY, San Mateo, CA

Date Requested: 03/16/2018 05:00 PM EST
Date of Last Report Refreshed: 03/16/2018 05:00 PM EST

Program Name: Health Center 330

Submission Status: Review In Progress

UDS Report - 2017

Table 3A: Patients By Age And By Sex Assigned At Birth - Migrant Health Center

S.No	Age Groups	Male Patients (a)	Female Patients (b)
1.	Under Age 1	14	16
2.	Age 1	13	4
3.	Age 2	4	10
4.	Age 3	9	9
5.	Age 4	13	9
6.	Age 5	13	13
7.	Age 6	17	6
8.	Age 7	16	9
9.	Age 8	12	8
10.	Age 9	14	12
11.	Age 10	20	8
12.	Age 11	18	16
13.	Age 12	9	16
14.	Age 13	16	10
15.	Age 14	9	18

S.No	Age Groups	Male Patients (a)	Female Patients (b)
16.	Age 15	11	14
17.	Age 16	14	8
18.	Age 17	18	11
Subtotal Patients (Sum lines 1-18)		**240**	**197**
19.	Age 18	8	21
20.	Age 19	2	9
21.	Age 20	4	11
22.	Age 21	7	10
23.	Age 22	2	4
24.	Age 23	6	2
25.	Age 24	6	4
26.	Ages 25-29	35	30
27.	Ages 30-34	27	49
28.	Ages 35-39	34	55
29.	Ages 40-44	47	61
30.	Ages 45-49	41	54
31.	Ages 50-54	23	34
32.	Ages 55-59	34	20
33.	Ages 60-64	20	15
Subtotal Patients (Sum lines 19-33)		**296**	**379**

UDS Report - 2017

Table 3A: Patients By Age And By Sex Assigned At Birth - Migrant Health Center

S.No	Age Groups	Male Patients (a)	Female Patients (b)
34.	Ages 65-69	13	8
35.	Ages 70-74	8	4
36.	Ages 75-79	5	4
37.	Ages 80-84	2	4
38.	Age 85 and over	1	1
Subtotal Patients (Sum lines 34-38)		**29**	**21**
39.	**Total Patients (Sum lines 1-38)**	**565**	**597**

UDS Report - 2017

Table 3A: Patients By Age And By Sex Assigned At Birth - Health Care For The Homeless

S.No	Age Groups	Male Patients (a)	Female Patients (b)
1.	Under Age 1	22	17
2.	Age 1	22	4
3.	Age 2	10	15
4.	Age 3	17	7
5.	Age 4	14	12
6.	Age 5	11	14
7.	Age 6	4	10
8.	Age 7	10	8
9.	Age 8	15	14
10.	Age 9	8	11
11.	Age 10	17	14
12.	Age 11	9	12
13.	Age 12	8	8
14.	Age 13	5	10
15.	Age 14	9	11
16.	Age 15	11	14
17.	Age 16	10	16
18.	Age 17	13	15
Subtotal Patients (Sum lines 1-18)		**215**	**212**
19.	Age 18	16	18
20.	Age 19	11	11
21.	Age 20	19	22
22.	Age 21	22	15
23.	Age 22	36	17
24.	Age 23	36	25
25.	Age 24	35	25
26.	Ages 25-29	271	156
27.	Ages 30-34	297	212
28.	Ages 35-39	304	193
29.	Ages 40-44	233	178
30.	Ages 45-49	274	220
31.	Ages 50-54	379	264
32.	Ages 55-59	442	269
33.	Ages 60-64	258	167
Subtotal Patients (Sum lines 19-33)		**2,633**	**1,792**

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Table 3A: Patients By Age And By Sex Assigned At Birth - Health Care For The Homeless

S.No	Age Groups	Male Patients (a)	Female Patients (b)

S.No	Age Groups	Male Patients (a)	Female Patients (b)
34.	Ages 65-69	141	115
35.	Ages 70-74	58	74
36.	Ages 75-79	34	54
37.	Ages 80-84	24	23
38.	Age 85 and over	12	22
Subtotal Patients (Sum lines 34-38)		**269**	**288**
39.	**Total Patients (Sum lines 1-38)**	**3,117**	**2,292**

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Table 3B - Demographic Characteristics - Universal

S.No	Patients by Race	Demographic Characteristics			
		Hispanic/Latino (a)	Non-Hispanic/Latino (b)	Unreported/Refused to Report Ethnicity (c)	Total (d)
1.	Asian	13	413		426
2a.	Native Hawaiian	3	6		9
2b.	Other Pacific Islander	8	163		171
2.	**Total Hawaiian/Other Pacific Islander (Sum lines 2a+2b)**	**11**	**169**		**180**
3.	Black/African American	26	610		636
4.	American Indian/Alaska native	57	32		89
5.	White	1,967	1,619		3,586
6.	More than one race	752	150		902
7.	Unreported/Refused to report race	214	321	128	663
8.	**Total Patients (Sum lines 1+2+3 through 7)**	**3,040**	**3,314**	**128**	**6,482**

S.No	Patients by Language	Number (a)
12.	Patients Best Served in a Language other than English	2,409

S.No	Patients by Sexual Orientation	Number (a)
13.	Lesbian or Gay	42
14.	Straight (not lesbian or gay)	2,456
15.	Bisexual	27
16.	Something else	7
17.	Don’t know	3,642
18.	Chose not to disclose	308
19.	**Total Patients (Sum Lines 13 to 18)**	**6,482**

S.No	Patients by Gender Identity	Number (a)
20.	Male	1,481
21.	Female	1,204

S.No	Patients by Gender Identity	Number (a)
22.	Transgender Male/ Female-to-Male	0
23.	Transgender Female/ Male-to-Female	4
24.	Other	3,593
25.	Chose not to disclose	200
26.	**Total Patients (Sum Lines 20 to 25)**	**6,482**

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Table 3B - Demographic Characteristics - Migrant Health Center

S.No	Patients by Race	Demographic Characteristics			
		Hispanic/Latino (a)	Non-Hispanic/Latino (b)	Unreported/Refused to Report Ethnicity (c)	Total (d)
1.	Asian	0	7		7
2a.	Native Hawaiian	0	0		0
2b.	Other Pacific Islander	1	3		4
2.	**Total Hawaiian/Other Pacific Islander (Sum lines 2a+2b)**	**1**	**3**		**4**
3.	Black/African American	1	11		12
4.	American Indian/Alaska native	5	1		6
5.	White	733	27		760
6.	More than one race	281	7		288
7.	Unreported/Refused to report race	67	2	16	85
8.	**Total Patients (Sum lines 1+2+3 through 7)**	**1,088**	**58**	**16**	**1,162**

S.No	Patients by Language	Number (a)
12.	Patients Best Served in a Language other than English	988

S.No	Patients by Sexual Orientation	Number (a)
13.	Lesbian or Gay	3
14.	Straight (not lesbian or gay)	450
15.	Bisexual	2
16.	Something else	0
17.	Don’t know	620
18.	Chose not to disclose	87
19.	**Total Patients (Sum Lines 13 to 18)**	**1,162**

S.No	Patients by Gender Identity	Number (a)
20.	Male	264
21.	Female	282
22.	Transgender Male/ Female-to-Male	0

S.No	Patients by Gender Identity	Number (a)
23.	Transgender Female/ Male-to-Female	0
24.	Other	565
25.	Chose not to disclose	51
26.	**Total Patients (Sum Lines 20 to 25)**	**1,162**

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Table 3B - Demographic Characteristics - Health Care For The Homeless

S.No	Patients by Race	Demographic Characteristics			
		Hispanic/Latino (a)	Non-Hispanic/Latino (b)	Unreported/Refused to Report Ethnicity (c)	Total (d)
1.	Asian	13	407		420
2a.	Native Hawaiian	3	6		9
2b.	Other Pacific Islander	7	160		167
2.	**Total Hawaiian/Other Pacific Islander (Sum lines 2a+2b)**	**10**	**166**		**176**
3.	Black/African American	25	603		628
4.	American Indian/Alaska native	52	31		83
5.	White	1,266	1,596		2,862
6.	More than one race	508	143		651
7.	Unreported/Refused to report race	150	319	120	589
8.	**Total Patients (Sum lines 1+2+3 through 7)**	**2,024**	**3,265**	**120**	**5,409**

S.No	Patients by Language	Number (a)
12.	Patients Best Served in a Language other than English	1,487

S.No	Patients by Sexual Orientation	Number (a)
13.	Lesbian or Gay	39
14.	Straight (not lesbian or gay)	2,044
15.	Bisexual	25
16.	Something else	7
17.	Don’t know	3,067
18.	Chose not to disclose	227
19.	**Total Patients (Sum Lines 13 to 18)**	**5,409**

S.No	Patients by Gender Identity	Number (a)
20.	Male	1,247
21.	Female	935
22.	Transgender Male/ Female-to-Male	0
23.	Transgender Female/ Male-to-Female	4
24.	Other	3,071

S.No	Patients by Gender Identity	Number (a)
25.	Chose not to disclose	152
26.	**Total Patients (Sum Lines 20 to 25)**	**5,409**

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Table 4 - Selected Patient Characteristics - Universal

S.No	Characteristic	Number of Patients (a)
Income as Percent of Poverty Guideline		
1.	100% and below	5,064
2.	101 - 150%	305
3.	151 - 200%	173
4.	Over 200%	72
5.	Unknown	868
6.	**Total (Sum lines 1-5)**	**6,482**

Principal Third Party Medical Insurance Source		0-17 Years Old (a)	18 and Older (b)
7.	None/Uninsured	98	1,967
8a.	Regular Medicaid (Title XIX)	752	2,971
8b.	CHIP Medicaid	0	0
8.	**Total Medicaid (Sum lines 8a+8b)**	**752**	**2,971**
9a.	Dually eligible (Medicare and Medicaid)	0	574
9.	Medicare (Inclusive of dually eligible and other Title XVIII beneficiaries)	0	630
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	5	59
12.	**Total (Sum lines 7+8+9+10+11)**	**855**	**5,627**

Managed Care Utilization

S.No	Payer Category	Medicaid (a)	Medicare (b)	Other Public Including Non-Medicaid CHIP (c)	Private (d)	Total (e)
13a.	Capitated Member months	20,967	0	0	0	20,967
13b.	Fee-for-service Member months	0	1,193	0	0	1,193
13c.	**Total Member Months (Sum lines 13a+13b)**	**20,967**	**1,193**	**0**	**0**	**22,160**

Managed Care Utilization

S.No	Payer Category	Medicaid (a)	Medicare (b)	Other Public Including Non-Medicaid CHIP (c)	Private (d)	Total (e)

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Table 4 - Selected Patient Characteristics - Universal

S.No	Special Populations	Number of Patients (a)
14.	Migratory (330g grantees only)	42
15.	Seasonal (330g grantees only)	1,120
16.	**Total Agricultural Workers or Dependents (All Health Centers Report This Line)**	**1,162**
17.	Homeless Shelter (330h grantees only)	1,489
18.	Transitional (330h grantees only)	827
19.	Doubling Up (330h grantees only)	1,601
20.	Street (330h grantees only)	657
21.	Other (330h grantees only)	835
22.	Unknown (330h grantees only)	0
23.	**Total Homeless (All Health Centers Report This Line)**	**5,409**
24.	**Total School Based Health Center Patients (All Health Centers Report This Line)**	**34**
25.	**Total Veterans (All Health Centers Report This Line)**	**103**
26.	**Total Patients Served at a Health Center Located In or Immediately Accessible to a Public Housing Site (All Health Centers Report This Line)**	**0**

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Table 4 - Selected Patient Characteristics - Migrant Health Center

S.No	Characteristic		Number of Patients (a)
Income as Percent of Poverty Guideline			
1.	100% and below		412
2.	101 - 150%		139
3.	151 - 200%		87
4.	Over 200%		13
5.	Unknown		511
6.	**Total (Sum lines 1-5)**		**1,162**
Principal Third Party Medical Insurance Source		**0-17 Years Old (a)**	**18 and Older (b)**
7.	None/Uninsured	18	426
8a.	Regular Medicaid (Title XIX)	416	252
8b.	CHIP Medicaid	0	0
8.	**Total Medicaid (Sum lines 8a+8b)**	**416**	**252**
9a.	Dually eligible (Medicare and Medicaid)	0	26
9.	Medicare (Inclusive of dually eligible and other Title XVIII beneficiaries)	0	30
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	3	17

S.No	Characteristic		Number of Patients (a)
12.	**Total (Sum lines 7+8+9+10+11)**	**437**	**725**

Managed Care Utilization

S.No	Payer 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)**					

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Table 4 - Selected Patient Characteristics - Migrant Health Center

S.No	Special Populations	Number of Patients (a)
14.	Migratory (330g grantees only)	42
15.	Seasonal (330g grantees only)	1,120
16.	**Total Agricultural Workers or Dependents (All Health Centers Report This Line)**	**1,162**
17.	Homeless Shelter (330h grantees only)	
18.	Transitional (330h grantees only)	
19.	Doubling Up (330h grantees only)	
20.	Street (330h grantees only)	
21.	Other (330h grantees only)	
22.	Unknown (330h grantees only)	
23.	**Total Homeless (All Health Centers Report This Line)**	**89**
24.	**Total School Based Health Center Patients (All Health Centers Report This Line)**	**4**
25.	**Total Veterans (All Health Centers Report This Line)**	**0**
26.	**Total Patients Served at a Health Center Located In or Immediately Accessible to a Public Housing Site (All Health Centers Report This Line)**	**0**

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

S.No	Characteristic	Number of Patients (a)
Income as Percent of Poverty Guideline		
1.	100% and below	4,737
2.	101 - 150%	167

S.No	Characteristic	Number of Patients (a)
3.	151 - 200%	89
4.	Over 200%	59
5.	Unknown	357
6.	**Total (Sum lines 1-5)**	**5,409**

Principal Third Party Medical Insurance Source		0-17 Years Old (a)	18 and Older (b)
7.	None/Uninsured	83	1,606
8a.	Regular Medicaid (Title XIX)	342	2,732
8b.	CHIP Medicaid	0	0
8.	**Total Medicaid (Sum lines 8a+8b)**	**342**	**2,732**
9a.	Dually eligible (Medicare and Medicaid)	0	549
9.	Medicare (Inclusive of dually eligible and other Title XVIII beneficiaries)	0	601
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	2	43
12.	**Total (Sum lines 7+8+9+10+11)**	**427**	**4,982**

Managed Care Utilization

S.No	Payer 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)**					

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

S.No	Special Populations	Number of Patients (a)
14.	Migratory (330g grantees only)	
15.	Seasonal (330g grantees only)	
16.	**Total Agricultural Workers or Dependents (All Health Centers Report This Line)**	**89**
17.	Homeless Shelter (330h grantees only)	1,489
18.	Transitional (330h grantees only)	827
19.	Doubling Up (330h grantees only)	1,601
20.	Street (330h grantees only)	657
21.	Other (330h grantees only)	835
22.	Unknown (330h grantees only)	0
23.	**Total Homeless (All Health Centers Report This Line)**	**5,409**

S.No	Special Populations	Number of Patients (a)
24.	**Total School Based Health Center Patients (All Health Centers Report This Line)**	**30**
25.	**Total Veterans (All Health Centers Report This Line)**	**103**
26.	**Total Patients Served at a Health Center Located In or Immediately Accessible to a Public Housing Site (All Health Centers Report This Line)**	**0**

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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	0.00	849	
2.	General Practitioners	1.00	2,188	
3.	Internists	2.20	4,839	
4.	Obstetrician/Gynecologists	0.30	739	
5.	Pediatricians	0.60	1,397	
7.	Other Specialty Physicians	2.00	4,395	
8.	**Total Physicians (Sum lines 1-7)**	**6.10**	**14,407**	
9a.	Nurse Practitioners	2.80	6,156	
9b.	Physician Assistants	0.10	637	
10.	Certified Nurse Midwives	0.00	35	
10a.	**Total NP, PA, and CNMs (Sum lines 9a - 10)**	**2.90**	**6,828**	
11.	Nurses	8.30	6,934	
12.	Other Medical Personnel	0.00		
13.	Laboratory Personnel	0.00		
14.	X-Ray Personnel	0.00		
15.	**Total Medical (Sum lines 8+10a through 14)**	**17.30**	**28,169**	**5,734**
Dental Services				
16.	Dentists	1.40	3,899	
17.	Dental Hygienists	0.00	67	
17a.	Dental Therapists	0.00	0	
18.	Other Dental Personnel	0.50		
19.	**Total Dental Services (Sum lines 16-18)**	**1.90**	**3,966**	**1,197**
Mental Health Services				
20a.	Psychiatrists	1.90	1,412	
20a1.	Licensed Clinical Psychologists	0.20	543	
20a2.	Licensed Clinical Social Workers	0.00	114	
20b.	Other Licensed Mental Health Providers	0.00	0	
20c.	Other Mental Health Staff	0.00	0	
20.	**Total Mental Health (Sum lines 20a-20c)**	**2.10**	**2,069**	**416**

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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	0.00	0	0
Other Professional Services				
22.	Other Professional Services (Specify: Podiatry)	0.20	470	247
Vision Services				
22a.	Ophthalmologists	0.10	259	
22b.	Optometrists	0.30	662	
22c.	Other Vision Care Staff	0.00		
22d.	**Total Vision Services (Sum lines 22a-22c)**	**0.40**	**921**	**633**
Pharmacy Personnel				
23.	Pharmacy Personnel	7.70		
Enabling Services				
24.	Case Managers	0.40	1,328	
25.	Patient/Community Education Specialists	0.00	2,207	
26.	Outreach Workers	0.00		
27.	Transportation Staff	0.00		
27a.	Eligibility Assistance Workers	0.00		
27b.	Interpretation Staff	0.00		
27c.	Community Health Workers	0.00		
28.	Other Enabling Services (Specify: -)	0.00		
29.	**Total Enabling Services (Sum lines 24-28)**	**0.40**	**3,535**	**1,311**

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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: -)	0.00		
29b.	Quality Improvement Staff	0.00		
Administration and Facility				
30a.	Management and Support Staff	3.30		

S.No	Personnel by Major Service Category	FTEs (a)	Clinic Visits (b)	Patients (c)
30b.	Fiscal and Billing Staff	0.00		
30c.	IT Staff	0.00		
31.	Facility Staff	0.00		
32.	Patient Support Staff	15.70		
33.	**Total Facility and Non-Clinical Support Staff (Lines 30a - 32)**	**19.00**		
Grand Total				
34.	**Grand Total (Lines 15+19+20+21+22+22d+23+29+29a+29b+33)**	**49.00**	**39,130**	

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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		0	
2.	General Practitioners		376	
3.	Internists		272	
4.	Obstetrician/Gynecologists		160	
5.	Pediatricians		959	
7.	Other Specialty Physicians		450	
8.	**Total Physicians (Sum lines 1-7)**		**2,217**	
9a.	Nurse Practitioners		1,029	
9b.	Physician Assistants		7	
10.	Certified Nurse Midwives		0	
10a.	**Total NP, PA, and CNMs (Sum lines 9a - 10)**		**1,036**	
11.	Nurses		581	
12.	Other Medical Personnel			
13.	Laboratory Personnel			
14.	X-Ray Personnel			
15.	**Total Medical (Sum lines 8+10a through 14)**		**3,834**	**949**
Dental Services				
16.	Dentists		1,025	
17.	Dental Hygienists		0	
17a.	Dental Therapists		0	
18.	Other Dental Personnel			
19.	**Total Dental Services (Sum lines 16-18)**		**1,025**	**319**
Mental Health Services				
20a.	Psychiatrists		2	
20a1.	Licensed Clinical Psychologists		0	

S.No	Personnel by Major Service Category	FTEs (a)	Clinic Visits (b)	Patients (c)
20a2.	Licensed Clinical Social Workers		0	
20b.	Other Licensed Mental Health Providers		0	
20c.	Other Mental Health Staff		0	
20.	**Total Mental Health (Sum lines 20a-20c)**		**2**	**2**

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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		0	0
Other Professional Services				
22.	Other Professional Services (Specify: Podiatry)		47	21
Vision Services				
22a.	Ophthalmologists		17	
22b.	Optometrists		9	
22c.	Other Vision Care Staff			
22d.	**Total Vision Services (Sum lines 22a-22c)**		**26**	**18**
Pharmacy Personnel				
23.	Pharmacy Personnel			
Enabling Services				
24.	Case Managers		111	
25.	Patient/Community Education Specialists		0	
26.	Outreach Workers			
27.	Transportation Staff			
27a.	Eligibility Assistance Workers			
27b.	Interpretation Staff			
27c.	Community Health Workers			
28.	Other Enabling Services (Specify: -)			
29.	**Total Enabling Services (Sum lines 24-28)**		**111**	**81**

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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: -)			
29b.	Quality Improvement Staff			
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 (Lines 15+19+20+21+22+22d+23+29+29a+29b+33)**		**5,045**	

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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)
Medical Care Services				
1.	Family Physicians		849	
2.	General Practitioners		1,828	
3.	Internists		4,607	
4.	Obstetrician/Gynecologists		585	
5.	Pediatricians		415	
7.	Other Specialty Physicians		3,975	
8.	**Total Physicians (Sum lines 1-7)**		**12,259**	
9a.	Nurse Practitioners		5,953	
9b.	Physician Assistants		550	
10.	Certified Nurse Midwives		35	
10a.	**Total NP, PA, and CNMs (Sum lines 9a - 10)**		**6,538**	
11.	Nurses		6,419	
12.	Other Medical Personnel			
13.	Laboratory Personnel			
14.	X-Ray Personnel			
15.	**Total Medical (Sum lines 8+10a through 14)**		**25,216**	**4,897**
Dental Services				
16.	Dentists		2,914	
17.	Dental Hygienists		67	
17a.	Dental Therapists		0	

S.No	Personnel by Major Service Category	FTEs (a)	Clinic Visits (b)	Patients (c)
18.	Other Dental Personnel			
19.	**Total Dental Services (Sum lines 16-18)**		**2,981**	**885**
Mental Health Services				
20a.	Psychiatrists		1,410	
20a1.	Licensed Clinical Psychologists		543	
20a2.	Licensed Clinical Social Workers		114	
20b.	Other Licensed Mental Health Providers		0	
20c.	Other Mental Health Staff		0	
20.	**Total Mental Health (Sum lines 20a-20c)**		**2,067**	**414**

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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		0	0
Other Professional Services				
22.	Other Professional Services (Specify: Podiatry)		424	227
Vision Services				
22a.	Ophthalmologists		243	
22b.	Optometrists		653	
22c.	Other Vision Care Staff			
22d.	**Total Vision Services (Sum lines 22a-22c)**		**896**	**641**
Pharmacy Personnel				
23.	Pharmacy Personnel			
Enabling Services				
24.	Case Managers		1,222	
25.	Patient/Community Education Specialists		2,207	
26.	Outreach Workers			
27.	Transportation Staff			
27a.	Eligibility Assistance Workers			
27b.	Interpretation Staff			
27c.	Community Health Workers			
28.	Other Enabling Services (Specify: -)			
29.	**Total Enabling Services (Sum lines 24-28)**		**3,429**	**1,238**

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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)
Other Programs/Services				
29a.	Other Programs and services (Specify: -)			
29b.	Quality Improvement Staff			
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 (Lines 15+19+20+21+22+22d+23+29+29a+29b+33)**		**35,013**	

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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	36	3,173	-	-
3.	Internists	41	2,904	-	-
4.	Obstetrician/Gynecologists	11	2,157	-	-
5.	Pediatricians	26	2,836	-	-
7.	Other Specialty Physicians	56	7,639	-	-
9a.	Nurse Practitioners	50	4,895	-	-
9b.	Physician Assistants	10	251	-	-
10.	Certified Nurse Midwives	-	-	-	-
11.	Nurses	61	8,755	-	-
16.	Dentists	25	1,928	-	-
17.	Dental Hygienists	-	-	-	-
17a.	Dental Therapists	-	-	-	-
20a.	Psychiatrists	27	904	-	-
20a1.	Licensed Clinical Psychologists	8	382	-	-
20a2.	Licensed Clinical Social Workers	-	-	-	-

S.No	Health Center Staff	Full and Part Time		Locum, On-Call, etc	
		Persons (a)	Total Months (b)	Persons (c)	Total Months (d)
20b.	Other Licensed Mental Health Providers	-	-	-	-
22a.	Ophthalmologist	2	205	-	-
22b.	Optometrist	3	218	-	-
30a1.	Chief Executive Officer	1	90	-	-
30a2.	Chief Medical Officer	1	50	-	-
30a3.	Chief Financial Officer	-	-	-	-
30a4.	Chief Information Officer	-	-	-	-

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Table 6A - Selected Diagnoses And Services Rendered - Universal

S.No	Diagnostic Category	Applicable ICD-10-CM Code	Number of Visits by Diagnosis Regardless of Primacy (a)	Number of Patients with Diagnosis (b)
Selected Infectious and Parasitic Diseases				
1-2.	Symptomatic / Asymptomatic HIV	B20, B97.35, O98.7-, Z21	503	78
3.	Tuberculosis	A15- through A19-	211	148
4.	Sexually transmitted infections	A50- through A64- (exclude A63.0), M02.3-	56	33
4a.	Hepatitis B	B16.0-B16.2, B16.9, B17.0, B18.0, B18.1, B19.10, B19.11, Z22.51	136	47
4b.	Hepatitis C	B17.10, B17.11, B18.2, B19.20, B19.21	389	144
Selected Diseases of the Respiratory System				
5.	Asthma	J45-	745	343
6.	Chronic obstructive pulmonary diseases	J40- through J44-, J47-	644	223
Selected Other Medical Conditions				
7.	Abnormal breast findings, female	C50.01-, C50.11-, C50.21-, C50.31-, C50.41-, C50.51-, C50.61-, C50.81-, C50.91-, C79.81, D05-, D48.6-, N63-, R92-	589	146
8.	Abnormal cervical findings	C53-, C79.82, D06-, R87.61-, R87.810, R87.820	60	40
9.	Diabetes mellitus	E08- through E13-, O24- (exclude O24.41-)	4,188	838
10.	Heart disease (selected)	I01-, I02- (exclude I02.9), I20- through I25-, I27-, I28-, I30- through I52-	3,203	632
11.	Hypertension	I10- through I16-	4,841	1,362

S.No	Diagnostic Category	Applicable ICD-10-CM Code	Number of Visits by Diagnosis Regardless of Primacy (a)	Number of Patients with Diagnosis (b)
12.	Contact dermatitis and other eczema	L23- through L25-, L30- (exclude L30.1, L30.3, L30.4, L30.5), L55- through L59- (exclude L57.0 through L57.4)	243	177
13.	Dehydration	E86-	2	2
14.	Exposure to heat or cold	T33-, T34-, T67-, T68-, T69-	0	0

Sources of Codes:
International Classification of Diseases, 2017, (ICD-10-CM). National Center for Health Statistics (NCHS).
Current Procedural Terminology (CPT), 2017. American Medical Association (AMA).
Current Dental Terminology (CDT), 2017 - Dental Procedure Codes. American Dental Association (ADA).
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Table 6A - Selected Diagnoses And Services Rendered - Universal

S.No	Diagnostic Category	Applicable ICD-10-CM Code	Number of Visits by Diagnosis Regardless of Primacy (a)	Number of Patients with Diagnosis (b)
14a.	Overweight and obesity	E66-, Z68- (exclude Z68.1, Z68.20 through Z68.24, Z68.51. Z68.52)	1,695	1,096
Selected Childhood Conditions (limited to ages 0 through 17)				
15.	Otitis media and Eustachian tube disorders	H65- through H69-	124	85
16.	Selected perinatal medical conditions	A33-, P22- through P29- (exclude P29.3), P35- through P96- (exclude P54-, P91.6-, P92-, P96.81), R78.81, R78.89	75	34
17.	Lack of expected normal physiological development (such as delayed milestone; failure to gain weight; failure to thrive); Nutritional deficiencies in children only.Does not include sexual or mental development.	E40- through E46-, E50- through E63-, P92-, R62- (exclude R62.7), R63.2, R63.3	954	438
Selected Mental Health and Substance Abuse Conditions				
18.	Alcohol related disorders	F10-, G62.1	962	339
19.	Other substance related disorders (excluding tobacco use disorders)	F11- through F19- (exclude F17-), G62.0, O99.32-	1,074	623
19a.	Tobacco use disorder	F17-	416	220
20a.	Depression and other mood disorders	F30- through F39-	2,561	585
20b.	Anxiety disorders including PTSD	F06.4, F40- through F42-, F43.0, F43.1-, F93.0	1,483	413
20c.	Attention deficit and disruptive behavior disorders	F90- through F91-	70	22

S.No	Diagnostic Category	Applicable ICD-10-CM Code	Number of Visits by Diagnosis Regardless of Primacy (a)	Number of Patients with Diagnosis (b)
20d.	Other mental disorders, excluding drug or alcohol dependence	F01- through F09- (exclude F06.4), F20- through F29-, F43- through F48- (exclude F43.0- and F43.1-), F50- through F59- (exclude F55-), F60- through F99- (exclude F84.2, F90-, F91-, F98-), R45.1, R45.2, R45.5, R45.6, R45.7, R45.81, R45.82, R48.0	1,482	521

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Table 6A - Selected Diagnoses And Services Rendered - Universal

S.No	Service Category	Applicable ICD-10-CM Code or CPT-4/II Code	Number of Visits (a)	Number of Patients (b)
Selected Diagnostic Tests/Screening/Preventive Services				
21.	HIV test	CPT-4: 86689; 86701 through 86703; 87389 through 87391	134	130
21a.	Hepatitis B test	CPT-4: 86704, 86706, 87515 through 87517	167	164
21b.	Hepatitis C test	CPT-4: 86803, 86804, 87520 through 87522	254	252
22.	Mammogram	CPT-4: 77052, 77057, 77065, 77066, 77067 OR ICD-10: Z12.31	370	335
23.	Pap test	CPT-4: 88141 through 88155, 88164 through 88167, 88174, 88175 OR ICD-10: Z01.41-, Z01.42, Z12.4 (exclude Z01.411 and Z01.419)	303	283
24.	Selected Immunizations: Hepatitis A, Hemophilus Influenza B (HiB), Pneumococcal, Diphtheria, Tetanus, Pertussis (DTaP) (DTP) (DT), Mumps, Measles, Rubella, Poliovirus, Varicella, Hepatitis B Child)	CPT - 4: 90633, 90634, 90645 through 90648, 90670, 90696 through 90702, 90704 through 90716, 90718 through 90723, 90743, 90744, 90748	938	768
24a.	Seasonal Flu vaccine	CPT-4: 90654 through 90662, 90672, 90673, 90685 through 90688	1,582	1,481

Sources of Codes:
International Classification of Diseases, 2017, (ICD-10-CM). National Center for Health Statistics (NCHS).
Current Procedural Terminology (CPT), 2017. American Medical Association (AMA).
Current Dental Terminology (CDT), 2017 - Dental Procedure Codes. American Dental Association (ADA).
Note: "X" in a code denotes any number including the absence of a number in that place. "-" (Dashes) in a code indicate that additional characters are required. ICD-10-CM codes all have at least four digits. These codes are not intended to reflect if a code is billable or not. Instead they are used to point out that other codes in the series are to be considered.

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Table 6A - Selected Diagnoses And Services Rendered - Universal

S.No	Diagnostic Category	Applicable ICD-10-CM Code	Number of Visits by Diagnosis Regardless of Primacy (a)	Number of Patients with Diagnosis (b)
25.	Contraceptive management	ICD-10: Z30-	513	282
26.	Health supervision of infant or child (ages 0 through 11)	CPT-4: 99381 through 99383, 99391 through 99393	483	353
26a.	Childhood lead test screening (9 to 72 months)	CPT-4: 83655	86	84
26b.	Screening, Brief Intervention, and Referral to Treatment (SBIRT)	CPT-4: 99408, 99409 HCPCS: G0396, G0397, H0050	157	152
26c.	Smoke and tobacco use cessation counseling	CPT-4: 99406, 99407 OR HCPCS: S9075 OR CPT-II: 4000F, 4001F	939	255
26d.	Comprehensive and intermediate eye exams	CPT-4: 92002, 92004, 92012, 92014	850	597

S.No	Service Category	Applicable ADA Code	Number of Visits (a)	Number of Patients (b)
Selected Dental Services				
27.	I. Emergency Services	ADA: D9110	18	18
28.	II. Oral Exams	ADA: D0120, D0140, D0145, D0150, D0160, D0170, D0171, D0180	855	681
29.	Prophylaxis - adult or child	ADA: D1110, D1120	420	356
30.	Sealants	ADA: D1351	41	37
31.	Fluoride treatment - adult or child	ADA: D1206, D1208	328	237
32.	III. Restorative Services	ADA: D21xx through D29xx	838	349
33.	IV. Oral Surgery (extractions and other surgical procedures)	ADA: D7111, D7140, D7210, D7220, D7230, D7240, D7241, D7250, D7251, D7260, D7261, D7270, D7272, D7280, D7290 through D7294	419	288
34.	V. Rehabilitative services (Endo, Perio, Prostho, Ortho)	ADA: D3xxx, D4xxx, D5xxx, D6xxx, D8xxx	486	276

Sources of Codes:
International Classification of Diseases, 2017, (ICD-10-CM). National Center for Health Statistics (NCHS).
Current Procedural Terminology (CPT), 2017. American Medical Association (AMA).
Current Dental Terminology (CDT), 2017 - Dental Procedure Codes. American Dental Association (ADA).
Note: "X" in a code denotes any number including the absence of a number in that place. "-" (Dashes) in a code indicate that additional characters are required. ICD-10-CM codes all have at least four digits. These codes are not intended to reflect if a code is billable or not. Instead they are used to point out that other codes in the series are to be considered.

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

S.No	Diagnostic Category	Applicable ICD-10-CM Code	Visits with Noted Diagnosis Regardless of Primacy (a)	Number of Patients with Diagnosis (b)
Selected Infectious and Parasitic Diseases				
1-2.	Symptomatic / Asymptomatic HIV	B20, B97.35, O98.7-, Z21	25	4

S.No	Diagnostic Category	Applicable ICD-10-CM Code	Visits with Noted Diagnosis Regardless of Primacy (a)	Number of Patients with Diagnosis (b)
3.	Tuberculosis	A15- through A19-	1	1
4.	Sexually transmitted infections	A50- through A64- (exclude A63.0), M02.3-	3	3
4a.	Hepatitis B	B16.0-B16.2, B16.9, B17.0, B18.0, B18.1, B19.10, B19.11, Z22.51	0	0
4b.	Hepatitis C	B17.10, B17.11, B18.2, B19.20, B19.21	0	0
Selected Diseases of the Respiratory System				
5.	Asthma	J45-	143	89
6.	Chronic obstructive pulmonary diseases	J40- through J44-, J47-	3	3
Selected Other Medical Conditions				
7.	Abnormal breast findings, female	C50.01-, C50.11-, C50.21-, C50.31-, C50.41-, C50.51-, C50.61-, C50.81-, C50.91-, C79.81, D05-, D48.6-, N63-, R92-	25	12
8.	Abnormal cervical findings	C53-, C79.82, D06-, R87.61-, R87.810, R87.820	13	10
9.	Diabetes mellitus	E08- through E13-, O24- (exclude O24.41-)	420	88
10.	Heart disease (selected)	I01-, I02- (exclude I02.9), I20- through I25-, I27-, I28-, I30- through I52-	54	16
11.	Hypertension	I10- through I16-	357	106
12.	Contact dermatitis and other eczema	L23- through L25-, L30- (exclude L30.1, L30.3, L30.4, L30.5), L55- through L59- (exclude L57.0 through L57.4)	21	21
13.	Dehydration	E86-	0	0
14.	Exposure to heat or cold	T33-, T34-, T67-, T68-, T69-	0	0
14a.	Overweight and obesity	E66-, Z68- (exclude Z68.1, Z68.20 through Z68.24, Z68.51. Z68.52)	386	233

Sources of Codes:
International Classification of Diseases, 2017, (ICD-10-CM). National Center for Health Statistics (NCHS).
Current Procedural Terminology (CPT), 2017. American Medical Association (AMA).
Current Dental Terminology (CDT), 2017 - Dental Procedure Codes. American Dental Association (ADA).
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S.No	Diagnostic Category	Applicable ICD-10-CM Code	Visits with Noted Diagnosis Regardless of Primacy (a)	Number of Patients with Diagnosis (b)
Selected Childhood Conditions (limited to ages 0 through 17)				
15.	Otitis media and Eustachian tube disorders	H65- through H69-	50	31
16.	Selected perinatal medical conditions	A33-, P22- through P29- (exclude P29.3), P35- through P96- (exclude P54-, P91.6-, P92-, P96.81), R78.81, R78.89	27	15
17.	Lack of expected normal physiological development (such as delayed milestone; failure to gain weight; failure to thrive); Nutritional deficiencies in children only.Does not include sexual or mental development.	E40- through E46-, E50- through E63-, P92-, R62- (exclude R62.7), R63.2, R63.3	175	100
Selected Mental Health and Substance Abuse Conditions				
18.	Alcohol related disorders	F10-, G62.1	8	7
19.	Other substance related disorders (excluding tobacco use disorders)	F11- through F19- (exclude F17-), G62.0, O99.32-	9	8
19a.	Tobacco use disorder	F17-	9	5
20a.	Depression and other mood disorders	F30- through F39-	73	48
20b.	Anxiety disorders including PTSD	F06.4, F40- through F42-, F43.0, F43.1-, F93.0	70	45
20c.	Attention deficit and disruptive behavior disorders	F90- through F91-	30	8
20d.	Other mental disorders, excluding drug or alcohol dependence	F01- through F09- (exclude F06.4), F20- through F29-, F43- through F48- (exclude F43.0- and F43.1-), F50- through F59- (exclude F55-), F60- through F99- (exclude F84.2, F90-, F91-, F98-), R45.1, R45.2, R45.5, R45.6, R45.7, R45.81, R45.82, R48.0	98	64

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

S.No	Service Category	Applicable ICD-10-CM Code or CPT-4/II Code	Number of Visits (a)	Number of Patients (b)
Selected Diagnostic Tests/Screening/Preventive Services				
21.	HIV test	CPT-4: 86689; 86701 through 86703; 87389 through 87391	0	0
21a.	Hepatitis B test	CPT-4: 86704, 86706, 87515 through 87517	5	5
21b.	Hepatitis C test	CPT-4: 86803, 86804, 87520 through 87522	19	19
22.	Mammogram	CPT-4: 77052, 77057, 77065, 77066, 77067 OR ICD-10: Z12.31	67	57
23.	Pap test	CPT-4: 88141 through 88155, 88164 through 88167, 88174, 88175 OR ICD-10: Z01.41-, Z01.42, Z12.4 (exclude Z01.411 and Z01.419)	60	60

S.No	Service Category	Applicable ICD-10-CM Code or CPT-4/II Code	Number of Visits (a)	Number of Patients (b)
Selected Diagnostic Tests/Screening/Preventive Services				
24.	Selected Immunizations: Hepatitis A, Hemophilus Influenza B (HiB), Pneumococcal, Diphtheria, Tetanus, Pertussis (DTaP) (DTP) (DT), Mumps, Measles, Rubella, Poliovirus, Varicella, Hepatitis B Child)	CPT - 4: 90633, 90634, 90645 through 90648, 90670, 90696 through 90702, 90704 through 90716, 90718 through 90723, 90743, 90744, 90748	216	172
24a.	Seasonal Flu vaccine	CPT-4: 90654 through 90662, 90672, 90673, 90685 through 90688	373	347

Sources of Codes:
International Classification of Diseases, 2017, (ICD-10-CM). National Center for Health Statistics (NCHS).
Current Procedural Terminology (CPT), 2017. American Medical Association (AMA).
Current Dental Terminology (CDT), 2017 - Dental Procedure Codes. American Dental Association (ADA).
Note: "X" in a code denotes any number including the absence of a number in that place. "-" (Dashes) in a code indicate that additional characters are required. ICD-10-CM codes all have at least four digits. These codes are not intended to reflect if a code is billable or not. Instead they are used to point out that other codes in the series are to be considered.

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

S.No	Diagnostic Category	Applicable ICD-10-CM Code	Visits with Noted Diagnosis Regardless of Primacy (a)	Number of Patients with Diagnosis (b)
25.	Contraceptive management	ICD-10: Z30-	176	99
26.	Health supervision of infant or child (ages 0 through 11)	CPT-4: 99381 through 99383, 99391 through 99393	279	216
26a.	Childhood lead test screening (9 to 72 months)	CPT-4: 83655	41	41
26b.	Screening, Brief Intervention, and Referral to Treatment (SBIRT)	CPT-4: 99408, 99409 HCPCS: G0396, G0397, H0050	81	78
26c.	Smoke and tobacco use cessation counseling	CPT-4: 99406, 99407 OR HCPCS: S9075 OR CPT-II: 4000F, 4001F	23	5
26d.	Comprehensive and intermediate eye exams	CPT-4: 92002, 92004, 92012, 92014	25	17

S.No	Service Category	Applicable ADA Code	Number of Visits (a)	Number of Patients (b)
Selected Dental Services				
27.	I. Emergency Services	ADA: D9110	3	3
28.	II. Oral Exams	ADA: D0120, D0140, D0145, D0150, D0160, D0170, D0171, D0180	235	185
29.	Prophylaxis - adult or child	ADA: D1110, D1120	181	141
30.	Sealants	ADA: D1351	33	30
31.	Fluoride treatment - adult or child	ADA: D1206, D1208	224	151
32.	III. Restorative Services	ADA: D21xx through D29xx	253	107

S.No	Service Category	Applicable ADA Code	Number of Visits (a)	Number of Patients (b)
Selected Dental Services				
33.	IV. Oral Surgery (extractions and other surgical procedures)	ADA: D7111, D7140, D7210, D7220, D7230, D7240, D7241, D7250, D7251, D7260, D7261, D7270, D7272, D7280, D7290 through D7294	36	27
34.	V. Rehabilitative services (Endo, Perio, Prostho, Ortho)	ADA: D3xxx, D4xxx, D5xxx, D6xxx, D8xxx	52	34

Sources of Codes:
International Classification of Diseases, 2017, (ICD-10-CM). National Center for Health Statistics (NCHS).
Current Procedural Terminology (CPT), 2017. American Medical Association (AMA).
Current Dental Terminology (CDT), 2017 - Dental Procedure Codes. American Dental Association (ADA).
Note: "X" in a code denotes any number including the absence of a number in that place. "-" (Dashes) in a code indicate that additional characters are required. ICD-10-CM codes all have at least four digits. These codes are not intended to reflect if a code is billable or not. Instead they are used to point out that other codes in the series are to be considered.

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

S.No	Diagnostic Category	Applicable ICD-10-CM Code	Visits with Noted Diagnosis Regardless of Primacy (a)	Number of Patients with Diagnosis (b)
Selected Infectious and Parasitic Diseases				
1-2.	Symptomatic / Asymptomatic HIV	B20, B97.35, O98.7-, Z21	478	74
3.	Tuberculosis	A15- through A19-	210	147
4.	Sexually transmitted infections	A50- through A64- (exclude A63.0), M02.3-	55	32
4a.	Hepatitis B	B16.0-B16.2, B16.9, B17.0, B18.0, B18.1, B19.10, B19.11, Z22.51	136	47
4b.	Hepatitis C	B17.10, B17.11, B18.2, B19.20, B19.21	389	144
Selected Diseases of the Respiratory System				
5.	Asthma	J45-	607	257
6.	Chronic obstructive pulmonary diseases	J40- through J44-, J47-	641	220
Selected Other Medical Conditions				
7.	Abnormal breast findings, female	C50.01-, C50.11-, C50.21-, C50.31-, C50.41-, C50.51-, C50.61-, C50.81-, C50.91-, C79.81, D05-, D48.6-, N63-, R92-	565	135
8.	Abnormal cervical findings	C53-, C79.82, D06-, R87.61-, R87.810, R87.820	47	30
9.	Diabetes mellitus	E08- through E13-, O24- (exclude O24.41-)	3,815	764

S.No	Diagnostic Category	Applicable ICD-10-CM Code	Visits with Noted Diagnosis Regardless of Primacy (a)	Number of Patients with Diagnosis (b)
10.	Heart disease (selected)	I01-, I02- (exclude I02.9), I20- through I25-, I27-, I28-, I30- through I52-	3,174	619
11.	Hypertension	I10- through I16-	4,585	1,277
12.	Contact dermatitis and other eczema	L23- through L25-, L30- (exclude L30.1, L30.3, L30.4, L30.5), L55- through L59- (exclude L57.0 through L57.4)	226	160
13.	Dehydration	E86-	2	2
14.	Exposure to heat or cold	T33-, T34-, T67-, T68-, T69-	0	0
14a.	Overweight and obesity	E66-, Z68- (exclude Z68.1, Z68.20 through Z68.24, Z68.51. Z68.52)	1,318	869

Sources of Codes:
International Classification of Diseases, 2017, (ICD-10-CM). National Center for Health Statistics (NCHS).
Current Procedural Terminology (CPT), 2017. American Medical Association (AMA).
Current Dental Terminology (CDT), 2017 - Dental Procedure Codes. American Dental Association (ADA).
Note: "X" in a code denotes any number including the absence of a number in that place. "-" (Dashes) in a code indicate that additional characters are required. ICD-10-CM codes all have at least four digits. These codes are not intended to reflect if a code is billable or not. Instead they are used to point out that other codes in the series are to be considered.

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

S.No	Diagnostic Category	Applicable ICD-10-CM Code	Visits with Noted Diagnosis Regardless of Primacy (a)	Number of Patients with Diagnosis (b)
Selected Childhood Conditions (limited to ages 0 through 17)				
15.	Otitis media and Eustachian tube disorders	H65- through H69-	74	54
16.	Selected perinatal medical conditions	A33-, P22- through P29- (exclude P29.3), P35- through P96- (exclude P54-, P91.6-, P92-, P96.81), R78.81, R78.89	48	19
17.	Lack of expected normal physiological development (such as delayed milestone; failure to gain weight; failure to thrive); Nutritional deficiencies in children only.Does not include sexual or mental development.	E40- through E46-, E50- through E63-, P92-, R62- (exclude R62.7), R63.2, R63.3	789	342
Selected Mental Health and Substance Abuse Conditions				
18.	Alcohol related disorders	F10-, G62.1	954	332
19.	Other substance related disorders (excluding tobacco use disorders)	F11- through F19- (exclude F17-), G62.0, O99.32-	1,067	616
19a.	Tobacco use disorder	F17-	409	216
20a.	Depression and other mood disorders	F30- through F39-	2,495	544

S.No	Diagnostic Category	Applicable ICD-10-CM Code	Visits with Noted Diagnosis Regardless of Primacy (a)	Number of Patients with Diagnosis (b)
20b.	Anxiety disorders including PTSD	F06.4, F40- through F42-, F43.0, F43.1-, F93.0	1,414	369
20c.	Attention deficit and disruptive behavior disorders	F90- through F91-	40	14
20d.	Other mental disorders, excluding drug or alcohol dependence	F01- through F09- (exclude F06.4), F20- through F29-, F43- through F48- (exclude F43.0- and F43.1-), F50- through F59- (exclude F55-), F60- through F99- (exclude F84.2, F90-, F91-, F98-), R45.1, R45.2, R45.5, R45.6, R45.7, R45.81, R45.82, R48.0	1,386	458

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

S.No	Service Category	Applicable ICD-10-CM Code or CPT-4/II Code	Number of Visits (a)	Number of Patients (b)
Selected Diagnostic Tests/Screening/Preventive Services				
21.	HIV test	CPT-4: 86689; 86701 through 86703; 87389 through 87391	134	130
21a.	Hepatitis B test	CPT-4: 86704, 86706, 87515 through 87517	166	163
21b.	Hepatitis C test	CPT-4: 86803, 86804, 87520 through 87522	244	242
22.	Mammogram	CPT-4: 77052, 77057, 77065, 77066, 77067 OR ICD-10: Z12.31	305	280
23.	Pap test	CPT-4: 88141 through 88155, 88164 through 88167, 88174, 88175 OR ICD-10: Z01.41-, Z01.42, Z12.4 (exclude Z01.411 and Z01.419)	246	226
24.	Selected Immunizations: Hepatitis A, Hemophilus Influenza B (HiB), Pneumococcal, Diphtheria, Tetanus, Pertussis (DTaP) (DTP) (DT), Mumps, Measles, Rubella, Poliovirus, Varicella, Hepatitis B Child)	CPT - 4: 90633, 90634, 90645 through 90648, 90670, 90696 through 90702, 90704 through 90716, 90718 through 90723, 90743, 90744, 90748	730	601
24a.	Seasonal Flu vaccine	CPT-4: 90654 through 90662, 90672, 90673, 90685 through 90688	1,243	1,167

Sources of Codes:
International Classification of Diseases, 2017, (ICD-10-CM). National Center for Health Statistics (NCHS).
Current Procedural Terminology (CPT), 2017. American Medical Association (AMA).
Current Dental Terminology (CDT), 2017 - Dental Procedure Codes. American Dental Association (ADA).
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Table 6A - Selected Diagnoses And Services Rendered - Health Care For The Homeless

S.No	Diagnostic Category	Applicable ICD-10-CM Code	Visits with Noted Diagnosis Regardless of Primacy (a)	Number of Patients with Diagnosis (b)
25.	Contraceptive management	ICD-10: Z30-	341	187
26.	Health supervision of infant or child (ages 0 through 11)	CPT-4: 99381 through 99383, 99391 through 99393	207	140
26a.	Childhood lead test screening (9 to 72 months)	CPT-4: 83655	47	45
26b.	Screening, Brief Intervention, and Referral to Treatment (SBIRT)	CPT-4: 99408, 99409 HCPCS: G0396, G0397, H0050	76	74
26c.	Smoke and tobacco use cessation counseling	CPT-4: 99406, 99407 OR HCPCS: S9075 OR CPT-II: 4000F, 4001F	916	250
26d.	Comprehensive and intermediate eye exams	CPT-4: 92002, 92004, 92012, 92014	826	581

S.No	Service Category	Applicable ADA Code	Number of Visits (a)	Number of Patients (b)
Selected Dental Services				
27.	I. Emergency Services	ADA: D9110	15	15
28.	II. Oral Exams	ADA: D0120, D0140, D0145, D0150, D0160, D0170, D0171, D0180	626	501
29.	Prophylaxis - adult or child	ADA: D1110, D1120	244	218
30.	Sealants	ADA: D1351	8	7
31.	Fluoride treatment - adult or child	ADA: D1206, D1208	104	86
32.	III. Restorative Services	ADA: D21xx through D29xx	594	245
33.	IV. Oral Surgery (extractions and other surgical procedures)	ADA: D7111, D7140, D7210, D7220, D7230, D7240, D7241, D7250, D7251, D7260, D7261, D7270, D7272, D7280, D7290 through D7294	385	262
34.	V. Rehabilitative services (Endo, Perio, Prostho, Ortho)	ADA: D3xxx, D4xxx, D5xxx, D6xxx, D8xxx	440	245

Sources of Codes:
International Classification of Diseases, 2017, (ICD-10-CM). National Center for Health Statistics (NCHS).
Current Procedural Terminology (CPT), 2017. American Medical Association (AMA).
Current Dental Terminology (CDT), 2017 - Dental Procedure Codes. American Dental Association (ADA).
Note: "X" in a code denotes any number including the absence of a number in that place. "-" (Dashes) in a code indicate that additional characters are required. ICD-10-CM codes all have at least four digits. These codes are not intended to reflect if a code is billable or not. Instead they are used to point out that other codes in the series are to be considered.

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Table 6B - Quality Of Care Measures

Prenatal Care Provided by Referral Only (Check if Yes):	**No**

Section A - Age Categories for Prenatal Care Patients:

	Demographic Characteristics of Prenatal Care Patients	
S.No	**Age**	**Number of Patients (a)**
1.	Less than 15 years	0
2.	Ages 15-19	13
3.	Ages 20-24	18
4.	Ages 25-44	70
5.	Ages 45 and over	1
6.	**Total Patients (Sum lines 1-5)**	**102**

Section B - Early Entry into Prenatal Care

S.No	Early Entry into Prenatal Care	Women Having First Visit with Health Center (a)	Women Having First Visit with Another Provider (b)
7.	First Trimester	48	2
8.	Second Trimester	41	2
9.	Third Trimester	8	1

Section C - Childhood Immunization Status (CIS)

S.No	Childhood Immunization Status (CIS)	Total Patients with 2nd Birthday (a)	Number Charts Sampled or EHR Total (b)	Number of Patients Immunized (c)
10.	MEASURE: Percentage of children 2 years of age who received age appropriate vaccines by their 2nd birthday	32	32	21

Section D - Cervical Cancer Screening

S.No	Cervical Cancer Screening	Total Female Patients Aged 23 through 64 (a)	Number Charts Sampled or EHR Total (b)	Number of Patients Tested (c)
11.	MEASURE: Percentage of women 23-64 years of age, who were screened for cervical cancer	1,761	70	44

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Table 6B - Quality Of Care Measures

Section E - Weight Assessment and Counseling for Nutrition and Physical Activity of Children and Adolescents

S.No	Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents	Total Patients Aged 3 through 17 (a)	Number Charts Sampled or EHR Total (b)	Number of Patients with Counseling and BMI Documented (c)
12.	MEASURE: Percentage of patients 3-17 years of age with a BMI percentile, and counseling on nutrition and physical activity documented	608	608	359

Section F - Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up Plan

Section F - Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up Plan				
S.No	Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up Plan	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)
S.No	Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up Plan	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.	MEASURE: Percentage of patients 18 years of age and older with (1) BMI documented and (2) follow-up plan documented if BMI is outside normal parameters	4,773	70	30

Section G - Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention				
S.No	Preventive Care and Screening: 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.	MEASURE: Percentage of patients 18 years of age and older who (1) were screened for tobacco use one or more times within 24 months and if identified to be a tobacco user (2) received cessation counseling intervention	4,563	4,563	3,551

Section H - Use of Appropriate Medications for Asthma				
S.No	Use of Appropriate Medications for Asthma	Total Patients Aged 5 through 64 with Persistent Asthma (a)	Number Charts Sampled or EHR Total (b)	Number of Patients with Acceptable Plan (c)
16.	MEASURE: Percentage of patients 5 through 64 years of age identified as having persistent asthma and were appropriately ordered medication	240	240	216

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Table 6B - Quality Of Care Measures

Section I - Coronary Artery Disease (CAD): Lipid Therapy				
S.No	Coronary Artery Disease (CAD): Lipid Therapy	Total Patients Aged 18 and Older with CAD Diagnosis (a)	Number Charts Sampled or EHR Total (b)	Number of Patients Prescribed A Lipid Lowering Therapy (c)
17.	MEASURE: Percentage of patients 18 years of age and older with a diagnosis of CAD who were prescribed a lipid lowering therapy	215	215	173

Section J - Ischemic Vascular Disease (IVD): Use of Aspirin or Another Antiplatelet				
S.No	Ischemic Vascular Disease (IVD): Use of Aspirin or Another Antiplatelet	Total Patients Aged 18 and Older with IVD Diagnosis or AMI, CABG, or PCI Procedure (a)	Charts Sampled or EHR Total (b)	Number of Patients with Documentation of Aspirin or Other Antiplatelet Therapy (c)
18.	MEASURE: Percentage of patients 18 years of age and older with a diagnosis of IVD or AMI, CABG, or PCI procedure with aspirin or another antiplatelet	357	357	308

Section K - Colorectal Cancer Screening

Section K - Colorectal Cancer Screening				
S.No	Colorectal Cancer Screening	Total Patients Aged 50 through 75 (a)	Charts Sampled or EHR Total (b)	Number of Patients with Appropriate Screening for Colorectal Cancer (c)
19.	MEASURE: Percentage of patients 50 through 75 years of age who had appropriate screening for colorectal cancer	2,030	2,030	1,160

S.No	Colorectal Cancer Screening	Total Patients Aged 50 through 75 (a)	Charts Sampled or EHR Total (b)	Number of Patients with Appropriate Screening for Colorectal Cancer (c)

Section L - HIV Linkage to Care				
S.No	HIV Linkage to Care	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.	MEASURE: Percentage of patients whose first ever HIV diagnosis was made by health center staff between October 1, of the prior year and September 30, of the measurement year and who were seen for follow-up treatment within 90 days of that first ever diagnosis	0	0	0

Section M - Preventive Care and Screening: Screening for Depression and Follow-Up Plan				
S.No	Preventive Care and Screening: Screening for Depression and Follow-Up Plan	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.	MEASURE: Percentage of patients 12 years of age and older who were (1) screened for depression with a standardized tool and, if screening was positive, (2) had a follow-up plan documented	4,936	70	29

Section N - Dental Sealants for Children between 6-9 Years				
S.No	Dental Sealants for Children between 6-9 Years	Total Patients Aged 6 through 9 at Moderate to High Risk for Caries (a)	Charts Sampled or EHR Total (b)	Number of Patients with Sealants to First Molars (c)
22.	MEASURE: Percentage of children 6 through 9 years of age, at moderate to high risk of caries who received a sealant on a first permanent molar	41	41	24

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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					
S.No	**Race and 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	1	0	0	1
1e.	White	27	0	1	26
1f.	More Than One Race	13	0	0	13
1g.	Unreported/Refused to Report Race	3	0	0	3
Subtotal Hispanic/Latino (Sum lines 1a-1g)		**45**	**0**	**1**	**44**
Non-Hispanic/Latino					
2a.	Asian	0	0	0	0
2b1.	Native Hawaiian	0	0	0	0
2b2.	Other Pacific Islander	4	0	0	4
2c.	Black/African American	2	0	0	2
2d.	American Indian/Alaska Native	0	0	0	0
2e.	White	5	0	0	5
2f.	More Than One Race	1	0	0	1
2g.	Unreported/Refused to Report Race	0	0	0	0
Subtotal Non-Hispanic/Latino (Sum lines 2a-2g)		**12**	**0**	**0**	**12**
Unreported/Refused to Report Ethnicity					
h.	Unreported /Refused to Report Race and Ethnicity	0	0	0	0
i.	**Total (Sum lines 1a-h)**	**57**	**0**	**1**	**56**

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Table 7 - Health Outcomes and Disparities

Section B: Controlling High Blood Pressure				
S.No	**Race and Ethnicity**	**Total Patients 18 through 85 Years of Age with Hypertension (2a)**	**Charts Sampled or EHR Total (2b)**	**Patients with HTN Controlled (2c)**
Hispanic/Latino				
1a.	Asian	10	10	8
1b1.	Native Hawaiian	0	0	0
1b2.	Other Pacific Islander	2	2	1

Section B: Controlling High Blood Pressure				
S.No	**Race and Ethnicity**	**Total Patients 18 through 85 Years of Age with Hypertension (2a)**	**Charts Sampled or EHR Total (2b)**	**Patients with HTN Controlled (2c)**
1c.	Black/African American	3	3	3
1d.	American Indian/Alaska Native	6	6	2
1e.	White	547	547	361
1f.	More Than One Race	87	87	56
1g.	Unreported/Refused to Report Race	26	26	15
Subtotal Hispanic/Latino (Sum lines 1a-1g)		**681**	**681**	**446**
Non-Hispanic/Latino				
2a.	Asian	208	208	136
2b1.	Native Hawaiian	1	1	0
2b2.	Other Pacific Islander	66	66	45
2c.	Black/African American	164	164	88
2d.	American Indian/Alaska Native	3	3	3
2e.	White	481	481	292
2f.	More Than One Race	42	42	30
2g.	Unreported/Refused to Report Race	6	6	4
Subtotal Non-Hispanic/Latino (Sum lines 2a-2g)		**971**	**971**	**598**
Unreported/Refused to Report Ethnicity				
h.	Unreported /Refused to Report Race and Ethnicity	11	11	4
i.	**Total (Sum lines 1a-h)**	**1,663**	**1,663**	**1,048**

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Table 7 - Health Outcomes and Disparities

Section C: Diabetes: Hemoglobin A1c Poor Control					
S.No	**Race and Ethnicity**	**Total Patients 18 through 75 Years of Age with Diabetes (3a)**	**Charts sampled or EHR Total (3b)**	**Patients with Hba1c < 8% (3d1)**	**Patients with HbA1c >9% Or No Test During Year (3f)**
Hispanic/Latino					
1a.	Asian	2	2	2	0
1b1.	Native Hawaiian	1	1	0	1
1b2.	Other Pacific Islander	2	2	2	0
1c.	Black/African American	2	2	1	1
1d.	American Indian/Alaska Native	3	3	3	0
1e.	White	291	291	164	89
1f.	More Than One Race	52	52	33	13
1g.	Unreported/Refused to Report Race	27	27	13	11

Section C: Diabetes: Hemoglobin A1c Poor Control					
S.No	**Race and Ethnicity**	**Total Patients 18 through 75 Years of Age with Diabetes (3a)**	**Charts sampled or EHR Total (3b)**	**Patients with Hba1c < 8% (3d1)**	**Patients with HbA1c >9% Or No Test During Year (3f)**
Subtotal Hispanic/Latino (Sum lines 1a-1g)		**380**	**380**	**218**	**115**
Non-Hispanic/Latino					
2a.	Asian	99	99	73	15
2b1.	Native Hawaiian	0	0	0	0
2b2.	Other Pacific Islander	46	46	26	14
2c.	Black/African American	76	76	48	22
2d.	American Indian/Alaska Native	5	5	4	1
2e.	White	166	166	107	39
2f.	More Than One Race	27	27	9	14
2g.	Unreported/Refused to Report Race	0	0	0	0
Subtotal Non-Hispanic/Latino (Sum lines 2a-2g)		**419**	**419**	**267**	**105**
Unreported/Refused to Report Ethnicity					
h.	Unreported /Refused to Report Race and Ethnicity	7	7	3	3
i.	**Total (Sum lines 1a-h)**	**806**	**806**	**488**	**223**

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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	4,779,022	3,543,811	8,322,833
2.	Lab and X-ray	760,344	673,286	1,433,630
3.	Medical/Other Direct	1,788,767	1,483,981	3,272,748
4.	**Total Medical Care Services (Sum lines 1-3)**	**7,328,133**	**5,701,078**	**13,029,211**
Financial Costs for Other Clinical Services				
5.	Dental	495,007	331,518	826,525
6.	Mental Health	839,634	696,569	1,536,203
7.	Substance Abuse	-	-	
8a.	Pharmacy not including pharmaceuticals	422,983	365,557	788,540
8b.	Pharmaceuticals	192,672		192,672
9.	Other Professional (Specify: Podiatry)	68,408	79,199	147,607
9a.	Vision	108,034	89,626	197,660
10.	**Total Other Clinical Services (Sum lines 5-9a)**	**2,126,738**	**1,562,469**	**3,689,207**
Financial Costs of Enabling and Other Services				

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) $
11a.	Case Management	568,961		568,961
11b.	Transportation	-		
11c.	Outreach	-		
11d.	Patient and Community Education	-		
11e.	Eligibility Assistance	-		
11f.	Interpretation Services	-		
11g.	Other Enabling Services (Specify: -)	-		
11h.	Community Health Workers	-		
11.	**Total Enabling Services Cost (Sum lines 11a-11h)**	**568,961**	**6,676**	**575,637**
12.	Other Related Services (Specify: -)	-	-	
12a.	Quality Improvement	-	-	
13.	**Total Enabling and Other Services (Sum Lines 11, 12, and 12a)**	**568,961**	**6,676**	**575,637**

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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) $
Facility and Non-Clinical Support Services and Totals				
14.	Facility	1,106,243		
15.	Non-Clinical Support Services	6,163,980		
16.	**Total Facility and Non-Clinical Support Services (Sum lines 14 and 15)**	**7,270,223**		
17.	**Total Accrued Costs (Sum lines 4+10+13+16)**	**17,294,055**		**17,294,055**
18.	Value of Donated Facilities, Services and Supplies (Specify: -)			-
19.	**Total with Donations (Sum lines 17-18)**			**17,294,055**

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

S.No	Payer 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 Payments: P4P, Risk Pools, Withholds, etc. (c3) $	Penalty/ Payback (c4) $			
1.	Medicaid Non-Managed Care	2,188,406	1,342,404	1,186,299	-	-	-	970,949		
2a.	Medicaid Managed Care (capitated)	9,093,982	2,453,513	1,350,530	-	-	-	6,640,469		
2b.	Medicaid Managed Care (fee-for-service)	-	-	-	-	-	-	-		
3.	**Total Medicaid (Sum lines 1+2a+2b)**	**11,282,388**	**3,795,917**	**2,536,829**				**7,611,418**		
4.	Medicare Non-Managed Care	2,129,977	759,333	138,936	-	-	-	1,166,048		
5a.	Medicare Managed Care (capitated)	-	-	-	-	-	-	-		
5b.	Medicare Managed Care (fee-for-service)	1,955,317	772,902	218,460	-	-	-	1,037,946		
6.	**Total Medicare (Sum lines 4+5a+5b)**	**4,085,294**	**1,532,235**	**357,396**				**2,203,994**		
7.	Other Public including Non-Medicaid CHIP (Non Managed Care)	352,399	56,197	11,533	-	-	-	339,006		
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)**	**352,399**	**56,197**	**11,533**				**339,006**		
10.	Private Non-Managed Care	27,736	5,940			-	-	5,396		
11a.	Private Managed Care (capitated)	3,013	305			-	-	2,708		
11b.	Private Managed Care (fee-for-service)	-	-			-	-	-		
12.	**Total Private (Sum lines 10+11a+11b)**	**30,749**	**6,245**					**8,104**		
13.	Self-pay	3,574,069	42,835						-	29,793
14.	**Total (Sum lines 3+6+9+12+13)**	**19,324,899**	**5,433,429**	**2,905,758**	**-**	**-**	**-**	**10,162,522**		**29,793**

OMB Control Number: 0195-0193

Submission Status: Review In Progress

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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	389,661
1b.	Community Health Center	-
1c.	Health Care for the Homeless	1,465,867
1e.	Public Housing Primary Care	-
1g.	**Total Health Center Cluster (Sum lines 1a-1e)**	**1,855,528**
1j.	Capital Improvement Program Grants	-
1k.	Capital Development Grants, including School Based Health Center Capital Grants	-
1.	**Total BPHC Grants (Sum lines 1g+1j+1k)**	**1,855,528**
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	-
5.	**Total Other Federal Grants (Sum lines 2-3a)**	
Non-Federal Grants or Contracts		
6.	State Government Grants and Contracts (Specify:-)	-
6a.	State/Local Indigent Care Programs (Specify:Affordable Care for Everyone (ACE) - a San Mateo County program)	10,005,098
7.	Local Government Grants and Contracts (Specify:-)	-
8.	Foundation/Private Grants and Contracts (Specify:-)	-
9.	**Total Non-Federal Grants and Contracts (Sum lines 6+6a+7+8)**	**10,005,098**
10.	Other Revenue (Non-patient related revenue not reported elsewhere) (Specify:-)	-
11.	**Total Revenue (Sum lines 1+5+9+10)**	**11,860,626**

OMB Control Number: 0195-0193

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Health Information Technology Capabilities and Quality Recognition

1. Does your center currently have an Electronic Health Record (EHR) system installed and in use?	[X] Yes, installed at all sites and used by all providers [_] Yes, but only installed at some sites or used by some providers [_] No
1a. Is your system certified by 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	10 SP1
Certified Health IT Product List Number	CHP-023393
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?	[_] Yes [X] 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?	[_] Yes [X] 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)?	[X] We use the EHR to extract automated reports [_] 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"?	[_] Yes, all eligible providers at all sites are participating [X] 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)?	[_] Received MU for Modified Stage 2 [_] Received MU for Stage 3 [X] Not Sure
8b. If no (c only), are your eligible providers planning to participate?	N/A

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Health Information Technology Capabilities and Quality Recognition

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)

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Other Data Elements

1. Medication-Assisted Treatment (MAT) for Opioid Use Disorder	
How many physicians, certified nurse practitioners and physician assistants, on-site or with whom the health center has contracts, have obtained a Drug Addiction Treatment Act of 2000 (DATA) waiver to treat opioid use disorder with medications specifically approved by the U.S. Food and Drug Administration (FDA) for that indication?	10
How many patients received medication-assisted treatment for opioid use disorder from a physician, certified nurse practitioner, or physician assistant, with a DATA waiver working on behalf of the health center?	81
2. Are you using telehealth? Telehealth is defined as the use of telecommunications and information technologies to share information, and provide clinical care, education, public health, and administrative services at a distance.	[X] Yes [_] No
If yes (a), how are you using telehealth?	[_] Provide primary care services [X] Provide specialty care services [_] Provide mental health services [_] Provide oral health services [X] Manage patients with chronic conditions [_] Other (Specify: -)
If no (b), please explain why you are not using telehealth:	-
3. Provide the number of all assists provided during the past year by all trained assisters (e.g., certified application counselor or equivalent) working on behalf of the health center (employees, contractors, or volunteers), regardless of the funding source that is supporting the assisters' activities. Outreach and enrollment assists are defined as customizable education sessions about affordable health insurance coverage options (one-on-one or small group) and any other assistance provided by a health center assister to facilitate enrollment through the Marketplace, Medicaid or CHIP.	297

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Data Audit Report

Table 3A-Patients by Age and by Sex Assigned at Birth

Edit 03950: Numbers Questioned For Patients Aged 15 - 44. - Females age 15-44 is outside the typical range when compared to total patients age 15-44. Please correct or explain. Females aged 15-44 (1,194);Males aged 15-44 (1,501);Ratio of Females age 15-44 to total patients age 15-44: (44.3)%
Related Tables: Table 3A(UR)
Elli Lo (Health Center) on 2/14/2018 4:29 PM EST: The number is driven by a large group of homeless single males who received care. A majority of the homeless

population are tilted toward single adult males. This has consistent over the past years.

Table 4-Selected Patient Characteristics

Edit 06104: School Based Health Center Patients in Question - On Health Care for the Homeless - There was a (-90.99) % change in School Based Health Center patients this year compared to the prior year on Line 24. Please correct or explain.

Related Tables: Table 4(HCH)

Elli Lo (Health Center) on 2/14/2018 5:11 PM EST: This number is driven by the reduction of homeless children who receive care. The County prioritizes getting homeless families off the street. With the Coordinated Entry System implemented in 2017, homeless families are prioritized getting into housing first before they get a visit at the health center. This shrinks the overall number of children reported as homeless. In addition, the homeless one day count for San Mateo County has decreased in 2017. This reduction is aligned and reflecting the decrease in number of homeless individuals in San Mateo County.

Edit 03851: Inter-year change in patients - Proportion of patients at or below 100 percent of the federal poverty guidelines for this year (78.12) differs substantially from last year (62.16). Please correct or explain.

Related Tables: Table 4(UR)

Elli Lo (Health Center) on 2/14/2018 5:43 PM EST: This is due to more available data on income and/or household of the patients. A majority of this increase comes from the unknown percent of federal poverty category last year.

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 ((0.99)%, (64)); Prior Year ((2.91)%, (195)). 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)

Elli Lo (Health Center) on 2/14/2018 5:52 PM EST: This number is driven by the reduction of homeless adults in families who receive care. The County prioritizes getting homeless families off the street. With the Coordinated Entry System implemented in 2017, homeless families are prioritized getting into housing first before they get a visit at the health center. The adults in these households have private insurance and since they get housed before a visit at the health center, this shrinks the numbers adults with private insurance reported as homeless.

Edit 01943: Private revenue reported in question - Private Managed Care Collections are reported on Table 9D with no matching Private Managed Care Member months on Table 4, Line 13c Column d. This is generally not possible. Please correct or explain.

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

Jim Beaumont (Health Center) on 2/14/2018 6:40 PM EST: We do not belong to any Private Managed Care plan networks, so we would not be able to report any member months. However, occasionally, an individual from such a plan will receive services in one of our clinics, for which we then attempt to make collections for those services.

Edit 01235: Inter-year Change in Patients - There is a decrease in the number of Migrant Health patients reported on Line 16 (1,162) from prior year (1,497) . Please correct or explain.

Related Tables: Table 4(UR)

Elli Lo (Health Center) on 2/14/2018 4:42 PM EST: This is largely due to fewer farmworkers seeking and accessing services from a public entity due to the political climate and many fear deportation.

Edit 06103: School Based Health Center Patients in Question - On Universal - There was a (-90.03) % change in School Based Health Center patients this year compared to the prior year on line 24. Please correct or explain.

Related Tables: Table 4(UR)

Elli Lo (Health Center) on 2/14/2018 5:11 PM EST: This number is driven by the reduction of homeless children who receive care. The County prioritizes getting homeless families off the street. With the Coordinated Entry System implemented in 2017, homeless families are prioritized getting into housing first before they get a visit at the health center. This shrinks the overall number of children reported as homeless. In addition, the homeless one day count for San Mateo County has decreased in 2017. This reduction is aligned and reflecting the decrease in number of homeless individuals in San Mateo County.

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 =(201) , CY = (414)). Please correct or explain.

Related Tables: Table 5(HCH)

Jim Beaumont (Health Center) on 2/14/2018 6:35 PM EST: With a continued focus on increasing the depression screening, there has been more internal referrals for Mental Health follow-up for patients.

Edit 06373: Mental Health Visit per Patient in Question - On Migrant Health Center - Mental Health visits per mental health patient varies substantially from national average.CY (1); PY National Average (3.07). Please correct and explain.

Related Tables: Table 5(MHC)

Jim Beaumont (Health Center) on 2/14/2018 6:34 PM EST: There were only 2 patients. This is a small sample size issue.

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 = (34) , CY = (18)). Please correct or explain.

Related Tables: Table 5(MHC)

Jim Beaumont (Health Center) on 2/14/2018 6:34 PM EST: While there has been an increased focus on vision services by our community partners, which would lead to an increased utilization of the services, this is also approaching small sample size area.

Edit 05141: Inter-year Patients questioned - On Health Care for the Homeless - A large change in Vision Services patients from the prior year is reported on Line 22d Column c (PY = (366) , CY = (641)). Please correct or explain.

Related Tables: Table 5(HCH)

Jim Beaumont (Health Center) on 2/14/2018 6:32 PM EST: Our community partners have focused on vision services recently, resulting in an increase in utilization of the services.

Edit 04148: Inter-year Patients questioned - On Health Care for the Homeless - A large change in Other Professional Services patients from the prior year is reported on Line 22 Column C. (PY = (115) , CY = (227)). Please correct or explain.

Related Tables: Table 5(HCH)

Jim Beaumont (Health Center) on 2/14/2018 6:31 PM EST: A renewed focus on the available 'foot clinic; for the homeless appears to have resulted to the increased access of Podiatry (Other Professional Services) Services.

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 = (1,809) , CY = (1,238)). Please correct or explain.

Related Tables: Table 5(HCH)

Jim Beaumont (Health Center) on 2/14/2018 6:30 PM EST: Note that the PY number was a significant increase in the PPY number (862). The PY number appears to be a outlying spike in enabling services patients. On a multi-year basis (862 - 1,238), with the increased level of contracts specifically for enabling services, the number appears to be reasonable.

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 = (222) , CY = (81)). Please correct or explain.

Related Tables: Table 5(MHC)

Jim Beaumont (Health Center) on 2/14/2018 6:25 PM EST: In the current political climate, it is exceeding difficult to engage the farmworker population, particularly in services provided by a government entity. This is also reflected in the decreased number of enabling services visits per patient.

Edit 04134: Substantial Inter-year variance in Providers - The number of Physician FTEs reported on Line 8 Column a differs from the prior year. Current Year - (6.1) . Prior Year - (4.8) . 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 2/14/2018 6:22 PM EST: Confirmed that FTE are based on paid hours. There are also more Medical visits in total. In addition, fewer Nurse visits - likely representing that the Physician was called into the visit, would account for the increase.

Edit 00158: PA Productivity Questioned - A significant change in Productivity of PAs on Line 9b (6,370) is reported from the prior year (5,060). Please check to see that the FTE and visit numbers are entered correctly.

Related Tables: Table 5(UR)

Jim Beaumont (Health Center) on 2/14/2018 6:19 PM EST: This is the result of working with a small sample size. The PA FTE count is 0.10 FTE and the variance around that (0.06 to 0.14) can account for all of the variation.

Edit 05138: Inter-year Patients questioned - On Universal - A large change in Vision Services patients from the prior year is reported on Line 22d Column c (PY = (471) , CY = (633)). Please correct or explain.

Related Tables: Table 5(UR)

Jim Beaumont (Health Center) on 2/14/2018 6:15 PM EST: There has been an increase emphasis with our community partners on the homeless and farmworkers accessing vision services, resulting in an increase in patients for these services.

Edit 04147: Inter-year Patients questioned - On Universal - A large change in Other Professional Services patients from the prior year is reported on Line 22 Column C. (PY = (150) , CY= (247)). Please correct or explain.

Related Tables: Table 5(UR)

Jim Beaumont (Health Center) on 2/14/2018 6:13 PM EST: A renwed focus on 'foot clinic' services for the homeless resulted in increased utilization of Podiatry services (Other Professional Services).

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 = (1,898) , CY = (1,311)). Please correct or explain.

Related Tables: Table 5(UR)

Jim Beaumont (Health Center) on 2/14/2018 6:11 PM EST: The reduction in Enabling Service patients is largely driven by the overall reduction in farmworker patients. There is a dramatic unwillingness for farmworkers to access any type of service, particularly one operated by a government entity.

Table 6A-Selected Diagnoses and Services Rendered

Edit 04737: Visits per Patient Questioned - A high number of Heart disease visits, Line 10, per patient is reported on the Health Care for the Homeless report. Please correct or explain.

Related Tables: Table 6A(HCH)

Linda Nguyen (Health Center) on 2/14/2018 3:55 PM EST: This is consistent with last year and average is about 3.5 visits per patient.

Edit 05460: Dental in Question - For Migrant Table: Total dental visits (1,017) on Table 6A(MHC) is less than the total dental visits reported on Table 5(MHC) Total Dental Services (Sum lines 16-18) Clinic Visits Line 19 Column b (1,025) . Please correct or explain.

Related Tables: Table 6A(MHC), Table 5(MHC)

Arthur Stickgold (Reviewer) on 3/2/2018 5:02 PM EST: 3. Table 5/6A. As a rule there is AT LEAST one procedure code for each dental visit – many have two. You are averaging less than 1 per visit. See if you can identify what visits do not have a countable code or correct table 6A. 3. Table 5/6A. As a rule there is AT LEAST one procedure code for each dental visit – many have two. You are averaging less than 1 per visit. See if you can identify what visits do not have a countable code or correct table 6A.

Edit 05461: Dental in Question - For Homeless Table: Total dental visits (2,416) on Table 6A(HCH) is less than the total dental visits reported on Table 5(HCH) Total Dental Services (Sum lines 16-18) Clinic Visits Line 19 Column b (2,981) . Please correct or explain.

Related Tables: Table 6A(HCH), Table 5(HCH)

Arthur Stickgold (Reviewer) on 3/2/2018 5:02 PM EST: 3. Table 5/6A. As a rule there is AT LEAST one procedure code for each dental visit – many have two. You are averaging less than 1 per visit. See if you can identify what visits do not have a countable code or correct table 6A. 3. Table 5/6A. As a rule there is AT LEAST one procedure code for each dental visit – many have two. You are averaging less than 1 per visit. See if you can identify what visits do not have a countable code or correct table 6A.

Edit 04717: Visits per Patient Questioned - A high number of Heart disease visits, Line 10, per patient is reported. Please correct or explain.

Related Tables: Table 6A(UR)

Linda Nguyen (Health Center) on 2/14/2018 4:15 PM EST: This is consistent with last year's reporting, this averages about 3.5 visits per patient.

Edit 05459: Dental in Question - Total dental visits (3,405) on Table 6A(Universal) are less than or equal to the total dental visits reported on Table 5(Universal) Total Dental Services (Sum lines 16-18) Clinic Visits Line 19 Column b (3,966) . This is unusual because dental visits often include more than one service, so on Table 6A each dental service would be counted on the corresponding line, but on Table 5, the combined services would be shown as one visit. Please correct or explain.

Related Tables: Table 6A(UR), Table 5(UR)

Arthur Stickgold (Reviewer) on 3/2/2018 5:02 PM EST: 3. Table 5/6A. As a rule there is AT LEAST one procedure code for each dental visit – many have two. You are averaging less than 1 per visit. See if you can identify what visits do not have a countable code or correct table 6A. 3. Table 5/6A. As a rule there is AT LEAST one procedure code for each dental visit – many have two. You are averaging less than 1 per visit. See if you can identify what visits do not have a countable code or correct table 6A.

Table 6B-Quality of Care Indicators

Edit 05787: Line 17 Universe in Question - Based on the universe for total patients with Coronary Artery Disease (CAD) on line 17 column A, we estimate a prevalence rate of (4.32)%. 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 4(UR), Table 5(UR)

Arthur Stickgold (Reviewer) on 3/2/2018 5:05 PM EST: 4. Table 6B. When asked about the high incidence of CAD you said it was the same as last year. Last year there were 94 cases. This year it is 214 – very different. Please explain or correct.

Edit 05789: Line 18 Universe in Question - Based on the universe reported for total patients with Ischemic Vascular Disease (IVD) on line 18 column A we estimate a prevalence rate of (7.17)%. 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 4(UR), Table 5(UR)

Arthur Stickgold (Reviewer) on 3/2/2018 5:06 PM EST: 5. Table 6B. When asked about the high incidence of IVD you said it was the same as last year. Last year there were 208 cases. This year it is 357 – very different. Please explain or correct.

Edit 05894: Missing Clinical Measure - You report no patients newly diagnosed with HIV. Please confirm that this is the case. If not, please complete Line 20.

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

Linda Nguyen (Health Center) on 2/14/2018 4:47 PM EST: This is correct, we have no newly diagnosed patients with HIV.

Table 7-Health Outcomes and Disparities

Edit 03959: Low Birthweights Questioned - The White LBW and VLBW percentage of births reported appears low. Please correct or explain. CY (3.13)%;PY National Average (6.81)%

Related Tables: Table 7

Linda Nguyen (Health Center) on 2/14/2018 4:52 PM EST: This is a sample size issue. There are only 32 total patients in the White sample. The movement of only one patient between categories causes a disproportionate change in the percentage.

Edit 06065: Hypertension Patients by Race or Ethnicity in Question - The total number of Asian patients with hypertension reported on Table 7 (218) is high compared to total Asian patients reported on Table 3B (426) . Please correct or explain.

Related Tables: Table 7, Table 3B(UR)

Linda Nguyen (Health Center) on 2/14/2018 5:06 PM EST: This is consistent with the trend that we are seeing; as Hypertension among Asian is has become a serious public health concern in recent years, as studies have been conducted recently in Southern California.

Edit 06323: Hypertension Patients by Race or Ethnicity in Question - The total number of Unreported/Refused to report race patients with hypertension reported on Table 7 (32) is low compared to total Unreported/Refused to report race patients reported on Table 3B (535). Please correct or explain.

Related Tables: Table 7, Table 3B(UR)

Linda Nguyen (Health Center) on 2/14/2018 5:11 PM EST: This is due to a small sample size of only 11.

Edit 06326: Hypertension Patients by Race or Ethnicity in Question - The total number of Unreported/Refused to Report Race and Ethnicity patients with hypertension reported on Table 7 (11) is low compared to total Unreported/Refused to Report Race and Ethnicity patients reported on Table 3B (128) . Please correct or explain.

Related Tables: Table 7, Table 3B(UR)

Linda Nguyen (Health Center) on 2/14/2018 5:12 PM EST: This is due to a small sample size of only 11.

Edit 05467: Hypertension Universe in Question - The universe of hypertensive patients reported on Table 7 is greater than the total hypertensive patients reported on Table 6A. This is possible only if you have seen hypertensive patients during the year without diagnosing them with hypertension. Please review and correct or explain.

Related Tables: Table 7, Table 6A(UR)

Linda Nguyen (Health Center) on 2/14/2018 5:16 PM EST: This is due to different reporting criteria; as table 6A only includes diagnosis from the reporting period and table 7-denominator includes diagnosis of hypertension within the first six months of the measurement period or any time prior to the measurement period.

Edit 06331: Diabetes Patients by Race or Ethnicity in Question - The total number of American Indian/Alaska native patients with Diabetes reported on Table 7 (8) is low compared to total American Indian/Alaska native patients reported on Table 3B (89) . Please correct or explain.

Related Tables: Table 7, Table 3B(UR)

Arthur Stickgold (Reviewer) on 3/2/2018 5:10 PM EST: difference between center and state is less that 0.75%.

Edit 06333: Diabetes Patients by Race or Ethnicity in Question - The total number of More than One Race patients with diabetes reported on Table 7 (79) is low compared to total More Than One Race patients reported on Table 3B (902) . Please correct or explain.

Related Tables: Table 7, Table 3B(UR)

Arthur Stickgold (Reviewer) on 3/2/2018 5:10 PM EST: difference between center and state is less that 0.75%.

Edit 06334: Diabetes Patients by Race or Ethnicity in Question - The total number of Unreported/Refused to report race patients with diabetes reported on Table 7 (27) is low compared to total Unreported/Refused to report race patients reported on Table 3B (535). Please correct or explain.

Related Tables: Table 7, Table 3B(UR)

Arthur Stickgold (Reviewer) on 3/2/2018 5:10 PM EST: difference between center and state is less that 0.75%.

Edit 06337: Diabetes Patients by Race or Ethnicity in Question - The total number of Unreported/Refused to Report Race and Ethnicity patients with diabetes reported on Table 7 (7) is low compared to total Unreported/Refused to Report Race and Ethnicity patients reported on Table 3B (128) . Please correct or explain.

Related Tables: Table 7, Table 3B(UR)

Arthur Stickgold (Reviewer) on 3/2/2018 5:10 PM EST: difference between center and state is less that 0.75%.

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 (276,244.05); PY National Average (95,429.23))

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

Arthur Stickgold (Reviewer) on 3/2/2018 5:13 PM EST: 6. Table 8A. Whatever you did for mental health costs, you are still left with some of he highest costs per visit in the state and the nation. Your costs for medical care is only three times normal.

Edit 04125: Cost Per Visit Questioned - Dental Care Cost Per Visit is substantially different than the prior year. Current Year (208.4); Prior Year (174.57).

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

Jim Beaumont (Health Center) on 2/14/2018 6:03 PM EST: This is a result in a decrease in the per capita visit rate for Dentists; fewer patients seen per FTE.

Edit 04126: Cost Per Visit Questioned - Mental Health Cost Per Visit is substantially different than the prior year. Current Year (742.49); Prior Year (876.12).

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

Jim Beaumont (Health Center) on 2/14/2018 6:01 PM EST: The per capita visit rate increased this year resulting in more visits for fewer FTE. This resulted in a decreased cost per visit.

Edit 04129: Cost Per Visit Questioned - Other Professional Cost Per visits is substantially different than the prior year. Current Year (314.06); Prior Year (200.78).

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

Jim Beaumont (Health Center) on 2/14/2018 5:57 PM EST: Per capita visit rates per FTE were down slightly this year, combined with increase staff costs, results in the increased visit cost.

Edit 04136: Costs and FTE Questioned - Other Professional Services are reported on Table 8A, Line 9 (68,408) (Podiatry) and Table 5, Line 22 (0.2) (Podiatry) . Review and confirm that FTEs relate to costs or correct.

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

Jim Beaumont (Health Center) on 2/14/2018 5:55 PM EST: This is the correct calculation. We are in a high cost labor market and have high benefit rate packages for staff.

Edit 05937: Cost per Visit Questioned - Vision Cost Per visit is substantially different than the prior year. Current Year (214.61); Prior Year (102.99).

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

Jim Beaumont (Health Center) on 2/14/2018 5:45 PM EST: This increase is the result of a 100% increase in the FTE delivering services for a 43% increase in visits. In addition, it appears in reviewing the prior year report that an incorrect salary was used in the vision staff cost calculation.

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 (1,106,243) ; Prior Year: Facility Accrued Cost Line 14 Column a (740,633)). Please correct or explain.

Related Tables: Table 8A

Arthur Stickgold (Reviewer) on 3/2/2018 5:19 PM EST: 7. Table 8A. You report facility costs are up $360,000 and admin costs are up $1.2 million, With the same number of facilities and 4 more patient support staff. Please explain or correct.

Edit 03945: Inter-Year variance questioned - Current Year Non-Clinical Support costs, Line 15 Column a (6,163,980) varies substantially from cost on the same line last year (4,971,969) . Please correct or explain.

Related Tables: Table 8A

Arthur Stickgold (Reviewer) on 3/2/2018 5:19 PM EST: 7. Table 8A. You report facility costs are up $360,000 and admin costs are up $1.2 million, With the same number of facilities and 4 more patient support staff. Please explain or correct.

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

Edit 01917: FQHC Medicaid Non-Managed Care retros questioned - FQHC Medicaid Non-Managed Care retros (1,186,299) exceed 50% of Medicaid Non-Managed Care Amount Collected This Period Line 1 Column b (1,342,404) . 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 2/14/2018 5:24 PM EST: The calculation is correct. This is the result of typical delays in payments.

Edit 01973: FQHC Medicaid Capitation retros exceed 50% total collections - FQHC Medicaid Capitation retros (1,350,530) exceed 50% of Medicaid Managed Care (capitated) Amount Collected This Period Line 2a Column b (2,453,513) . 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 2/14/2018 5:23 PM EST: The calculation are correct. This is the result of typical delays in payments.

Edit 04155: Inter-year Capitation PMPM questioned - The average Medicaid capitation PMPM reported on Line 2a (52.61) is significantly different from the prior year (29.91). Please correct or explain.

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

Jim Beaumont (Health Center) on 2/14/2018 5:19 PM EST: This appears to be primarily caused by the timing of collections, as the rate per member in total is only slightly higher than prior year.

Edit 05099: PMPM collections in question - Medicaid Capitation PMPM (52.61) 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 2/14/2018 5:16 PM EST: Data appears to be correct. It is unclear from the edit what the "typical range" is. There is often a lag in payments, which may distort the PMPM calculation. The PMPM rate is substantially higher than last reporting year.

Edit 04062: Inter-year Medicare patients and charges Questioned - A (44.16)% change in MEDICARE patients is reported, but (128.22)% in charges is reported. Review the report for consistency. Please correct or explain.

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

Arthur Stickgold (Reviewer) on 3/2/2018 5:24 PM EST: 9. Table 9D. Please confirm that you did not show charges for both the CPT codes and the G-code on the Medicare lines. If you did, remove the G codes and any associated allowances.

Edit 05982: Private Insurance Managed Care Capitated revenue reported in question - Private Insurance managed care capitated collections are reported on Table 9D Line 11a Column b (305) , with no matching managed care capitated member months on Table 4 Line 13a Column d (0) . This is generally not possible. Please correct or explain.

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

Jim Beaumont (Health Center) on 2/14/2018 4:55 PM EST: We are not within any private insurers network, but on occasion do deliver care to someone who comes to the clinics who has this coverage (as is indicated by the small amount of charges). Because we are not a part of their network, we have no way to count the member months, but we will still attempt to make collection for the services.

Edit 02028: Large change in accounts receivable for Total Private is reported - Total Private, Line 12: When we subtract collections (Column b) and adjustments (Column d) from your total Private charges (Column a) there is a large difference (53.34)%. While we do not expect it to be zero, a difference this large is unusual. Please explain or correct.

Related Tables: Table 9D

Jim Beaumont (Health Center) on 2/14/2018 4:51 PM EST: We are not typically included in any private insurers network, as indicated by the Private Insurance charges being less than two-tenths of one percent (0.15%) of our total charges. This results in processing for these charges (requests for payment, receipt of payment, etc.) to be slow and cumbersome. This results in these charges being on the books longer.
Edit 02021: Large change in accounts receivable for Total Self Pay is reported - Total Self Pay, Line 13: When we subtract collections (Column b), sliding discounts (Column e), and bad debt (Column f) from your total Self Pay charges (Column a) there is a large difference (97.97)%. While we do not expect it to be zero, a difference this large is unusual. Please explain or correct.
Related Tables: Table 9D
Jim Beaumont (Health Center) on 2/14/2018 4:46 PM EST: There is available a local program that provides coverage for everyone who is not covered by federal programs. It is not insurance, and therefore, all of the patients it covers are reported as self-pay for the UDS. The vast majority of the charges will actually be reimbursed through the local program payments.
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
Jim Beaumont (Health Center) on 2/14/2018 4:41 PM EST: We serve a small number of homeless and farmworkers that have greater than 200% of FPL and, thus, do not qualify for the sliding fee program. This represents collections form these patients. There is an available local program that provides coverage for everyone who does not otherwise qualify for federal programs, so there is typically no use of the sliding fee program for those under 200% FPL.
Edit 04064: Average Charges - Average charge per medical + dental + mental health + vision visits varies substantially from the prior year national average. Current Year (701.98); Prior Year National Average (267.85). Please correct or explain.
Related Tables: Table 9D, Table 5(UR)
Jim Beaumont (Health Center) on 2/14/2018 4:34 PM EST: Being in a high cost area, costs would normally be higher than the national average. Charges are established to recover all costs, including unreimbursed costs, so they would be even higher. Charges are lower this year than last, while the National Average continued to increase.

Table 9E-Other Revenues

Edit 04089: State/Local Indigent Care Program Exceeds Sliding Discounts - State/Local Indigent Care Programs Amount Line 6a Column a (10,005,098) on Table 9E exceeds Self-pay Sliding Discounts Line 13 Column e () on Table 9D. Please correct or explain.
Related Tables: Table 9E, Table 9D
Arthur Stickgold (Reviewer) on 3/2/2018 5:28 PM EST: grantee does not attempt payment or calculate a sliding discount for patients.

BHCMIS ID: 091140 - SAN MATEO COUNTY HEALTH SERVICES AGENCY, San Mateo, CA

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Program Name: Health Center 330

Submission Status: Review In Progress

UDS Report - 2017

Comments

Report Comments

Not Available