Period	**9**
Current Month	**March**
Percentage of Year	**75%**

CAB Financial Report

Line Item	Budget	Current Month	Year to date	*Target amount (Budget x %)*	YTD Percentage	Notes
Revenue						
Intrafund Reimbursements	$9,669,568	$672,053	$6,199,703	*$7,252,176*	64%	
Intergovernmental Revenue	$11,928,600	$655,762	$9,431,905	*$8,946,450*	79%	
Charges for Services	$76,800	$12,717	$105,934	*$57,600*	138%	CMISP old pre-2014 service charges
Miscellaneous Revenue	$17,368	$0	$1,179,191	*$13,026*	6789%	FY 2018-19 Cost settlement and accrual vs actual claims mismatch causes huge discrepancy vs. budget
Total Revenue	**$21,692,336**	**$1,340,532**	**$16,916,733**	*$16,269,252*	**78%**	
Expenses						
Personnel	$10,394,126	$771,852	$6,872,188	*$7,795,595*	66%	
Services & Supplies	$11,479,039	$686,292	$6,425,719	*$8,609,279*	56%	
Other Charges	$894,833	$104,432	$634,352	*$671,125*	71%	
Equipment	$250,000	$0	$94,510	*$187,500*	38%	
Intrafund Charges (Allocation costs)	$2,679,271	$160,787	$1,239,939	*$2,009,453*	46%	
				$0		
Total Expenses	**$25,697,269**	**$1,723,363**	**$15,266,708**	***$19,272,952***	**59%**	
GRAND TOTAL (Net County Cost)	**-$4,004,933**		**-$1,650,025**	***-$3,003,700***	41%	

Grants	Start	End	Amount
HRSA (HCH)	3/1/2020	2/28/2021	$1,386,602
HRSA H8C	3/15/2020	3/14/2021	$62,151
HRSA H8D	4/1/2020	3/31/2021	$723,200
HRSA H8E	5/1/2020	4/30/2021	$261,424

All are included in line 10 Intergovernmental Revenue. Part of H8E needs to be rebudgeted since van construction will continue into next FY.

COUNTY OF SACRAMENTO, CALIFORNIA

Single Audit Report
(Uniform Guidance)

For the Fiscal Year Ended June 30, 2020

COUNTY OF SACRAMENTO, CALIFORNIA

SINGLE AUDIT REPORT
(UNIFORM GUIDANCE)

FOR THE FISCAL YEAR ENDED JUNE 30, 2020

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Independent Auditor's Report on Internal Control Over Financial Reporting and on Compliance and Other Matters Based on an Audit of Financial Statements Performed in Accordance With *Government Auditing Standards*

To the Honorable Board of Supervisors
of the County of Sacramento, California

We have audited, in accordance with auditing standards generally accepted in the United States of America and the standards applicable to financial audits contained in *Government Auditing Standards* issued by the Comptroller General of the United States, the financial statements of the governmental activities, the business-type activities, the discretely presented component unit, each major fund, and the aggregate remaining fund information of the County of Sacramento, California (County), as of and for the fiscal year ended June 30, 2020, and the related notes to the financial statements, which collectively comprise the County's basic financial statements, and have issued our report thereon dated November 24, 2020.

Internal Control Over Financial Reporting

In planning and performing our audit of the financial statements, we considered the County's internal control over financial reporting (internal control) as a basis for designing audit procedures that are appropriate in the circumstances for the purpose of expressing our opinions on the financial statements, but not for the purpose of expressing an opinion on the effectiveness of the County's internal control. Accordingly, we do not express an opinion on the effectiveness of the County's internal control.

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

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

Compliance and Other Matters

As part of obtaining reasonable assurance about whether the County's financial statements are free from material misstatement, we performed tests of its compliance with certain provisions of laws, regulations, contracts, and grants agreements, noncompliance with which could have a direct and material effect on the financial statements. However, providing an opinion on compliance with those provisions was not an objective of our audit, and accordingly, we do not express such an opinion. The results of our tests disclosed no instances of noncompliance or other matters that are required to be reported under *Government Auditing Standards*.

Purpose of this Report

The purpose of this report is solely to describe the scope of our testing of internal control and compliance and the results of that testing, and not to provide an opinion on the effectiveness of the entity's internal control or on compliance. This report is an integral part of an audit performed in accordance with *Government Auditing Standards* in considering the entity's internal control and compliance. Accordingly, this communication is not suitable for any other purpose.

Macias Gini & O'Connell LLP

Sacramento, California
November 24, 2020

Independent Auditor's Report on Compliance for Each Major Federal Program; Report on Internal Control Over Compliance; and Report on Schedule of Expenditures of Federal Awards Required by the Uniform Guidance

To the Honorable Board of Supervisors
of the County of Sacramento, California

Report on Compliance for Each Major Federal Program

We have audited the County of Sacramento, California's (County) compliance with the types of compliance requirements described in the *OMB Compliance Supplement* that could have a direct and material effect on each of the County's major federal programs for the fiscal year ended June 30, 2020. The County's major federal programs are identified in the summary of auditor's results section of the accompanying schedule of findings and questioned costs.

Management's Responsibility

Management is responsible for compliance with federal statutes, regulations, and the terms and conditions of its federal awards applicable to its federal programs.

Auditor's Responsibility

Our responsibility is to express an opinion on compliance for each of the County's major federal programs based on our audit of the types of compliance requirements referred to above. We conducted our audit of compliance in accordance with auditing standards generally accepted in the United States of America; the standards applicable to financial audits contained in *Government Auditing Standards*, issued by the Comptroller General of the United States; and the audit requirements of Title 2 U.S. *Code of Federal Regulations* Part 200, *Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards* (Uniform Guidance). Those standards and the Uniform Guidance require that we plan and perform the audit to obtain reasonable assurance about whether noncompliance with the types of compliance requirements referred to above that could have a direct and material effect on a major federal program occurred. An audit includes examining, on a test basis, evidence about the County's compliance with those requirements and performing such other procedures as we considered necessary in the circumstances.

We believe that our audit provides a reasonable basis for our opinion on compliance for each major federal program. However, our audit does not provide a legal determination of the County's compliance.

Opinion on Each Major Federal Program

In our opinion, the County complied, in all material respects, with the types of compliance requirements referred to above that could have a direct and material effect on each of its major federal programs for the fiscal year ended June 30, 2020.

Report on Internal Control Over Compliance

Management of the County is responsible for establishing and maintaining effective internal control over compliance with the types of compliance requirements referred to above. In planning and performing our audit of compliance, we considered the County's internal control over compliance with the types of requirements that could have a direct and material effect on each major federal program to determine the auditing procedures that are appropriate in the circumstances for the purpose of expressing an opinion on compliance for each major federal program and to test and report on internal control over compliance in accordance with the Uniform Guidance, but not for the purpose of expressing an opinion on the effectiveness of internal control over compliance. Accordingly, we do not express an opinion on the effectiveness of the County's internal control over compliance.

A *deficiency in internal control over compliance* exists when the design or operation of a control over compliance does not allow management or employees, in the normal course of performing their assigned functions, to prevent, or detect and correct, noncompliance with a type of compliance requirement of a federal program on a timely basis. A *material weakness in internal control over compliance* is a deficiency, or a combination of deficiencies, in internal control over compliance, such that there is a reasonable possibility that material noncompliance with a type of compliance requirement of a federal program will not be prevented, or detected and corrected, on a timely basis. A *significant deficiency in internal control over compliance* is a deficiency, or a combination of deficiencies, in internal control over compliance with a type of compliance requirement of a federal program that is less severe than a material weakness in internal control over compliance, yet important enough to merit attention by those charged with governance.

Our consideration of internal control over compliance was for the limited purpose described in the first paragraph of this section and was not designed to identify all deficiencies in internal control over compliance that might be material weaknesses or significant deficiencies. We did not identify any deficiencies in internal control over compliance that we consider to be material weaknesses. However, material weaknesses may exist that have not been identified.

The purpose of this report on internal control over compliance is solely to describe the scope of our testing of internal control over compliance and the results of that testing based on the requirements of the Uniform Guidance. Accordingly, this report is not suitable for any other purpose.

Report on Schedule of Expenditures of Federal Awards Required by the Uniform Guidance

We have audited the financial statements of the governmental activities, the business-type activities, the discretely presented component unit, each major fund, and the aggregate remaining fund information of the County, as of and for the fiscal year ended June 30, 2020, and the related notes to the financial statements, which collectively comprise the County's basic financial statements. We issued our report thereon dated November 24, 2020, which contained unmodified opinions on those financial statements. Our audit was conducted for the purpose of forming opinions on the financial statements that collectively comprise the basic financial statements. The accompanying schedule of expenditures of federal awards is presented for purposes of additional analysis as required by the Uniform Guidance and is not a required part of the basic financial statements. Such information is the responsibility of management and was derived from and relates directly to the underlying accounting and other records used to prepare the basic financial statements. The information has been subjected to the auditing procedures applied in the audit of the financial statements and certain additional procedures, including comparing and reconciling such information directly to the underlying accounting and other records used to prepare the basic financial statements or to the basic financial statements themselves, and other additional procedures in accordance with auditing standards generally accepted in the United States of America. In our opinion, the schedule of expenditures of federal awards is fairly stated in all material respects in relation to the basic financial statements as a whole.

Macias Gini & O'Connell LLP

Sacramento, California
March 29, 2021

COUNTY OF SACRAMENTO, CALIFORNIA
SCHEDULE OF EXPENDITURES OF FEDERAL AWARDS
FOR THE FISCAL YEAR ENDED JUNE 30, 2020

FEDERAL GRANTOR PASSED THROUGH GRANT PROGRAM TITLE/CLUSTER COUNTY PROGRAM NAME	FEDERAL CFDA NUMBER	DIRECT/PASS-THROUGH AGENCY GRANT NUMBER	FEDERAL EXPENDITURES	AMOUNTS PASSED THROUGH TO SUBRECIPIENTS
U.S. DEPARTMENT OF AGRICULTURE				
PASSED THROUGH CALIFORNIA DEPARTMENT OF FOOD AND AGRICULTURE				
Plant and Animal Disease, Pest Control, and Animal Care				
European Grape Vine (I)	10.025	19-0994-012-SF	$ 64,003	$ -
European Grape Vine (II)	10.025	18-0619-004-SF	51,271	-
Glassy-winged Sharpshooter (GWSS)	10.025	17-0453-015-SF	213,216	-
Detector Dog Team	10.025	19-0266-005-SF	378,730	-
Light Brown Apple Moth - Detection	10.025	19-0268-037-SF	10,171	-
Light Brown Apple Moth - Regulatory	10.025	19-0268-008-SF	23,445	-
Sudden Oak Death	10.025	19-0267-008-SF	33,242	-
Pest Detection	10.025	19-0262	556,527	-
CATALOG TOTAL			1,330,605	-
CHILD NUTRITION CLUSTER				
PASSED THROUGH CALIFORNIA DEPARTMENT OF EDUCATION				
School Breakfast Program- State Nutrition Program (SNP)	10.553	02227-SN-34-R	89,423	-
National School Lunch Program- State Nutrition Program (SNP)	10.555	02227-SN-34-R	139,031	-
CHILD NUTRITION CLUSTER TOTAL			228,454	-
PASSED THROUGH CALIFORNIA DEPARTMENT OF PUBLIC HEALTH				
WIC Special Supplemental Nutrition Program for Women, Infants, and Children	10.557	19-10178	5,189,790	-
SNAP CLUSTER				
PASSED THROUGH CALIFORNIA DEPARTMENT OF PUBLIC HEALTH				
State Administrative Matching Grants for the Supplemental Nutrition Assistance Program	10.561	19-10376	1,743,058	855,093
PASSED THROUGH CALIFORNIA DEPARTMENT OF SOCIAL SERVICES				
State Administrative Matching Grants for the Supplemental Nutrition Assistance Program				
SNAP E&T 50% Participant Reimbursement - CalFresh Employment or Training (CFET) Program Supply of Service	10.561	207CACA4S2520	37,496	-
SNAP E&T 50% - CalFresh Employment or Training Program	10.561	207CACA4S2519	1,087,887	351,205
SNAP State Administrative Expense - CalFresh	10.561	207CACA4S2514	35,604,795	-
CalFresh (Food Stamps) – CalWIN Project	10.561	207CACA4S2514	818,432	-
SNAP CLUSTER TOTAL			39,291,668	1,206,298
TOTAL U.S. DEPARTMENT OF AGRICULTURE			46,040,517	1,206,298

See accompanying notes to the schedule of expenditures of federal awards.

COUNTY OF SACRAMENTO, CALIFORNIA
SCHEDULE OF EXPENDITURES OF FEDERAL AWARDS (CONTINUED)
FOR THE FISCAL YEAR ENDED JUNE 30, 2020

FEDERAL GRANTOR PASSED THROUGH GRANT PROGRAM TITLE/CLUSTER COUNTY PROGRAM NAME	FEDERAL CFDA NUMBER	DIRECT/PASS-THROUGH AGENCY GRANT NUMBER	FEDERAL EXPENDITURES	AMOUNTS PASSED THROUGH TO SUBRECIPIENTS
U.S. DEPARTMENT OF DEFENSE				
DIRECT PROGRAM				
Defense Environmental Restoration Program:				
Environmental Services Cooperative Agreement (ESCA) (I)	12.U01	FA8903-09-2-0002	$ 38,742	$ -
Environmental Services Cooperative Agreement (ESCA) (II)	12.U01	McClellan Foset #2 ESCA	969,361	-
Environmental Services Cooperative Agreement (ESCA) (III)	12.U01	McClellan Foset #3 ESCA	9,871,778	-
TOTAL U.S. DEPARTMENT OF DEFENSE			10,879,881	-
U.S. DEPARTMENT OF HOUSING AND URBAN DEVELOPMENT				
CDBG - ENTITLEMENT GRANTS CLUSTER				
PASSED THROUGH SACRAMENTO HOUSING AND REDEVELOPMENT AGENCY				
Community Development Block Grants/Entitlement Grants:				
CDBG I	14.218	B-18-UC-06-0005	3,642,631	-
CDBG II	14.218	B-20-UC-06-0005	47,114	-
CDBG - ENTITLEMENT GRANTS CLUSTER TOTAL			3,689,745	-
TOTAL U.S. DEPARTMENT OF HOUSING AND URBAN DEVELOPMENT			3,689,745	-
U.S. DEPARTMENT OF INTERIOR				
DIRECT PROGRAMS				
Payments in Lieu of Taxes	15.226	P.L. 116-94	5,753	-
Wild Horse and Burro Resource Management Wild Horse Training Grant	15.229	L17AC000241	66,006	-
PASSED THROUGH REGIONAL WATER AUTHORITY				
Reclamation States Emergency Drought Relief	15.514	R18AP00085	3,665	-
TOTAL U.S. DEPARTMENT OF INTERIOR			75,424	-
U.S. DEPARTMENT OF JUSTICE				
DIRECT PROGRAMS				
Domestic Cannabis Eradication and Suppression Program (I)	16.U01	2020-34	51,659	-
Domestic Cannabis Eradication and Suppression Program (II)	16.U01	2019-37	40,144	-
CATALOG TOTAL			91,803	-
Missing Children's Assistance				
Internet Crimes Against Children (I)	16.543	2016-MC-FX-K020	82,703	-
Internet Crimes Against Children (II)	16.543	2019-MC-FX-K032	340,334	-
CATALOG TOTAL			423,037	-
Public Safety Partnership and Community Policing Grants				
Community Oriented Policing Services (COPS) Anti-Gang Initiative Program (CAGI)	16.710	2015-GV-WX-0006	4,980	-
Edward Byrne Memorial Justice Assistance Grant Program				
Sacramento Multiple Advocate Resource Team (SMART) Policing Homeless Initiative	16.738	2016-WY-BX-0001	133,141	60,172
Edward Byrne Memorial Justice Assistance Grant Program - Justice Assistance Grant (JAG)	16.738	2018-DJ-BX-0825	221,595	-
CATALOG TOTAL			354,736	60,172

See accompanying notes to the schedule of expenditures of federal awards.

COUNTY OF SACRAMENTO, CALIFORNIA
SCHEDULE OF EXPENDITURES OF FEDERAL AWARDS (CONTINUED)
FOR THE FISCAL YEAR ENDED JUNE 30, 2020

FEDERAL GRANTOR PASSED THROUGH GRANT PROGRAM TITLE/CLUSTER COUNTY PROGRAM NAME	FEDERAL CFDA NUMBER	DIRECT/PASS-THROUGH AGENCY GRANT NUMBER	FEDERAL EXPENDITURES	AMOUNTS PASSED THROUGH TO SUBRECIPIENTS
U.S. DEPARTMENT OF JUSTICE (CONTINUED)				
DIRECT PROGRAMS (CONTINUED)				
DNA Backlog Reduction Program				
2017 DNA Capacity Enhancement and Backlog Reduction Program	16.741	2017-DN-BX-0054	$ 13,727	$ -
2018 DNA Capacity Enhancement and Backlog Reduction Program	16.741	2018-DN-BX-0007	329,270	-
CATALOG TOTAL			342,997	-
Second Chance Act Reentry Initiative				
2nd Chance Auto	16.812	2019-RV-BX-0002	164,355	88,865
PASSED THROUGH BOARD OF STATE AND COMMUNITY CORRECTIONS				
Residential Substance Abuse Treatment for State Prisoners	16.593	BSCC 528-19	290,936	-
Edward Byrne Memorial Justice Assistance Grant Program				
Juvenile Assistance Grant (JAG)	16.738	BSCC 619-19	136,737	-
Statewide Mental Health Training	16.738	BSCC-5227	1,600	-
CATALOG TOTAL			138,337	-
PASSED THROUGH GOVERNOR'S OFFICE OF EMERGENCY SERVICES				
Crime Victim Assistance				
County Victim Services Program (I)	16.575	XC 16 01 0340	349,143	253,535
County Victim Services Program (II)	16.575	XC 19 02 0340	240,657	200,935
Human Trafficking and Advocacy (I)	16.575	HA 18 01 0340	26,787	-
Human Trafficking and Advocacy (II)	16.575	HA 19 02 0340	60,653	-
Unserved/Underserved Victim Advocacy/Outreach (I)	16.575	UV 18 03 0340	39,324	-
Unserved/Underserved Victim Advocacy/Outreach (II)	16.575	UV 19 04 0340	167,872	-
Victim Witness Assistance Program (I)	16.575	VW 18 37 0340	476,530	-
Victim Witness Assistance Program (II)	16.575	VW 19 38 0340	1,507,254	-
CATALOG TOTAL			2,868,220	454,470
Paul Coverdell Forensic Sciences Improvement Grant Program				
Paul Coverdell FSIA (CA Coverdell) (I)	16.742	CQ 18 14 0340	44,451	-
Paul Coverdell FSIA (CA Coverdell) (II)	16.742	CQ 19 15 0340	27,823	-
CATALOG TOTAL			72,274	-
TOTAL U.S. DEPARTMENT OF JUSTICE			4,751,675	603,507
U.S. DEPARTMENT OF TRANSPORTATION				
DIRECT PROGRAM				
Airport Improvement Program	20.106	3-06-0204-058-2019	19,920,520	-
COVID-19 Airport Improvement Program	20.106	3-06-0204-060-2020	34,498,599	-
CATALOG TOTAL			54,419,119	-
HIGHWAY PLANNING AND CONSTRUCTION CLUSTER				
PASSED THROUGH STATE DEPARTMENT OF TRANSPORTATION				
Highway Planning and Construction				
Moving Ahead for Progress in the 21st Century Act (MAP-21 I)	20.205	03-5924F15	20,606,869	-
HIGHWAY PLANNING AND CONSTRUCTION CLUSTER TOTAL			20,606,869	-
Formula Grants for Rural Areas and Tribal Transit Program	20.509	N/A	44,953	-

See accompanying notes to the schedule of expenditures of federal awards.

COUNTY OF SACRAMENTO, CALIFORNIA
SCHEDULE OF EXPENDITURES OF FEDERAL AWARDS (CONTINUED)
FOR THE FISCAL YEAR ENDED JUNE 30, 2020

FEDERAL GRANTOR PASSED THROUGH GRANT PROGRAM TITLE/CLUSTER COUNTY PROGRAM NAME	FEDERAL CFDA NUMBER	DIRECT/PASS-THROUGH AGENCY GRANT NUMBER	FEDERAL EXPENDITURES	AMOUNTS PASSED THROUGH TO SUBRECIPIENTS
U.S. DEPARTMENT OF TRANSPORTATION (CONTINUED)				
HIGHWAY SAFETY CLUSTER				
PASSED THROUGH CALIFORNIA OFFICE OF TRAFFIC SAFETY				
State and Community Highway Safety				
Pedestrian and Bicycle Safety Program (I)	20.600	PS19016	$ 23,369	$ 23,369
Pedestrian and Bicycle Safety Program (II)	20.600	PS20017	18,897	18,897
CATALOG TOTAL			42,266	42,266
National Priority Safety Programs				
Child Passenger Safety Program (I)	20.616	OP20013	51,877	51,877
Child Passenger Safety Program (II)	20.616	OP19009	42,284	42,284
CATALOG TOTAL			94,161	94,161
HIGHWAY SAFETY CLUSTER TOTAL			136,427	136,427
PASSED THROUGH CALIFORNIA OFFICE OF TRAFFIC SAFETY				
Minimum Penalties for Repeat Offenders for Driving While Intoxicated				
Selective Traffic Enforcement Program (STEP) (I)	20.608	PT 19150	34,834	-
Selective Traffic Enforcement Program (STEP) (II)	20.608	PT 20109	13,902	-
Intensive Probation Supervision For High Risk Felony and Repeat DUI Offender (I)	20.608	AL19007	81,722	-
Intensive Probation Supervision For High Risk Felony & Repeat DUI Offender (II)	20.608	AL 20022	307,778	-
CATALOG TOTAL			438,236	-
TOTAL U.S. DEPARTMENT OF TRANSPORTATION			75,645,604	136,427
U.S. DEPARTMENT OF TREASURY				
DIRECT PROGRAM				
COVID-19 Coronavirus Relief Fund	21.019	2020-0257	134,936,324	-
PASSED THROUGH CALIFORNIA EMPLOYMENT DEVELOPMENT DEPARTMENT				
COVID-19 Coronavirus Relief Fund	21.019	2020-0257	400,973	-
TOTAL U.S. DEPARTMENT OF TREASURY			135,337,297	-
U.S. ENVIRONMENTAL PROTECTION AGENCY				
PASSED THROUGH CALIFORNIA STATE WATER RESOURCES BOARD				
Superfund Technical Assistance Grants (TAG) for Community Groups at National Priority List (NPL) Sites				
Local Oversight Program	66.806	D19-08-003	417,456	-
TOTAL U.S. ENVIRONMENTAL PROTECTION AGENCY			417,456	-

See accompanying notes to the schedule of expenditures of federal awards.

COUNTY OF SACRAMENTO, CALIFORNIA
SCHEDULE OF EXPENDITURES OF FEDERAL AWARDS (CONTINUED)
FOR THE FISCAL YEAR ENDED JUNE 30, 2020

FEDERAL GRANTOR PASSED THROUGH GRANT PROGRAM TITLE/CLUSTER COUNTY PROGRAM NAME	FEDERAL CFDA NUMBER	DIRECT/PASS-THROUGH AGENCY GRANT NUMBER	FEDERAL EXPENDITURES	AMOUNTS PASSED THROUGH TO SUBRECIPIENTS
U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES				
HEALTH CENTER PROGRAM CLUSTER				
DIRECT PROGRAMS				
Health Center Program (Community Health Centers, Migrant Health Centers, Health Care for the Homeless and Public Housing Primary Care)				
McKinney Homeless Grant	93.224	H80CS00045	$ 1,598,138	$ -
HEALTH CENTER PROGRAM CLUSTER TOTAL			1,598,138	-
Substance Abuse and Mental Health Services Projects of Regional and National Significance				
Drug Court Treatment	93.243	1H79TI081902-01	323,194	135,060
Ending the HIV Epidemic: A Plan for America - Ryan White HIV/AIDS Program Parts A and B	93.686	UT8HA33957	18,889	-
HIV Emergency Relief Projects Grants				
Ryan White Part A	93.914	H89HA00048	3,170,694	2,546,530
MEDICAID CLUSTER				
PASSED THROUGH CALIFORNIA DEPARTMENT OF HEALTH CARE SERVICES				
Medical Assistance Program				
Child Health Disability Prevention (CHDP- Medical and Foster Care)	93.778	2019-2020	1,354,952	-
Dental Transformation Initiative	93.778	16-93574	1,521,266	1,252,545
Medi-Cal	93.778	2005CA5MAP	36,475,176	-
Medi-Cal - CalWIN Project	93.778	2005CA5MAP	2,365,091	-
SUBTOTAL			41,716,485	1,252,545
PASSED THROUGH CALIFORNIA DEPARTMENT OF SOCIAL SERVICES				
Medical Assistance Program				
Adult Protective Services	93.778	County 34	1,497,024	-
Community Services Block Grant (CSBG)	93.778	County 34	697,892	-
In-Home Support Services (IHSS)	93.778	County 34	17,074,204	-
SUBTOTAL			19,269,120	-
MEDICAID CLUSTER TOTAL			60,985,605	1,252,545
AGING CLUSTER				
PASSED THROUGH CALIFORNIA DEPARTMENT OF AGING				
Special Programs for the Aging - Title III, Part B - Grants for Supportive Services and Senior Centers				
IIIB - Peer Counseling	93.044	1100-20	74,351	-
AGING CLUSTER TOTAL			74,351	-

See accompanying notes to the schedule of expenditures of federal awards.

COUNTY OF SACRAMENTO, CALIFORNIA
SCHEDULE OF EXPENDITURES OF FEDERAL AWARDS (CONTINUED)
FOR THE FISCAL YEAR ENDED JUNE 30, 2020

FEDERAL GRANTOR PASSED THROUGH GRANT PROGRAM TITLE/CLUSTER COUNTY PROGRAM NAME	FEDERAL CFDA NUMBER	DIRECT/PASS-THROUGH AGENCY GRANT NUMBER	FEDERAL EXPENDITURES	AMOUNTS PASSED THROUGH TO SUBRECIPIENTS
U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES (CONTINUED)				
PASSED THROUGH CALIFORNIA DEPARTMENT OF SOCIAL SERVICES				
Temporary Assistance for Needy Families				
Child Welfare Service - Emergency Assistance (EA)	93.558	County 34	$ 12,416,111	$ -
CalWORKS (TANF)	93.558	2001CATANF	74,638,338	3,272,940
CalWORKS (TANF) - Approved Relative Care (ARC)	93.558	2001CATANF	230,127	-
CalWORKS (TANF) - CalWIN Project	93.558	2001CATANF	555,064	-
CalWORKS (TANF) - Federal	93.558	2001CATANF	34,747,624	-
CalWORKS (TANF) - Fraud Incentives	93.558	2001CATANF	149,928	-
CalWORKS (TANF) - Stage One Child Care	93.558	2001CATANF	9,444,898	388,706
CATALOG TOTAL			132,182,090	3,661,646
PASSED THROUGH CALIFORNIA DEPARTMENT OF HEALTH CARE SERVICES				
Affordable Care Act (ACA) Maternal, Infant, and Early Childhood Home Visiting Program California Home Visiting Program (CHVP)	93.505	19.34	775,927	18,312
Community Services Block Grant	93.569	County 34	611,586	-
Children's Health Insurance Program California Children's Services (CCS) - Target Low-Income Children's Program (TLICP)	93.767	2019-0406	775,256	-
Block Grants for Community Mental Health Services Substance Abuse and Mental Health Services Administration	93.958	County 34	2,902,991	1,771,023
Block Grants for Prevention and Treatment of Substance Abuse Substance Abuse Block Grant	93.959	2B08TIO10062-20	6,616,905	2,656,278
Maternal and Child Health Services Block Grant to the States California Children's Services	93.994	CCS FY2019-20	4,003,009	50,000
PASSED THROUGH CALIFORNIA DEPARTMENT OF PUBLIC HEALTH				
Maternal and Child Health Services Block Grant to the States				
Black Infant Health	93.994	201934	99,432	-
Maternal Child and Adolescent Health	93.994	201934	233,069	17,317
CATALOG TOTAL			4,335,510	67,317

See accompanying notes to the schedule of expenditures of federal awards.

COUNTY OF SACRAMENTO, CALIFORNIA
SCHEDULE OF EXPENDITURES OF FEDERAL AWARDS (CONTINUED)
FOR THE FISCAL YEAR ENDED JUNE 30, 2020

FEDERAL GRANTOR PASSED THROUGH GRANT PROGRAM TITLE/CLUSTER COUNTY PROGRAM NAME	FEDERAL CFDA NUMBER	DIRECT/PASS-THROUGH AGENCY GRANT NUMBER	FEDERAL EXPENDITURES	AMOUNTS PASSED THROUGH TO SUBRECIPIENTS
U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES (CONTINUED)				
PASSED THROUGH CALIFORNIA DEPARTMENT OF SOCIAL SERVICES				
Public Health Emergency Preparedness	93.069	17-10184	$ 1,489,512	$ -
Affordable Care Act (ACA) Personal Responsibility Education Program				
CA Prep	93.092	18-10239 A01	187,861	-
Project Grants and Cooperative Agreements for Tuberculosis Control Programs				
Tuberculosis Program	93.116	1934BASSE00	436,431	-
Immunization Cooperative Agreements				
Immunization Assistance Program	93.268	17-10341 A01	405,706	-
State Physical Activity and Nutrition (SPAN)	93.439	18-10549	89,990	17,802
Refugee and Entrant Assistance State/Replacement Designee Administered Programs				
Refugee Health Promotion	93.566	18-34-90893-00	93,914	-
National Bioterrorism Hospital Preparedness Program				
Hospital Preparedness Program (HPP) (II)	93.889	17-10184	500,920	8,000
HIV Care Formula Grants				
HIV Care (Part B and MAI)	93.917	18-10883 A01	1,050,996	929,059
HIV Prevention Activities Health Department Based				
HIV Prevention Program	93.940	18-10766	607,192	185,121
Refugee and Entrant Assistance State/Replacement Designee Administered Programs				
Refugee and Entrant Assistance (RCA)	93.566	2001CARCMA	1,442,002	-
Refugee and Entrant Assistance (RCA) - CalWIN Project (I)	93.566	201CARCMA	637	-
Refugee and Entrant Assistance (RCA) - CalWIN Project (II)	93.566	2001CARCMA	4,683	-
CATALOG TOTAL			1,447,322	-
Guardianship Assistance				
Kinship Guardianship Assistance Program Title IV-E (Kin-GAP) 18+	93.090	1901CAGARD	286,385	-
Kinship Guardianship Assistance Payment Title IV-E (Fed-GAP) 4T	93.090	1901CAGARD	3,135,896	-
Kinship Guardianship Program - Title IV-E (Kin-GAP IV-E)	93.090	1901CAGARD	428,649	-
CATALOG TOTAL			3,850,930	-

See accompanying notes to the schedule of expenditures of federal awards.

COUNTY OF SACRAMENTO, CALIFORNIA
SCHEDULE OF EXPENDITURES OF FEDERAL AWARDS (CONTINUED)
FOR THE FISCAL YEAR ENDED JUNE 30, 2020

FEDERAL GRANTOR PASSED THROUGH GRANT PROGRAM TITLE/CLUSTER COUNTY PROGRAM NAME	FEDERAL CFDA NUMBER	DIRECT/PASS-THROUGH AGENCY GRANT NUMBER	FEDERAL EXPENDITURES	AMOUNTS PASSED THROUGH TO SUBRECIPIENTS
U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES (CONTINUED)				
PASSED THROUGH CALIFORNIA DEPARTMENT OF SOCIAL SERVICES				
MaryLee Allen Promoting Safe and Stable Families Program	93.556	County 34	$ 894,068	$ 268,195
Adoption and Legal Guardianship Incentive Payments				
Adoption Incentive Program	93.603	County 60	72,986	-
Stephanie Tubbs Jones Child Welfare Services Program				
Child Welfare Services - Title IV-B	93.645	County 34	1,984,179	1,984,179
Foster Care Title IV-E				
Child Welfare Services Case Records - Case Reviews	93.658	County 60	202,265	-
Child Welfare Services Outcome Improvement Project (CWSOIP) - COHORT	93.658	County 60	374,631	160,906
Child Welfare Services (CWS) - Title IV-E California	93.658	County 60	26,492,607	191,297
Child Welfare Services - Continuum of Care Reform Child and Family Team (CFT)	93.658	County 60	440,623	440,623
Child Welfare Services - Continuum of Care Reform - Foster Parent Recruitment	93.658	County 60	46,597	-
Child Welfare Services - Commercially Sexually Exploited Children (CSEC)	93.658	County 60	491,092	348,251
Child Welfare Services - Emergency Child Care Bridge (ECCB)	93.658	County 60	146,456	146,456
Child Welfare Services - Resource Family Approval (RFA)	93.658	County 60	1,827,460	-
Community Care Licensing (CCL) - Foster Family Homes (FFH)	93.658	County 60	2,831	-
Group Home Monthly Visits	93.658	County 60	27,741	-
Kinship and Foster Care Emergency Funds	93.658	County 60	6,909	-
Statewide Automated Child Welfare Information System (SACWIS)	93.658	County 60	39,691	-
Foster Parent Training & Recruitment (AB2129)	93.658	County 60	19,096	-
Aid to Families with Dependent Children (AFDC) - Foster Care	93.658	2001CAFOST	16,046,685	-
Emergency Assistance Foster Care	93.658	2001CAFOST	2,559,794	-
Extended Foster Care 18+	93.658	2001CAFOST	3,123,630	-
Foster Care - CalWIN Project	93.658	2001CAFOST	9,773	-
Program (I)	93.658	1901CAFOST	1,731,663	212,361
Program (II)	93.658	2001CAFOST	2,186,174	-
Program (III)	93.658	2001CAFOST	1,418,188	-
CATALOG TOTAL			57,193,906	1,499,894

See accompanying notes to the schedule of expenditures of federal awards.

COUNTY OF SACRAMENTO, CALIFORNIA
SCHEDULE OF EXPENDITURES OF FEDERAL AWARDS (CONTINUED)
FOR THE FISCAL YEAR ENDED JUNE 30, 2020

FEDERAL GRANTOR PROGRAM TITLE/CLUSTER PASSED THROUGH GRANT COUNTY PROGRAM NAME	FEDERAL CFDA NUMBER	DIRECT/PASS-THROUGH AGENCY GRANT NUMBER	FEDERAL EXPENDITURES	AMOUNTS PASSED THROUGH TO SUBRECIPIENTS
U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES (CONTINUED)				
PASSED THROUGH CALIFORNIA DEPARTMENT OF SOCIAL SERVICES (CONTINUED)				
Adoption Assistance				
Title IV-E (I)	93.659	County 60	$ 1,747,451	$ 360
Title IV-E (II)	93.659	2001CAADPT	28,748,583	-
Title IV-E (III)	93.659	2001CAADPT	517,083	-
Adoption Assistance Program - 18+ Federal	93.659	2001CAADPT	19,837	-
CATALOG TOTAL			31,032,954	360
Social Services Block Grant				
Child Welfare Services - Title XX	93.667	County 60	2,561,601	-
AFDC Foster Care Title XX	93.667	2001CASOSR	2,055,664	-
CATALOG TOTAL			4,617,265	-
John H. Chafee Foster Care Program for Successful Transition to Adulthood Independent Living Program	93.674	County 60	548,446	245,817
PASSED THROUGH CALIFORNIA DEPARTMENT OF CHILD SUPPORT SERVICES				
Child Support Enforcement	93.563	1901CACSES	23,982,579	-
TOTAL U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES			344,858,293	17,247,138
CORPORATION FOR NATIONAL AND COMMUNITY SERVICE				
FOSTER GRANDPARENT/SENIOR COMPANION CLUSTER				
DIRECT PROGRAMS				
Foster Grandparent Program - Foster Grandparent Program (FGP)	94.011	17SFPCA001	419,033	-
Senior Companion Program	94.016	19SCPCA001	102,957	-
FOSTER GRANDPARENT/SENIOR COMPANION CLUSTER TOTAL			521,990	-
Retired and Senior Volunteer Programs				
Training and Technical Assistance	94.002	19SRPCA005	199,900	-
TOTAL CORPORATION FOR NATIONAL AND COMMUNITY SERVICE			721,890	-
EXECUTIVE OFFICE OF THE PRESIDENT				
DIRECT PROGRAMS				
High Intensity Drug Trafficking Areas Program				
Central Valley California High Intensity Drug Trafficking Area (I)	95.001	G18CV0002A	588,550	357,017
Central Valley California High Intensity Drug Trafficking Area (II)	95.001	G19CV0002A	1,727,383	259,599
Central Valley California High Intensity Drug Trafficking Area (III)	95.001	G20CA0002A	170,805	8,682
TOTAL EXECUTIVE OFFICE OF THE PRESIDENT			2,486,738	625,298
U.S. DEPARTMENT OF HOMELAND SECURITY				
DIRECT PROGRAM				
Cooperating Technical Partners	97.045	EMF-2019-CA-00008-S01	37,132	-
PASSED THROUGH CALIFORNIA DEPARTMENT OF PARKS AND RECREATION				
Boating Safety Financial Assistance				
Marine Law Enforcement Equipment Grant Program	97.012	C18L0616	1,907	-

See accompanying notes to the schedule of expenditures of federal awards.

COUNTY OF SACRAMENTO, CALIFORNIA
SCHEDULE OF EXPENDITURES OF FEDERAL AWARDS (CONTINUED)
FOR THE FISCAL YEAR ENDED JUNE 30, 2020

FEDERAL GRANTOR PASSED THROUGH GRANT PROGRAM TITLE/CLUSTER COUNTY PROGRAM NAME	FEDERAL CFDA NUMBER	DIRECT/PASS-THROUGH AGENCY GRANT NUMBER	FEDERAL EXPENDITURES	AMOUNTS PASSED THROUGH TO SUBRECIPIENTS
U.S. DEPARTMENT OF HOMELAND SECURITY (CONTINUED)				
PASSED THROUGH GOVERNOR'S OFFICE OF EMERGENCY SERVICES				
Emergency Management Performance Grants				
Emergency Management Performance Grant (EMPG)	97.042	2019-0003	$ 433,646	$ -
Homeland Security Grant Program (HSGP)				
HSGP - (I)	97.067	2019-0627	592,400	-
HSGP - (II)	97.067	2017-0083	320,872	-
HSGP - (III)	97.067	2018-0054	1,873,510	-
HSGP - (IV)	97.067	2018-0054	504,815	-
HSGP - 2017	97.067	2017-0083	504,360	289,746
HSGP - 2018	97.067	2018-0054	201,973	-
CATALOG TOTAL			3,997,930	289,746
TOTAL U.S. DEPARTMENT OF HOMELAND SECURITY			4,470,615	289,746
TOTAL EXPENDITURES OF FEDERAL AWARDS			$ 629,375,135	$ 20,108,414

See accompanying notes to the schedule of expenditures of federal awards.

COUNTY OF SACRAMENTO, CALIFORNIA
NOTES TO SCHEDULE OF EXPENDITURES OF FEDERAL AWARDS
FOR THE FISCAL YEAR ENDED JUNE 30, 2020

NOTE 1 – BASIS OF PRESENTATION

The accompanying Schedule of Expenditures of Federal Awards (Schedule) includes the federal award activity of the County of Sacramento, California (County) under programs of the federal government for the fiscal year ended June 30, 2020. The information in this Schedule is presented in accordance with the requirements of Title 2 U.S. *Code of Federal Regulations* Part 200, *Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards* (Uniform Guidance). Because the Schedule presents only a selected portion of the operations of the County, it is not intended to and does not present the financial position, changes in net position, or cash flows of the County.

Expenditures funded by the Coronavirus Aid, Relief, and Economic Security (CARES) Act are denoted by the prefix COVID-19 in the federal program title.

NOTE 2 – SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES

Expenditures reported on the Schedule are reported on the modified accrual basis of accounting for the governmental funds and the accrual basis of accounting for the proprietary funds. Such expenditures are recognized following the cost principles contained in the Uniform Guidance, wherein certain types of expenditures are not allowable or are limited as to reimbursement.

NOTE 3 – MEDICAID CLUSTER

Except for Medi-Cal administrative expenditures, Medicaid (Medi-Cal) and Medicare program expenditures are excluded from the schedule of expenditures of federal awards. These expenditures represent fees for services; therefore, neither is considered a federal award program of the County for purposes of the Schedule or in determining major programs. The County assists the State of California (the State) in determining eligibility and provides Medi-Cal and Medicare services through County-owned health facilities. Medi-Cal administrative expenditures are included in the Schedule as they do not represent fees for services.

NOTE 4 – PASS-THROUGH ENTITIES' IDENTIFYING NUMBER

When federal awards were received from a pass-through entity, the Schedule shows, if available, the identifying number assigned by the pass-through entity. When no identifying number is shown, the County has determined that no identifying number is assigned for the program or the County was unable to obtain an identifying number from the pass-through entity.

NOTE 5 – INDIRECT COST RATE

The County elected not to use the 10-percent de minimis indirect cost rate allowed under the Uniform Guidance.

COUNTY OF SACRAMENTO, CALIFORNIA
SCHEDULE OF FINDINGS AND QUESTIONED COSTS
FOR THE FISCAL YEAR ENDED JUNE 30, 2020

I. SUMMARY OF AUDITOR'S RESULTS

FINANCIAL STATEMENTS

Type of report the auditor issued on whether the financial statements audited were prepared in accordance with GAAP:	Unmodified
Internal control over financial reporting:	
Material weakness(es) identified?	No
Significant deficiency(ies) identified?	None Reported
Noncompliance material to financial statements noted?	No

FEDERAL AWARDS

Internal control over major federal programs:	
Material weakness(es) identified?	No
Significant deficiency(ies) identified?	None Reported
Type of auditor's report issued on compliance for major federal programs:	Unmodified
Any audit findings disclosed that are required to be reported in accordance with 2 CFR 200.516(a)?	No

Identification of major federal programs:

CFDA Numbers	Name of Federal Programs or Clusters
10.557	WIC Special Supplemental Nutrition Program for Women, Infants and Children
	CDBG - Entitlement Grants Cluster:
14.218	Community Development Block Grants/Entitlement Grants
21.019	Coronavirus Relief Fund
93.658	Foster Care Title IV-E
93.914	HIV Emergency Relief Project Grants
93.958	Block Grants for Community Mental Health Services
93.959	Block Grants for Prevention and Treatment of Substance Abuse
97.067	Homeland Security Grant Program

Dollar threshold used to distinguish between type A and type B programs:	$ 3,000,000
Auditee qualified as low-risk auditee?	Yes

II. FINANCIAL STATEMENT FINDINGS

None reported.

III. FEDERAL AWARDS FINDINGS AND QUESTIONED COSTS

None reported.

COUNTY OF SACRAMENTO, CALIFORNIA
SUMMARY SCHEDULE OF PRIOR AUDIT FINDINGS
FOR THE FISCAL YEAR ENDED JUNE 30, 2020

There were no findings reported in the prior year.

Strategic Planning Sub-Committee (SPSC)
Progress Report to the Co-Applicant
May 21, 2021

March 30, 2021 Meeting

Staff explained that strategic planning is an organizational process; a way of allocating resources to pursue targeted goals and objectives. The priorities should be fleshed out with specific, measurable, attainable, relevant and timely (SMART) objectives that enumerate specific and measurable outcomes. Currently, the Health Center (HC) is expanding and revising existing programs, not starting new ones. We need to create financial bridges, secure funding, increase and expand human capital (staffing), advance information technology, and obtain medical equipment for the HC. The Strategic Plan builds the infrastructure needed for the HC's vision and mission. Change management is an internal and external process. If we achieve the identified priorities over the next three years (or longer), we will be in a place where we can actually live up to the mission and vision.

The Strategic Plan Sub-Committee (SPSC) reviewed the priorities set at the previous meeting and finalized strategies and action steps. The next step is to develop the SMART objectives.

April 9, 2021 Meeting

Before the meeting, staff sent proposed SMART objectives to SPSC members. During the meeting, the SPSC reviewed and discussed the full Action Plan with SMART objectives and began discussing metrics for each action step as a whole. The SMART objectives contain a metric within them; but what is desired is a metric that can assess progress for the entire action step. The timeline for each action step was discussed and deliverable dates were modified.

The SPSC was asked to consider how CAB and individual members of the CAB could support the Strategic Plan. CAB members are community experts; they can help with introductions and warm handoffs to potential collaborating organizations, serve as ambassadors of the plan, and advocate for the plan including at the Board of Supervisors meeting(s) or other places when applicable.

The SPSC wanted to ensure that the plan is not too ambitious for staff and leadership to complete. Staff will bring the full plan to the Admin Team to make sure that the timelines are realistic, or modify them as needed.

The SPSC also decided what would be presented at the next CAB meeting to keep all CAB members up to date on the strategic planning process.

April 27, 2021 Meeting

The goal for this meeting was to have a finalized Strategic Plan (SP) to present to the CAB on May 21 and to identify what CAB members can do to support the SP during implementation and throughout the strategic plan period. SPSC was asked to focus on the following questions:

1. Is it clear to CAB members how success of the SP will be measured?
2. Are you satisfied with the metrics and the due dates?

Two new funding opportunities were shared that affect the SP and potentially the deliverables timeline, specifically the need to push staffing deliverables back as we develop the proposal for space, and shortening the timeline to develop a space plan to have the information needed for grant applications.

The SPSC discussed how CAB could support all three priorities and decided CAB's role is to ensure the SP is progressing on schedule. In addition, CAB members with knowledge, perspectives of expertise in particular areas will assist SCHC staff and leadership to identify potential partners. CAB members will publically support the SP and educate others on its importance. SPSC members suggested the Governance Sub-Committee take on the responsibility of monitoring the SP once it is approved by CAB.

The SPSC requested more detail in the SP including identifying what actions leadership is taking and how/when items will transition to CAB, and clearly identifying when CAB will review deliverables and how often they will receive reports on the metrics. The SPSC Chair will present the draft SP and the proposal to have the Governance Sub-Committee serve as the oversight body for the SP to CAB on May 21.

Strategic Plan Timeline

Year: 2021			
Month	**Space**	**Staffing**	**Homeless**
May	• Map current space – Broadway and L&F (Mason, Stacholy) • Prepare plans to propose in the ARP-Capital grant application (Leadership)		• List assigned homeless pts who have not made an appt. (Hutchins)
June	• Leadership to review site map and associated information at a meeting to discuss possible changes • Submit APR-Capital grant application (Hutchins, Stanley) • Work w/ Macman Consulting to identify experts for financing options (Hutchins, Alongi)		• Begin outreach to homeless pts to make appt. (volunteer – Princess?) • Develop SOW for the Sac Covered staff at L&F (up to Sac Covered) [Stacholy, Alongi] – Martha Fridays at L&F
Jul	• Decide which programs and supportive services to move off site (Mishra) • Dev plan for supporting staff and functions off site (Burow, Stacholy, Hutchins) • Leadership reviews and approves finalized maps for current space utilization; CAB members get email confirming map is finalized.		• Research # of persons experiencing homelessness and insurance status • Distribute, collect, analyze homeless needs assessment surveys • Place Sac Covered staff at L&F (up to Sac Covered)
Aug		• Research staffing ratios (Hutchins, Alongi)	• CAB Governance received semi-annual reports on Sac Covered associated metrics • Assign staff to attend Medi-Cal Managed Care meetings
Sep	• Dev. initial plan for utilization of mobile van (Sapargaliyeva, Stacholy, Mishra)	• Leadership reviews staff ratios • Cost estimate for additional staff (Burow) • Draft list tech needs for add'l staff and get estimate (Burow, Mason, Stacholy)	• CAB reviews needs assessment data / submit to HRSA • Leadership meets to develop plan to expand services at L&F
Oct	• Outreach to partners regarding space needs • Ask for a cost estimate for proposed space changes • Report to CAB regarding what the HC plans to do with captured space and which programs will stay in 4600 Broadway.	• CAB discuss/decide staffing needs • Research technologies to offset need for staff	• Explore options for free phones/discounted Broadband • Meet with DTech to discuss new tech for patient care
Nov	CAB reviews mobile van plan	• Receive cost estimate for	

		additional staff and tech for those staff	
Dec	• John and Sumi will talk to the County Executive and CEO office regarding political and financial viability of new space • Develop space plan • Receive cost estimate for proposed space changes - renovations • SCHC Leadership meet to discuss the estimate for the proposed changes at Broadway and how these can be funded. • CAB receives update on financing options for space • Conduct outreach to patients experiencing homelessness to inform them about plans for the mobile van	• Determine costs of technologies. • Leadership determines location of new staff and equipment	• 30% of homeless pts will make initial appt. • Finalize L&F service expansion plan • Finalize a plan for mobile van • List Co. and comm programs serving homeless. Leadership decides which orgs to partner with or refer to. • Share needs assessment data with partners • Final list of poss new tech and costs for leadership review and include in business plan • CAB Governance receives semiannual reports on the results of outreach to current homeless pts to make initial appt. • Leadership finalizes plan for mobile van • Create list of programs serving homeless
Year: 2022			
Month	**Space**	**Staffing**	**Homeless**
Jan	• CAB reviews draft space plan	• Decide which technologies to implement and est. contracts with vendors • Draft business case for staff/tech (by Jan 10) • CAB reviews business case	• Determine what changes can be made based on needs assess. to improve homeless pt satisfaction • CAB reviews 1. L&F service expansion plan 2. CAB reviews mobile van plan
Feb		• CAB discuss identified technologies	• Choose at least one area to focus HC changes based on needs assessment • Leadership to review identified tech • CAB Governance received semi-annual reports on Sac Covered associated metrics • Mobile van operational – implement plan
Mar	• Develop a financing plan for enhancing existing space and adding additional space	• Submit business case/growth to include tech request to BOS	• Identify staff to develop plan for identified changes • Identify community partner willing to install telemedicine “outstation.” • Leadership selects orgs to approach regarding referral processes • CAB reviews 1. Area(s) selected for homeless change efforts 2. List of selected organizations to approach regarding referral processes
Apr	• Develop a list of unmet space requirements		• Develop written agreement with the identified community partner for outstation
May			• Leadership to review a draft plan for homeless improvements • Select orgs to approach re: partnership
June	• Implement Broadway reorg/ renovation plan • CAB	• BOS budget decisions	• Implement the homeless plan • Identify staff to connect to outstation, tech needs, workflows, outreach plan, and metrics

	1. Reviews financial plan 2. Receives report on L&F and mobile van metrics		• Develop community partnership plan • CAB Governance receives semiannual report on 1. Metrics re: L&F expansion plan. 2. Mobile van metrics 3. Reviews list of orgs for possible partnership
Jul	• Determine whether these space needs are best met within the footprint of existing space	• Implement staff/tech changes as a result of BOS decisions	• Conduct outreach to pts re: outstation • MOUs with community partners finalized • ID MyChart modules to increase access to care • Outreach to selected orgs serving homeless to explore collaboration
Aug	• CAB 1. Reviews justification for add'l space 2. Reviews plan for maximizing Broadway space 3. Decides about securing new space	• Finalized signed agreements with tech vendors	• CAB Governance receives semi-annual report on Sac Covered associated metrics • Dev promo plan to increase registration/use of MyChart
Sep	CAB reviews final space plan based on BOS decisions re: budget		• Create plan to promote new MyChart modules • Activate identified MyChart modules
Oct			
Nov			
Dec	• CAB Governance receives semiannual report 1. Space Plan (reorg/renovation) metrics 2. L&F and mobile van metrics	• CAB Governance receives report on metrics for implemented tech	• Finalize MOU's with selected collaborative organizations • Final list of health education messages for lobby TV • Implement telemedicine at outstation site • CAB Governance receives semiannual report on: 1. Homeless improvements as a result of the needs assessment 2. Mobile van metrics 3. Metrics in the partnership plan
Year: 2023			
Month	**Space**	**Staffing**	**Homeless**
Jan		• CAB Governance receives report on growth request metrics	• Request BOS permission to establish MOU's with partner orgs
Feb			• CAB Governance received semi-annual reports on Sac Covered associated metrics
Mar			• SCHC and collaborating partners begin providing identified services to homeless • Implement health education on lobby TV's
Apr			
May			
June	• CAB Governance receives semiannual report 1. Space Plan (reorg/renovation) metrics 2. L&F and mobile van metrics	• CAB Governance receives report on metrics for implemented tech	• CAB Governance receives semiannual report: 1. Collaborative partnerships, services and patient outcomes 2. Homeless satisfaction improvements as a result of strategies chosen from the needs assessment 3. MyChart metrics as a result of promotion and opening new modules 4. Mobile van metrics 5. Metrics in the partnership plan • Purchase, install and deploy approved technologies

Jul		• Report growth request metrics to CAB	
Aug			• CAB Governance received semi-annual reports on Sac Covered associated metrics
Sep			
Oct			
Nov			
Dec	• CAB Governance receives semiannual report 1. Space Plan (reorg/renovation) Metrics to CAB 2. L&F and mobile van metrics	• CAB Governance receives report on 1. Metrics for implemented tech 2. Growth request metrics	• CAB Governance receives semiannual report 1. MyChart metrics as a result of promotion and opening new modules 2. Mobile van metrics 3. Metrics in the partnership plan • Identify SOW, roles, goals, metrics with partner org. • Established MOU's with community partners

Action Plan

I. Priority: *Sufficient and Appropriate Space to Carry Out the SCHC's Mission*

Strategy 1: Identify funds to expand to new buildings and enhance space at Broadway and Loaves and Fishes sites.		
CAB Support: 1. Notify staff of funding opportunities 2. Contribute ideas to the financing plan		
Action Steps	**SMART Objectives**	**Metrics**
1. Staff will look for and apply for grants that can fund space.	A. Throughout the Strategic Plan period, Sharon will read BPHC and HRSA newsletters and emails and communicate with Marian Ladipo to identify possible grant opportunities to fund renovations or new space. B. SCHC staff will apply for grants and other funding when applicable and possible. C. SCHC leadership will report to the CAB quarterly regarding grant opportunities.	A. Number of grants that the SCHC applied for during the Strategic Plan period 2021-23. B. Number of grants obtained. C. Amount of funds obtained that can be used for renovations or new space. D. Information on grants identified will be presented to the **CAB Finance Sub-Committee** and then to **CAB**, who will review and grant permission to apply.
2. Develop a financing plan for additional space and ancillary costs such as technology, staff and furniture.	A. By June 30, 2021, Sharon will work with Macman Consulting to identify experts and peer organizations (including list from OSV team) with whom to discuss financing options such as new market tax credits, bonds, and public/private partnerships. B. By October 1, 2021, SCHC will outreach to partners regarding space needs and possible funding opportunities. C. By December 31, 2021, John and Sumi will talk to the County Executive and CEO office regarding political and financial viability of renovations and new space. D. By December 31, 2021, SCHC leadership will discuss options with a range of experts and peers. E. By March 31, 2022, SCHC will develop a financing plan for enhancing existing space and adding additional space, both initial costs and on-going expenses.	A. Update on financing options for space given to the **CAB Finance Sub-Committee** at December 2021 meeting. B. Finalized financial plan submitted and approved by the **CAB** by the June 2022 meeting.

Strategy 2: Maximize existing space.		
CAB Support: 1. Suggest where, when and in conjunction with what organizations to reach out to homeless patients 2. Use connections to support outreach efforts		
Action Steps	**SMART Objectives**	**Metrics**
1. Map current space utilization in the Broadway and the Loaves and Fishes sites and identify spaces where changes could be made to enhance space utilization.	A. By May 10, 2021, SCHC staff will map the current space at 4600 Broadway and Loaves and Fishes and what it is used for, the number of staff utilizing the space, the average number of patients (where applicable) seen in that space per day. B. By June 1, 2021, SCHC staff will send the map and associated information to leadership for review and set up a meeting to discuss possible changes.	A. Review and approval of finalized maps for current space utilization by leadership by July 1, 2021. B. Provide written report to the **CAB Governance Committee** via email confirming the map was finalized.
2. Develop a plan to support permanent remote work.	A. By July 30, 2021, SCHC and D-Tech will develop a plan for supporting selected staff/ support functions located off site including identifying necessary technology and cost.	A. Finalized plan with documented amount of space captured to maximize clinic operations. B. Report at the October 2021 **CAB** meeting what leadership proposes to do with the captured space and obtain approval to move forward.
3. Decide whether to move programs (e.g. Family Medicine or Refugee off site or renovate existing space or end/reduce programs) and supportive services (e.g. referrals, call center, some admin functions) to remote work.	A. By June 1, 2021, receive an answer from federal Office of Refugee Resettlement (ORR) about the ability to continue to provide telemedicine visits post-pandemic OR will assume that permission will not be granted. B. By July 31, 2021, SCHC leadership will decide which programs and supportive services to move (or attempt to move) off site.	A. Leadership will document which programs and support services will move from 4600 Broadway and incorporate this information into the Financial Plan (Strategy 1.2). B. Report to the **CAB Governance Committee** on the plans included in the report at the October 2021 meeting.
4. Develop a plan for maximizing space at 4600 Broadway.	A. Based on the outcomes of Action Steps 1, 2, and 3, by December 31, 2021, SCHC Leadership will develop a Space Plan. B. By October 1, 2021, SCHC staff will ask Facilities for a cost estimate for the proposed space changes. C. By December 15, 2021, Facilities will finalize and send an estimate for proposed changes for leadership to review.	A. Present to the **CAB** by the January 2022 meeting. B. A final plan will be presented to the **CAB** within 60 days after the Board of Supervisors approves the fiscal year budget.

	D. By December 23, 2021, SCHC Leadership will meet to discuss the estimate for the proposed changes at Broadway and how these can be funded. E. SCHC leadership will send proposed changes and cost estimates for existing site renovation and other changes to CAB for discussion and decisions at the January 21, 2022 meeting.	
5. Implement a plan for reorgan-ization and renovation of Broadway.	A. Within 90 days of BOS approval of the fiscal year budget, SCHC will begin implementing the plan for maximizing and enhancing existing space at 4600 Broadway if funding is available.	A. Implement the plan; measure changes in: 1. Revenue 2. # Patient visits B. Report to the **CAB Governance Committee** semiannually on the identified metrics beginning December 2022 and through December 2023.
6. Develop a plan for mobile medical center van usage *(See also Priority #3).*	A. SCHC will work with Loaves and Fishes regarding mobile medical van services. B. By September 30, 2021, SCHC leadership will develop an initial plan for utilization of mobile van including staffing, hours, locations of service, and services offered.	A. A draft plan will be presented to the CAB by the November, 2021 meeting.
7. Develop plan for Loaves & Fishes	See details in Priority 3, Strategy 2	
8. Implement the plan for Loaves and Fishes and the mobile medical center van usage *(See also Priority #3).*	A. By December 31, 2021, SCHC will conduct outreach to patients experiencing homelessness to inform them about plans for the mobile van and other services available at L & F. B. See details in Priority 3, Strategy 2.6 for the mobile medical van.	A. Develop, distribute and post flyers, work with partners to inform potential and existing patients and measure outcomes by: 1. The number of patients seen on the mobile van. 2. Patients demographics including homeless status 3. The number of each service delivered. B. Report to the **CAB Governance Committee** semiannually on the identified metrics beginning June 2022 and through December 2023.

Strategy 3: Secure additional space (contingent).		
CAB Support: 1. Help identify priorities for program retention and expansion		
Action Steps	**SMART Objectives**	**Metrics**
1. After decisions have been made about what needs cannot be met with the existing space or the mobile medical center van and funding options are understood, Develop priorities for program retention and expansion based on community and SCHC patient health needs and identify ideal space and configuration needs.	A. By April 1, 2022, SCHC leadership will develop a list of space requirements to handle unmet priority needs. B. By July 1, 2022, SCHC and Facilities staff will determine whether these space needs are best met within the footprint of existing space (e.g. within 4600 Broadway) or outside (purchase space or contract for space from partner agency). C. SCHC and Facilities will develop a budget for the needed space. D. SCHC leadership will present the determination and reasons to CAB at the August 19, 2022 meeting. E. SCHC will outreach to partners with services helpful to patients that could co-locate. F. SCHC leadership will pursue funding options to secure space. G. Once funding is secured, SCHC will reach out to Facilities and DGS to pursue obtaining additional space. H. Within 60 days of securing funding, SCHC Leadership will meet to discuss and finalize the list of needs and choose a point person to lead the effort to obtain new space. I. Through December 31, 2023, SCHC leadership will ask for updates from DGS on progress towards finding new space. J. If new space is found, a transition plan will be developed.	A. **CAB** to review, discuss and make a decision about securing new space by the August 2022 meeting and will be updated semiannually thereafter on progress.

II. Priority: *Sufficient and Appropriate Staffing to Carry Out Mission*

Strategy 1: Determine appropriate ratios of staff per provider/patient for each program including support and administrative staff.		
CAB Support: 1. Contribute personal knowledge of ideal staffing ratios		
Action Steps	**SMART Objectives**	**Metrics**
1. Conduct research to determine ideal staff/provider ratios and effects on revenue, quality metrics and staff morale, by consulting a) Literature b) California Primary Care Association c) Similar health centers d) Macman Consulting	A. SCHC staff will research staffing ratios for each program by August 31, 2021. B. The research on staffing will be presented to SCHC leadership by September 17, 2021.	A. **CAB** to review, discuss and make a decision about staffing at the October 15, 2021 meeting.

Strategy 2: Investigate how technology can offset the need for staff.		
CAB Support: 1. Suggest possible technology(s) and vendors based on experience or research 2. Support implementation of technologies with patients		
Action Steps	**SMART Objectives**	**Metrics**
1. Research technology that can reduce need for staff at a reasonable cost, including: a) Kiosks for registration. b) MyChart for patient self-scheduling appointments. c) Training on OCHIN to increase	A. By October 31 2021, research how technologies could decrease the need for staff to check-in and schedule patients. B. By December 31, 2021, determine the costs associated with these technologies. C. By January 31, 2022, determine which technologies to implement, given budget and potential savings. D. Pursue agreements with vendors, health plans, and/or other stakeholders to be able to implement the chosen technologies.	A. **CAB** will discuss the identified technologies at the February 2022 meeting. B. Signed agreements in place with County approved vendors. C. Measure the effects of the technologies over time including: 1. Increase in productivity 2. Patient satisfaction 3. Employee satisfaction 4. Reduced costs to the HC D. Report to the **CAB Governance Committee** semiannually on the identified metrics of added

Strategy 2: Investigate how technology can offset the need for staff.		
CAB Support: 1. Suggest possible technology(s) and vendors based on experience or research 2. Support implementation of technologies with patients		
Action Steps	**SMART Objectives**	**Metrics**
referrals efficiency. d) Improved coordination between SCHC technology and that of IPAs and health plans. e) Video interpretation kiosks for patients.	E. By August 1, 2022, signed agreements will be finalized.	technology beginning December 2022 and through December 2023.

Strategy 3: Write a business case for staffing needs and present it to County Executives, the Board of Supervisors and/or others who have influence over budgetary decisions.		
CAB Support: 1. Attend Board of Supervisors meeting(s) to support Sacramento County Health Center agenda items. 2. Use relationships with the community, organizations, and decisions makers to gain support for the business plan and growth request.		
Action Steps	**SMART Objectives**	**Metrics**
1. Consult with Finance to determine the cost of additional staff identified for ideal ratios.	A. By September 1, 2021, SCHC staff will consult with Finance to request a cost estimate for each additional staff position identified in Priority 2, Strategy 1.	A. Finalized cost estimate for staff.
2. Determine the technological needs for additional staff and the cost of those technologies.	A. By September 15, 2021, SCHC staff will draft a list of technological needs for additional staff and send the list to the Department of Technology for input and an estimate.	A. Finalized list of technology needed for each staff; documented email to DTech with the list. B. Receive cost estimates from DTech by November 1, 2021.
3. Determine onsite space needs for additional staff and any necessary equipment.	A. Based on the revised map of 4600 and the decisions made in the staffing strategy, by November 30, 2021, Leadership will determine where new staff will work and where the necessary equipment will be located.	A. New staff will be incorporated into the Space Priority 1.2.2,3 by July 31, 2021 and the financial plans Priority 2.3.1,4. By January 30, 2022.

Strategy 3: Write a business case for staffing needs and present it to County Executives, the Board of Supervisors and/or others who have influence over budgetary decisions.		
CAB Support: 1. Attend Board of Supervisors meeting(s) to support Sacramento County Health Center agenda items. 2. Use relationships with the community, organizations, and decisions makers to gain support for the business plan and growth request.		
Action Steps	**SMART Objectives**	**Metrics**
4. Write a business case for staff and technologies.	A. Using the financial and space plans, and ideal staffing ratios, by January 10, 2022, leadership will write a business case and present it to CAB for review and decision.	A. **CAB** will review, discuss and make a decision about the proposed business case at the January 2022 meeting.
5. Present the business case to the Board of Supervisors.	A. By February 28, 2022, SCHC will include the business case for staff and technologies in its annual budget submission to the CEO's office. B. SCHC staff will answer questions from County decision makers regarding the budget and business case. C. By June 1, 2022, SCHC Leadership will have vetted the business case with the County Executives and will ensure the final version of the business case is included in the County's growth request. D. Within 90 days of budget approval, SCHC will begin implementing staffing and technology changes allowable by BOS and CAB if funding is available. E. Through December 2023, SCHC will track the impact of these changes.	A. By July 1, 2022, The Board of Supervisors will review the growth request and make decisions. B. Tracked changes in: 1. Patient satisfaction 2. Employee satisfaction 3. SCHC revenue 4. HEDIS measures 5. Number of assigned patients 6. Feedback from Health Plans C. Report to the **CAB Governance Committee** semiannually beginning January 2023 through December 2023.

III. Priority: *Maintain the historical focus on serving individuals experiencing homelessness*

Continue to improve access and continuity of care at 4600 Broadway and Loaves and Fishes

Strategy 1: Conduct a health and related needs assessment of individuals experiencing homelessness.		
CAB Support: 1. Based on the needs assessment results, suggest ways to better serve homeless patients. 2. Use community connections to support identified services and promote the strategic plan.		
Action Steps	**SMART Objectives**	**Metrics**
1. Obtain existing data on number of homeless people in the Sacramento area in need of health services (e.g. not assigned elsewhere).	A. By July 1, 2021, Robyn Alongi will research the number of persons experiencing homelessness in Sacramento who 1) are not insured and 2) are insured but are not utilizing their Medi-Cal benefits, and 3) where they reside/shelter. Findings will be stored as a document and contribute to the overall needs assessment data.	A. Data collected will contribute to the needs assessment data that will be used to develop a plan to better serve homeless and indigent patients.
2. Conduct a survey of individuals experiencing homelessness to understand: a) Their health care needs; b) The driving forces for selecting a place to obtain health care; and c) What improvements SCHC could make to serve them better.	A. By April 30, 2021, SCHC staff will talk with Dr. Landefeld to understand his progress in conducting a needs assessment. B. By July 31, 2021, Dr. Landefeld will distribute surveys (staff and homeless individuals), collect and analyze the results and share them with SCHC leadership. C. SCHC leadership will present findings to the CAB at the September 2021 meeting. D. Data will be shared with collaborating partners by December 1, 2021.	A. **CAB** will review and discuss the needs assessment data at the September 2021 meeting to determine how SCHC should proceed to better serve homeless and indigent patients. B. By December 2021, SCHC will distribute the needs assessment findings to partners and through the Sacramento County Communications team.
3. Use homeless survey results to develop a plan to better serve homeless patients, either directly or through collaboration.	A. By January 30, 2022, SCHC will review the areas of the HC (4600 and Loaves and Fishes) identified in the survey to determine if and what changes can be made to achieve 75% "very good or good" score on following survey elements: • Able to get appointments for check-ups. • Able to make same day appointment when sick or hurt. • Length of time waiting at the clinic.	A. By the March 2022 **CAB** meeting, CAB will receive, review, discuss and make a decision regarding the proposed focused change(s) to better serve homeless and indigent patients. B. By June 30, 2022, SCHC will begin implementing the plan C. Report to the **CAB Governance Committee** semiannually on

Strategy 1: Conduct a health and related needs assessment of individuals experiencing homelessness.		
CAB Support: 1. Based on the needs assessment results, suggest ways to better serve homeless patients. 2. Use community connections to support identified services and promote the strategic plan.		
Action Steps	**SMART Objectives**	**Metrics**
	B. By February 15, 2022, the SCHC will choose at least one area on which to focus change efforts and present to the CAB for approval at the March 2022 meeting. C. By March 25, 2022 staff will identify SCHC staff who will contribute to developing a plan for the identified changes. D. By May 15, 2022, a draft plan, including metrics, costs, staffing, partners, etc., will be developed and presented to SHCH leadership for review and approval. E. By June 30, 2022, SCHC will implement the plan and will report to the CAB semiannually on progress beginning December 2022.	progress December 2022 and through December 2023.

Strategy 2: Improve care to existing and/or assigned patients experiencing homelessness.		
CAB Support: 1. Identify/suggest key health messages and/or resources to use on in-house media 2. Suggest technology(s)		
Action Steps	**SMART Objectives**	**Metrics**
1. Conduct outreach efforts to currently assigned homeless patients who have not made an initial appointment and assist them to make an initial appointment within 120 days of being assigned to the SCHC.	A. By May 30, 2021, SCHC staff will compile a list of assigned homeless patients who have not made an initial appointment. B. By June 5, 2021, SCHC will begin outreach to those patients by phone to set up an appointment. C. By December 30, 2021 and moving forward, 30% of assigned homeless people will make an initial appointment within 120 days of being assigned to SCHC or will be assisted to change their assignment to a different medical home.	A. SCHC staff work to ensure at least 30% of patients assigned by the IPAs to SCHC and identified as homeless make an initial appointment. B. Report to the **CAB Governance Committee** semiannually on the results and of changes in metrics beginning December 2021 and through December 2023: 1. Number and percent of known homeless patients who had an initial appointment within 120 days of being assigned to SCHC.

Strategy 2: Improve care to existing and/or assigned patients experiencing homelessness.		
CAB Support: 1. Identify/suggest key health messages and/or resources to use on in-house media 2. Suggest technology(s)		
Action Steps	**SMART Objectives**	**Metrics**
2. Place a Sacramento Covered staff member at Loaves and Fishes to: a) Help homeless individuals sign up for insurance. b) Change the provider assignment to SCHC when applicable - current Medi-Cal beneficiaries who are seen by SCHC but are assigned to another provider. c) Connect homeless people with their assigned provider. d) Work with the health plans to arrange trans-portation and interpretation services as needed.	A. By June 30, 2021, develop a scope of work for the Sacramento Covered staff member that is compatible with SCHC's intent and needs and the data SCHC wants to collect. B. By July 31, 2021, a Sacramento Covered staff member will be located at Loaves and Fishes. C. By July 15, 2021 and monthly thereafter, Sacramento Covered will report to SCHC on the metrics identified and agreed upon for this project. This data will be reported to the CAB semiannually for the duration of the arrangement with Sacramento Covered.	A. Report to the **CAB Governance Committee** semiannually on the identified metrics beginning August 2021 through December 2023.
3. Use SCHC's current technology to its fullest capacity and investigate/add other technology to enhance patient access, improve	<u>MyChart</u> A. By August 31, 2022, SHCH staff will review necessary workflows for use of MyChart. B. By July 15, 2022, SCHC staff will identify potential MyChart modules that could increase access to care.	A. Implement strategies and track the changes in: 1. Number of appointments missed or were started late as a result of delayed registration.

Strategy 2: Improve care to existing and/or assigned patients experiencing homelessness.		
CAB Support: 1. Identify/suggest key health messages and/or resources to use on in-house media 2. Suggest technology(s)		
Action Steps	**SMART Objectives**	**Metrics**
the patient/ provider relationship and remove barriers to care for patients experiencing homelessness (and other SDOH barriers), including a) MyChart b) OCHIN and HEDIS reports to identify patients with gaps in care c) Lobby TVs	C. By September 1, 2022, staff will create a plan to promote the MyChart modules to patients and educate staff on the promotion plan and how to help patients. D. With SCHC Leadership approval of the developed plan, by September 30, 2022, SHCH will enable the identified MyChart modules and collect data on the number of patients who use the new modules. <u>OCHIN/HEDIS</u>: A. Identify patients with gaps in care on an on-going basis. B. Develop culturally-sensitive strategies to close these gaps. <u>Lobby TVs</u> A. By December 1, 2022, finalize an initial list of health education messages and other information to display on lobby (and mobile medical center van) TVs consistent with results of needs assessment and other identified needs. B. By March 1, 2023, implement consistent use of lobby TVs for health education and awareness.	2. Number of scheduled and kept appointments. 3. Increased MyChart users. 4. Number of patients who utilize the new modules. B. Report to the **CAB Governance Committee** semiannually on the identified metrics in June 2023 and December 2023.
4. Research other technology to determine what may enhance patient access, improve the patient/provider relationship, and/or remove barriers to care.	A. By October 31, 2021, SCHC staff will meet with DTech to discuss potential new technologies that could benefit the HC and patient care. B. By December 31, 2021, SCHC staff will compile a list of possible new technologies and costs to present to leadership for direction. 1. SCHC staff will search for grants and other sources of technology funding through the end of December 2023. 2. By February 1, 2022, SCHC staff will create a request for identified technology and present it to leadership for review and approval.	A. Identified technologies and costs will be incorporated into the business case and used for the growth request to the Board of Supervisors. B. Based on BOS decisions, if funding is available, SCHC will implement technology and report to the **CAB Governance Committee** semiannually beginning December 2022. Data will be collected to measure: 1. Patient access 2. Patient satisfaction 3. Patient reported barriers

Strategy 2: Improve care to existing and/or assigned patients experiencing homelessness.		
CAB Support: 1. Identify/suggest key health messages and/or resources to use on in-house media 2. Suggest technology(s)		
Action Steps	**SMART Objectives**	**Metrics**
	3. By February 28, 2022, SCHC will include identified technology in the budget for Board of Supervisor approval. 4. By June 30, 2023, approved technologies will be purchased, installed and deployed. SCHC will report to CAB semi-annually on the technologies deployed and the effects on staff, patients and the Health Center overall. 5. SCHC staff will measure the impact of the new technologies through December 31, 2023.	
5. Expand services provided at Loaves & Fishes including: a) Dental services b) Substance abuse services (including MAT), and c) Behavioral health services	A. By September 30, 2021 SCHC leadership will meet to begin the process of developing a plan to expand services including costs, equipment needs, partners, performance metrics, etc. B. By December 31, 2021, the plan will be finalized and presented to CAB at the January 2022 meeting. C. During 2022, SCHC will seek funding to expand services and will implement the plan as funding becomes available. D. Through December 2023, SCHC Leadership will report to the CAB semiannually on progress towards implementing additional services at Loaves and Fishes.	A. By the January 2022 meeting, **CAB** will receive, review, discuss and make a decision regarding expanded services at Loaves and Fishes. B. Report to the **CAB Governance Committee** semiannually beginning June 2022 and through December 2023, on: 1. The utilization of each additional services 2. Patients' satisfaction with services offered at L& F and on the mobile medical van 3. Revenue generated from services provided.
6. Implement a plan for the mobile medical van (see Space Strategy I.2.6.)	A. By December 30, 2021, SCHC's leadership will finalize a plan for the mobile medical van, including but not limited to: a) Services offered b) Staffing c) Days/hours of operation d) Location of services e) Partners	A. **CAB** will review the draft plan for the mobile medical van at the January 2022 meeting. B. Report to the **CAB Governance Committee** semiannually beginning June 2022, and through December 2023, on: 1. Number of patients seen

Strategy 2: Improve care to existing and/or assigned patients experiencing homelessness.		
CAB Support: 1. Identify/suggest key health messages and/or resources to use on in-house media 2. Suggest technology(s)		
Action Steps	**SMART Objectives**	**Metrics**
	B. CAB will review draft plan for the mobile medical van at the January 2022 meeting. C. By February 28, 2022, the mobile van will be operational. D. Through December 31, 2023, mobile medical van performance metrics will be collected and reported to the CAB semiannually, including: a) Number of patients seen b) Number of patients seen that are already assigned to SCHC c) Number of patients seen not assigned to SCHC that are assisted to switch care to SCHC. d) Type of insurance e) Services received	2. Number of patients seen that are already assigned to SCHC 3. Number of patients seen not assigned to SCHC that are assisted to switch care to SCHC. 4. Type of insurance services Received 5. Revenue generated

Strategy 3: Collaborate with community partners and resources to better serve the homeless population.		
CAB Support: 1. Identify and connect staff to community partners 2. Promote the Strategic Plan with partners		
Action Steps	**SMART Objectives**	**Metrics**
1. Work with community partners (Sac Covered, L&F) and the health plans to connect with assigned homeless patients to help them overcome barriers to accessing care, including via a) Free cell phones b) Telemedicine outstations	A. By August 31, 2021, assign a SCHC staff to attend the Medi-Cal Managed Care meetings. B. By October 15, 2021, explore options (e.g. California LifeLine) for free phones (and how to provide this resource) and discounted Broadband for individuals experiencing homelessness and link our patients to those resources to assist with MyChart and telemedicine usage. C. By March 1, 2022, identify at least one community partner located in an area frequented by many patients experiencing homelessness that is willing to install a telemedicine "outstation."	A. By June 30, 2022, develop a community partnership plan to better serve the homeless and indigent population. B. Implement the plan and report to the **CAB Governance Committee** semiannually beginning December 2022 through December 2023, including: 1. Utilization rate of the outstation for telemedicine 2. Number of free phones issued to SCHC patients

Strategy 3: Collaborate with community partners and resources to better serve the homeless population.		
CAB Support: 1. Identify and connect staff to community partners 2. Promote the Strategic Plan with partners		
Action Steps	**SMART Objectives**	**Metrics**
	D. By April 30, 2022, develop written agreement with the identified community partner to install the outstation. E. By June 30, 2022, identify staff that will be connected with the outstation, any additional technology needed, develop workflows, an outreach plan to patients, and metrics to measure success. F. Contingent on the BOS decisions regarding the budget request, by July 15, 2022, begin outreach to patients. G. By December 31, 2022, begin implementing telemedicine services at the partner site. H. Report metrics and encounter data to the CAB semi-annually.	3. Number of persons signing up for discounted broadband service.
2. Identify partners that provide support services to homeless and indigent people and establish partnerships for referring patients to assist them in overcoming Social Determinants of Health.	A. By December 31, 2021, SCHC staff will create a list of County and community programs offering services to homeless and indigent people (e.g. El Hogar) and will present the list to leadership to decide which organizations the SCHC could partner with or refer to. B. By May 31, 2022, SCHC leadership will select organizations to approach regarding referral processes. C. Present this list at the June 2022 CAB meeting.	A. At the June 2022 meeting, **CAB** will provide direction on which identified organizations SCHC should attempt to establish MOU's.
3. Choose which organizations to partner with. a) Decide how the partnership will work. b) Create MOU's with partner organizations.	A. By July 31, 2022, SCHC staff will reach out to identified organization(s) to explore collaboration. B. By January 31, 2023, SCHC will request permission from the Board of Supervisors to establish MOU's with identified organizations. C. By July 31, 2023, SCHC will work with selected organizations and establish MOU's.	A. Established MOUs by December 31, 2023. B. Identify mutually beneficial metrics. C. Report to the **CAB Governance Committee** on the identified metrics at the December 2023 meeting.

Strategy 3: Collaborate with community partners and resources to better serve the homeless population.		
CAB Support: 1. Identify and connect staff to community partners 2. Promote the Strategic Plan with partners		
Action Steps	**SMART Objectives**	**Metrics**
c) Decide what services will be provided. d) Decide where to provide services.	D. By December 31, 2023, MOU's that detail the scope of work, roles, goals, deliverables and metrics will be finalized.	

Strategy 4: Identify other sites at to serve homeless patients if the needs assessment shows need and space and financing plans permit this. *Integrate with Strategy 1.3.1.(contingent)		
CAB Support:		
Action Steps	**SMART Objectives**	**Metrics**
1. Explore possible sites – either building, co-locating, or bringing mobile van to a site.	A. TBD	

Appendix A: Patient Satisfaction Survey

~~Registration~~ Staff Script

Note: If the patient speaks a language other than English or Spanish, an interpreter will be needed to administer the survey.

"We want to know how you feel about the care you get at our health center. ~~Please~~ We invite you to ~~take a few minutes to~~ complete this feedback survey and then return it to one of the locked boxes marked ~~"~~*Completed Patient Surveys*.~~"~~ Completion of the survey is voluntary and anonymous. Your feedback will help us improve the quality of our services."

"Are you interested in providing feedback to us today?"

If the patient answers no,

"We understand that your time is valuable. Perhaps another time."

If the patient answers yes,

*"*Would you like to fill out the written version of the survey yourself? If not, we would be happy to help you complete the survey once your appointment is over."

Patient wishes to complete the survey on their own,

Hand them the survey form and a #2 pencil.

"Once your appointment is finished, p~~P~~lease read the survey and fill in the circles for your answer choices completely with the provided pencil. Please do not make a line through your answer choice. Fill in the entire bubble.

Please do not ~~or~~ fold or bend the form. When you are done, please put the finished survey in the locked box marked *Completed Patient Surveys*" and put the pencil in the *Used Pencils* jar."~~Completion of the survey is voluntary and anonymous. Your feedback will help us improve the quality of our services.~~

Patient would like help to complete the survey,

~~Would you like help completing this survey? "~~ ~~I~~We would be happy to help. Once your appointment is finished, please let your Medical Assistant know that you would like help in filling out the survey and a staff member will come assist you."

NATIONAL ASSOCIATION OF Community Health Centers

Health Center Board Roles

Role	What are the responsibilities of the board?	What unique requirements must a health center board fulfill related to this role?
Strategic Planning & Thinking	• Approve the mission, vision, values and use these statements to guide decision-making • Ensure a community needs assessment informs strategic planning • Engage in strategic planning along with the CEO and staff • Approve and provide oversight of the strategic plan • Engage in ongoing strategic thinking in partnership with the CEO	• View and adhere to requirements in the Health Center Program Compliance Manual that apply – for example: – Chapter 3: Needs Assessment ▪ Health Center undertakes a community needs assessment at least once every three years – Chapter 19: Board Authority ▪ Board authority for conducting long-range/strategic planning at least once every three years, which at a minimum addresses financial management and capital expenditure needs
Strategic Board Composition	• Ensure that board composition and recruitment is an ongoing focus • Consider establishing a committee to lead the work of recruiting and vetting candidates, orienting new members, ongoing board education and assessment • Vote on slate of candidates (often recommended by the Governance Committee or an equivalent committee) • Decide on the board's approach to rotation and renewal	• View and adhere to requirements in the Health Center Program Compliance Manual that apply: – Chapter 20: Board Composition – for example: ▪ 9 to 25 members ▪ At least 51% patient majority, represent patients served by the center in terms of various demographic factors, etc. ▪ Non-patient board members are representative of the community served and selected for relevant expertise/skills ▪ No more than half of the non-patient board members derive more than 10% of their annual income from the health care industry ▪ Representatives from special population(s) on board if center receives special populations funding ▪ Health center employees and immediate family members may not serve on the board

Role	What are the responsibilities of the board?	What unique requirements must a health center board fulfill related to this role?
Oversight	**Finance** • Review and approve budget • Review financial statements regularly, monitor financial status of health center • Ensure financial controls are in place • Review audit, meet in executive session with the auditor, ensure appropriate follow-up • Approve policies and review or update (at least every 3 years) policies that support financial management and accounting systems, billing and collections, partial payment • Adopt a three-year plan for financial management and capital expenditures connected to the long-range plan	**Finance** • View and adhere to requirements in the Health Center Program Compliance Manual that apply – for example: – Chapter 19: Board Authority ▪ Role in budget approval, monitoring health center financial performance, reviewing the audit, etc. ▪ Specifies various policies to adopt, evaluate, approve periodically – e.g., Sliding Fee Discount Program, Billing and Collections, financial management and accounting systems ▪ Additional details can be found in: – Chapter 9: Sliding Fee Discount Program – Chapter 16: Billing and Collections – Chapter 17: Budget
	Quality • Set tone • Ensure sufficient resources • Establish and revise quality assurance (QA) and quality improvement (QI) policies (e.g., patient satisfaction, patient grievance, patient safety) • Review measures and ask questions at board meetings • Ensure follow-up taken regarding quality, patient grievances, etc. and reflect in board meeting minutes	**Quality** • View and adhere to requirements in the Health Center Program Compliance Manual that apply – for example: – Chapter 19: Board Authority ▪ Evaluate performance based on QA/QI and ensure follow-up action taken regarding various items (e.g., quality of care, patient satisfaction) ▪ Adopt, evaluate, and update various QA/QI policies ▪ Additional details can be found in: – Chapter 10: Quality Improvement/Assurance
	Risk Management • Review and approve the center's risk management program • Assure effective communication by establishing a system for staff (a designated point person – the "Risk Manager") to report to the board about the risk management program and progress for improvement and for the board to communicate with the CEO about key expectations • If FTCA deemed, ensure compliance with requirements for the deeming application, requirements associated with the Operational Site Visit, and, as appropriate, with the requirements of the FTCA Site Visit Protocol	**Risk Management** • View and adhere to requirements in the Health Center Program Compliance Manual that apply – for example: – Chapter 21: Federal Tort Claims Act (FTCA) Deeming Requirements (Health Center Program Compliance Manual) • See PAL 2019-02 Year 2020 Requirements for Federal Tort Claims Act (FTCA) Coverage for Health Centers and their Covered Individuals (and subsequent updates)

Role	What are the responsibilities of the board?	What unique requirements must a health center board fulfill related to this role?
	Corporate Compliance • Board provides oversight of the Corporate Compliance Program	**Corporate Compliance** • See OIG Compliance Program for Individual and Small Group Physician Practices (65 Fed. Reg. 59434 et. seq., October 5, 2000)
	Health Center Program Compliance • Board has responsibility for oversight of the Health Center Program project	**Health Center Program Compliance** • Ensure familiarity with and adherence to HRSA Health Center Program Compliance Manual and Site Visit Protocol
CEO Oversight & Partnership	• Hire the Chief Executive Officer (CEO) • Ensure the CEO has clear goals • Evaluate the CEO's performance • Have a CEO succession plan • Establish CEO compensation based on comparable market data	• View and adhere to requirements in the *Health Center Program Compliance Manual* that apply – for example: – Chapter 11: Key Management Staff ▪ Specifies that the CEO reports to the board and other relevant processes to be in place – Chapter 19: Board Authority ▪ Approves the selection (and termination or dismissal, as appropriate) of the CEO
Approving Policies	• Approve, periodically review and ensure compliance with the bylaws • Ensure bylaws are periodically reviewed by legal counsel • Approve appropriate policies including – Board-specific items – Conflict of interest policies – Whistleblower policies – Others required by federal and state law, as well as the Health Center Program Compliance Manual	• View and adhere to requirements in the *Health Center Program Compliance Manual* that apply – for example: – Chapter 13: Conflicts of Interest – Chapter 19: Board Authority – Chapter 20: Board Composition – Chapters 19 and 20 also link to various other chapters which provide additional details on certain policies including: ▪ Chapter 9: Sliding Fee Discount Program, ▪ Chapter 10: Quality Improvement/Assurance, and ▪ Chapter 16: Billing and Collections

Role	What are the responsibilities of the board?	What unique requirements must a health center board fulfill related to this role?
Ensuring Resources	• Ensure the health center has the financial resources it needs – e.g., by considering engaging in fundraising (if conducted by health center) • Leverage the community voice, appropriate advocacy in coordination with staff • Approve major partnership activities	• View and adhere to requirements in the *Health Center Program Compliance Manual* that apply: – Chapter 14: Collaborative Relationships includes requirements for partnerships – Chapter 19: Board Authority and Chapter 20: Board Composition include limitations on third-party or partner involvement in selecting board members and exercising authorities of the health center board
Effective Board Functioning	• Ensure board has effective meetings • Ensure effective committee structure in place • Defines and ensures a healthy board culture	• View and adhere to requirements in the *Health Center Program Compliance Manual* that apply: – Chapter 19: Board Authority – for example: ▪ Monthly meetings ▪ Capturing actions in board minutes

Key Resources:

Health Center Program Compliance Manual https://bphc.hrsa.gov/programrequirements/compliancemanual/index.html

Health Center Program Site Visit Protocol https://bphc.hrsa.gov/programrequirements/svprotocol.html

For additional discussion of Board Roles, please see NACHC's *Governance Guide for Health Center Boards* available through the Health Center Resource Clearinghouse (https://www.healthcenterinfo.org/)

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SACRAMENTO COUNTY

Co-Applicant Board Required Annual Activities - 2021												
Annual / Periodic Activities	**Jan**	**Feb**	**Mar**	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**
HRSA Grant Application												
Service Area Competition (SAC)*							X	X	X			
Needs Assessment	X	X				X	X					
Other Grant Applications	X	X			X	X						
HRSA Grant Awards - Reports												
COVID Supplemental Award	X	X					X					
HRSA CARES	X			X			X					
Enhancing Capacity for Testing	X			X			X				X	
HRSA APRA					X		X			X		
Main grant report								X	X			
Budget												
Approve proposed HRSA Program & County budget		X					X					
Updates			X			X					X	
Sliding Fee Discount												
Adopt new SFDS		X										
Audit												
Summary of Program Fiscal Audit				X								
Quality Improvement (QI)												
QI Plan Review	X			X			X			X		
QI Data Reports**	X			X			X			X		
UDS Report		X						X				
Patient Grievances and Safety Review								X			X	
Patient Feedback Survey Findings	X			X			X					
Long-Range Planning												
Adopt Strategic Plan*					X	X						
Review Strategic Plan	X								X			X
Select Services and Hours												
Services Provided			X				X					X
Service Sites						X	X				X	X

Co-Applicant Board Required Annual Activities – 2020 - CONTINUED												
Annual Activities	**Jan**	**Feb**	**Mar**	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**
Governance												
Review & Revise Bylaws		X	X	X								
Review Co-Applicant Agreement			X	X		X						
Review Sub-Committee Structure						X						X
Review Membership Applications	TBD											
Review Key Policies		X	X	X					X	X	X	
Project Director												
Approve Selection /Dismissal	X	X										
Performance Evaluation										X		
Board Member Development												
Elect Chair and Co-Chair											X	
Approve CAB Member Recruitment Plan								X				
Approve new Members	TBD											

* Every 3 years

** Every 3 Months

Co-Applicant Board Required Policies and Procedures for Adoption			
Governance (Governance Committee)	**Policy and Procedure**	**Latest Revision Date**	**Latest CAB Adoption Date**
Board Authority (CH: 19)	01-02 Co-Applicant Board Authority	07/17/20	07/17/20
Board Composition (CH: 20)	01-04 Co-Applicant Board Member Recruitment & Retention	05/22/20	05/22/20
Services (Clinical Operations Committee)	**Policy and Procedure**	**Latest Revision Date**	**Latest CAB Adoption Date**
Scope of Service and Service Site Location(s) (CH: 4, 6, 12, 19)	01-05 Medical Home Program Design	10/06/20	10/16/20
Hours of Operation (CH: 6, 7, 19)	01-05 Medical Home Program Design	10/06/20	10/16/20
Patient Satisfaction (CH: 10, 19)	04-12 Patient Satisfaction Survey	06/19/20	06/19/20
Patient Grievances (CH:10, 19)	02-05 Variance Reporting	22/06/20	11/20/20
Patient Safety and Adverse Events (CH: 10, 19)	03-03 Incident Reporting	10/13/20	11/20/20
Quality Improvement Policy (CH:10, 19)	01-01 Quality Improvement *	06/25/20	07/17/20
QI Plan (CH:10, 19)	2020 Quality Improvement Plan *(annual)*	06/25/20	07/17/20
Quality Improvement Policy (CH:10, 19)	01-09 Clinical Performance Management*	07/09/20	07/17/20
Credentialing and Privileges (CH: 5)	07-05 Credentialing and Privileges	05/05/20	05/17/19
Management and Finance (Finance Committee)	**Policy and Procedure**	**Latest Revision Date**	**Latest CAB Adoption Date**
Personnel and Conflict of Interest (CH: 13, 19)	01-03 Co-Applicant Board Conflict of Interest	05/07/20	05/22/20
Billing and Collections (CH: 16, 19)	11-02 Billing and Collections *	10/05/20	10/16/20
Emergency Preparedness and Management Plan (PIN 2007-15)	06-10 Emergency Training and Response	09/07/20	09/18/20
Sliding Fee Discount Program/Schedule (CH: 9, 19)	11-01 Sliding Fee Discount *	10/01/20	10/16/20

CH = HRSA Compliance Manual Chapter

PIN = HRSA Policy Information Notice

* = The CAB adopts, evaluates at least once every three years, and, as needed, approves updates to policies in these areas

After Hours Clinician Form

Time: _____

Date: _____

Patient Name: _____ Patient DOB: _____

Medi-Cal Client ID Number (CIN): _____ *AND/OR* **SSN: _____**
(First 9 digits on CA Benefits ID Card)

Call Back Number :_____

Chief Complaint/Reason for Call: _____

Documentation:

Follow-Up Plan:

OFFICE ASSISTANT ASSIGNMENT

Mail

- ✓ Retrieve outgoing mail from the in basket. Make sure each piece of mail has a barcode. Deliver outgoing mail to security before 12:00 noon
- ✓ Retrieve incoming mail from security at the time you deliver the outgoing mail

Processing Mail:

- ✓ For safety reason and efficient patient care, Open **ALL** mail and sorted immediately

Scanning (*follow scanning protocol*)

- ✓ Health Plan case management/care management reports/assessments. Place report in a folder and place the folder in the scanning basket.

Referral Team

- ✓ Consultation reports from specialist, diagnostic reports, referral authorizations and denials, lab results and any other medical consolations from outside providers, place correspondence in the "Referral Basket" located in suite 1100, restoration area, in front of office 1114
  - PEDS basket is located
  - Family Medicine is located

Medical Records Request (Request of medical records from our provider)

- ✓ Records with less than 50 pages, place records in a scanning folder and place the folder in the scanning basket. Scanning basket is located in suite 1100, on top of the counter in registration area
- ✓ Records containing more than 50 pages, place records in a scanning folder and deliver to provider's assigned medical assistant

Pharmacy

- ✓ Correspondence regarding prescription request, denial/approvals for medication or anything regarding medication, place correspondence in a scanning folder and deliver to Clinical Pharmacist

Medical Bills/Checks

- ✓ Place correspondence in an interoffice envelope, write "Suite 2600" and deliver to security desk. Staff in administration suite will pick correspondence

Returned Mail

- ✓ Undelivered mail sent to patients, place correspondence in a scanning folder and deliver mail to provider assigned medical assistant

Forms *(Follow Forms Workflow)*

- ✓ Any forms regarding patients, follow Forms workflow.

Mail for other departments

- ✓ Mail received from other departments, sort correspondence by department/suite and deliver to security to place in the correct inbox.

NAME
Adult Medicine
Alex Legostaev
Ryan Martin
Elizabeth Larios
PEDs
Nikia Allison
Lenny Cervantes
Cynthia Vasquez
Family Medicine

Absence Line	NAME
✓ 7:30 AM retrieve message (follow instructions in logbook). In the logbook, write the names of the staff who called the absence line and the time of call. ✓ Send email to: Health Program Manager, Sr. Mental Health Program Coordinator, Supervising RN (s), Radiology Supervisor, Pharmacy Director, Medical Director, and any other staff member who supervising staff. ✓ In the subject line of the email type: Absence calls and Date (Absence calls July 30, 2020). ✓ 8:00 AM retrieve message (follow step 1). Using the original email, send an update; include the name(s) of staff who called after 7:30 AM. If no additional no came in, indicate "No additional absences calls"	Sandra Barringer Marisela Nunez Sandra Johnson

MyChart Messages	Program/staff
✓ Throughout the day and in-between assisting patients, staff will manage and reply to "MyChart" messages. ✓ In OCHIN 2nd tool bar, click on the icon below (in basket). Second, click "Pt schedule Request w/responsibility. Third: The message will appear on the right hand side. 1.  2. **Pt Schedule Request w/ responsibility** 3. New 08/11/2020 9:49 AM [redacted] S ✓ Open new message and follow the steps below: ○ Patients requesting appointments, follow appointment-scheduling policy. Reply to message using .phrase ○ If patient is requesting to speak to their doctor, send telephone encounter to the assigned medical assistant. If the message from the patient does not include enough information. Reply to patient message to obtain additional information. ○ Refill request (follow refill request workflow), send telephone encounter ○ Medical records request, leave message in "in box" Medical record staff will retrieve and manage messages ✓ To reply to messages, use **.phrases** (need to develop .phrases) ○ Appointment scheduled ○ Already have an appointment scheduled ○ Refill request ○ Message to provider	**Adult Medicine** Ryan Martin Alex Legostaev Elizabeth Larios Sandra Bringer **PEDS** Lenny Cervantes Nikia Allison Cynthia Vasquez Donna Seese **Family Medicine** Edith Martinez

Retrieval (Afterhours) Messages	NAME
✓ 8:00 am, assigned office assistant, will retrieve After Hour Messages from **875-2465**. The phone is located in suite 1100, cubical 1114 C. PW 4600. To Retrieve voice mail messages: 1. Call 875-2465 (after you dial or voice message press **) 2. Press ****** 3. You will hear the following "If you have a mail box in the system, please press: **#".** 4. Enter **ID**: 5-2465 5. Enter **Pin**: 4600 Messages ○ Messages from pharmacies follow Pharmacy Workflow ○ Patient is requesting to speak to their doctor, send telephone encounter to the assigned medical assistant. Follow telephone encounter protocol. If the message from the patient does not include enough information. Attempt to get in touch with the patient to obtain more detail. If patient does not answer, send telephone encounter and explain why the message does not include detail. Example: Patient called the After Hours line, left message stating s/he need to speak to my doctor. Patient did not leave any details. Tried to call patient, but there was no answer". ○ Patients requesting appointments call patient and schedule appointment. Messages for other departments: ○ Pediatrics transfer message to PEDs: ○ Family Medicine transfer message to: ○ Refugee transfer message to:	Sandra Johnson Maricela Nunez

Patient Reminder Calls 2 days before in-person appointments	NAME
✓ Sr. OA print provider schedule, assign list of patients to each office assistant. ✓ Office Assistant will contact patients' scheduled "In-Person" visit/appointment. ✓ Remind patient they have an "In-Person" visit provide (Date, Time, and Name of provider). ✓ Screen patients for COVID-19 **COVID-19 Symptom checklist:** • Fever or chills • Cough • Shortness of breath or difficulty breathing • Fatigue • Muscle or body aches • Headache • New loss of taste or smell • Sore throat • Congestion or runny nose • Nausea or vomiting • Diarrhea • Have you been in contact with anyone who has any of the symptoms above? • Have you been in contact with anyone with COVID or you suspect have COVID? • Are you on COVID rule out (waiting for COVID-19 test result)? ✓ Patients with two or more symptoms, ……	Sandra Bringer Marvetta Wright Cynthia Vasquez Lenny Cervantes

✓ If unable to contact patient, enter patient message and type: “Date, Unable to make contact and screen patient” type your full name and close note.	

Attachment D: IPA Contact Information

Nivano
Olivia Martinez
Provider Relations Supervisor
Desk: 916.407.2000 Ex. 2563
Cell: 916.926.3398
Fax: 916.604.9837
www.nivanophysicians.com
1420 River Park Dr. Ste. 200, Sacramento, CA 95815

River City Medical Group
Jessica Muniz
Provider Relations Specialist
Phone: (916) 228-4300 ext. 2310
Fax: (916) 329-8019
jmuniz@rcmg.com
7311 Greenhaven Drive, Suite 145
Sacramento, CA. 95831

UC Davis Health Net
TBD

	County of Sacramento **Department of Health Services** **Division of Primary Health Services** **Policy and Procedure**	Policy Issuer (Unit/Program)	**Clinic Services**
		Policy Number	**03-05**
		Effective Date	**07-20-12**
		Revision Date	**05-11-2021**
Title: **After-Hours Services**		Functional Area: **Clinic Operations**	
Approved By: Susmita Mishra, MD - Medical Director			

Policy:

The Sacramento County Health Center (SCHC) has an established protocol to ensure patients have access to a medical professional after the clinic's business hours. Calls will be managed through the following as appropriate: automated phone tree, medical advice line, or on-call clinician.

Procedures:

A. After-Hours Phone Tree

1. SCHC utilizes an automated phone tree. This includes general information about clinic services, business hours and telephone numbers.
2. For non-clinical messages, the patient has the option to leave a voice mail message.
3. If a patient needs to speak with a medical professional, the call will be transferred to FONEMED, a nurse advice line, if the patient selects option #1.
    a. Medi-Cal managed care patients also have the option to call the Registered Nurse (RN) advice line phone number located on the back of their health plan card.

B. FONEMED – Nurse Advice Line

Sacramento County has contracted with FONEMED, an established phone triage process that is protocol-based with qualified medical professionals and Registered Nurses (RN).

1. After business hours, clients who have a medical question or concern and select option #1, will automatically be transferred to the FONEMED RN triage service.
2. The FONEMED RN will complete the triage process. All medical advice will be documented on the FONEMED Report and faxed to the established clinic fax line, (916) 854-9399 (DHS-Fax-PHS-FONEMED), after completion of each call.
3. For patients whose needs are urgent or complex, and beyond the nursing scope of practice, the FONEMED RN will obtain patient information on Telephone Encounter Report and inform patient that a clinician will call patient.
    a. FONEMED RN will be provided with the on-call clinician calendars and will call the scheduled clinician with patient information.

4. If the clinician is not immediately available, the FONEMED RN will leave a message for a return call.
    a. If clinician has not returned FONEMED RN call within 30 minutes, RN will call clinician again and leave another message.
    b. If second call is not returned within 10 minutes, FONEMED RN will call Medical Director (unless otherwise designated).

C. After-Hours Clinicians

1. Clinician will respond to patient calls within 15 minutes of receiving patient information from the FONEMED RN.
    a. If clinician is not immediately available, FONEMED RN will leave a voice message and clinician will return call within 30 minutes
2. The clinician will attempt to access the client record in OCHIN to assist with treatment plan. Access to OCHIN will either be by VPN or by Remote OCHIN Access.
3. For patients with an OCHIN chart, the after-hours clinician will check whether a PCP has been assigned
    a. If yes, the after-hours clinician will send a telephone encounter to the assigned program's Supervising nurse (see Attachment A) and to the PCP. The after-hours clinician will use the list of assigned providers for each clinical area to identify the appropriate supervising nurse.
        i. The clinician will note the treatment plan in patient's EMR chart, if available. If not available immediately, the clinician will enter into chart by the next business day.
    b. If there is no assigned PCP, the clinician will send a telephone encounter explaining that fact to the Supervising Nurses of Adult, Family Medicine, and Pediatrics (include Pediatrics only if patient is less than 18).
        i. The clinician will note the treatment plan in patient's EMR chart, if available. If not available immediately, the clinician will enter into chart by the next business day.
4. For patients who do not have an OCHIN chart, the after-hours clinician will fill out the After-Hours Clinician Form and emails it to Supervising RN (Attachment B). Please see *Next Business Day Procedures*.

D. Next Business Day Procedures

1. Reviewing Phone Tree After Hour Messages
    a. Assigned office assistant, will retrieve After-Hours Messages from **875-2465**. The phone is located in suite 1100, cubicle 1114 C. PW 4600.
    b. The messages will be addressed according to urgency and need.
        i. Messages from pharmacies will follow steps according to telephone protocol, PP-CS-03-01 Telephone Protocol.
        ii. Messages for other departments will be addressed as follows:

a) Patients requesting appointments will be called and scheduled an appointment according to patient's need.

b) Patient is requesting to speak to their doctor, staff will send telephone encounter to the assigned medical assistant.

2. Reviewing FONEMED Messages:

    a. Designated staff (see Attachment A) will check the FONEMED Outlook fax inbox each morning for FONEMED reports of the calls received and will do the following:

        i. Check eligibility of the patient and determine if the patient is assigned to the Sacramento County Health Center (SCHC).

        ii. Forward email containing report and patient eligibility assignment to the appropriate program Supervising Nurse and RN/PHN based on patient's assigned PCP (see Attachment A: FONEMED Reports Nurse Assignments)

        iii. Move the email to the completed folder.

    b. The appropriate RN will:

        i. Review FoneMed Reports

        ii. If patient has an OCHIN record:

            a) If the call was not transferred to after-hours provider—document info from FoneMed report (or copy and paste it) and route to PCP.

            b) If the call was transferred to after-hours provider and note was documented in chart—Locate provider encounter and addend if necessary.

        iii. If patient does not have an OCHIN record:

            a) RN will check member rosters from the three IPAs to see if the patient is assigned to us.

                i. If the patient is assigned to us but has never seen a provider, the RN will

                    1. Create a chart.

                    2. Document action per the After-Hours Clinician Form completed by After-Hours provider and follow up as needed.

                    3. Send a message to Registration Staff to schedule a new patient appointment.

                        a. Registration staff will complete the registration process and assign a PCP at the time of appointment.

                ii. If the patient is NOT assigned to us, route the After-Hours Clinician form to Member Services.

3. Receipt of After-Hours Clinician Form by Member Services

   a. Member Services staff who are assigned to review After-Hour Clinician Forms will check the inbox at least twice per day (morning and afternoon).

   b. For each After-Hour Clinician Form received, staff will

      i. Check insurance status and assignment.

         1) For uninsured patients, Member Services will inform the patient of health coverage options, If needed, the Member services staff will assist with the application process or refer to DHA/Community Resources, i.e. Sacramento Covered.

         2) For insured patients, Member Services will

            i. Fax the form to the appropriate IPA (Attachment E).

            ii. Contact the patient to notify them of their assigned health plan and suggest that they make a follow up appointment with their assigned PCP.

References:
PP-CS-03-01 Telephone Protocol

Attachments:
Attachment A: FONEMED Reports Nurse Assignments
Attachment B: After Hours Clinician Form
Attachment C: After Hours Message Workflow
Attachment D: IPA Contact Information

Contact:

Vanessa Stacholy, Health Program Manager for Operations

CAB Approval: 05-11-2021

The Role of the Health Center Board and Board Members

Christina Hicks, Director of Health Center Operations

April 8, 2021

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1

Objectives

By the end of this session, you will be able to:

- Describe health center board roles
- Explain the responsibilities of individual board members
- Discuss the importance of the board-CEO partnership in health center governance
- Apply tools for building a positive board culture and governance impact

2

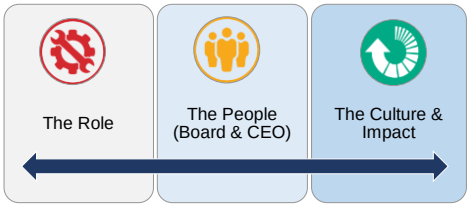
Let's Get Acquainted Poll

How would you best describe yourself?

- I'm a new board member with less than a year board experience.
- I have 3 years board experience or less.
- I have more than 3 years board experience and would like a refresher.
- I am a CHC leader or staff member.
- Other

3

Components to Consider



Components adapted from BoardSource, Leading with Intent (2017).

4

The Role:
Health Center Board Roles and Board Member Responsibilities

5

Governance vs. Management

"Effective boards understand the difference between ***governing*** and *managing*."

- "Distinguishing Governance from Management," *Great Boards*

- As a collective, the board *governs* the health center
- The CEO *manages* the health center

6

What External Forces Are You Facing?

To respond to this upcoming question you can:

- Visit PollEv.com/cpca in a browser on your computer/laptop
- Text CPCA to 22333 once to join on your phone, then text your response

7

What External Forces Are You Facing?

In 1-3 words, share some of the external forces that are impacting your organization and/or your governing board.

Start the presentation to see live content. For screen share software, share the entire screen. Get help at pollev.com/app

8

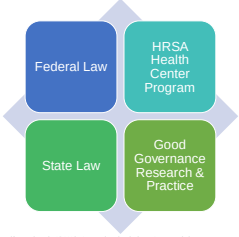
External Forces

9

Internal Forces

10

Health Center Governance



11

Roles of a Health Center Board

12

Poll Question

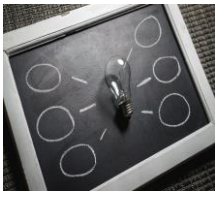
Which top three areas are most challenging for your board?

- Strategic Thinking/Planning
- Providing Oversight
- Effective Board Functioning
- Ensuring Resources
- CEO Oversight & Partnership

If "Approve Policies" is a top challenge, please type it in chat

Handout: Health Center Board Roles

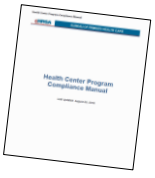
Strategic Planning & Thinking



- Ensure a community needs assessment informs strategic planning
- Approve the mission, vision, values and use to guide decision-making
- Engage in strategic planning along with the CEO and staff
- Approve and provide oversight of the strategic plan
- Engage in ongoing strategic thinking in partnership with the CEO

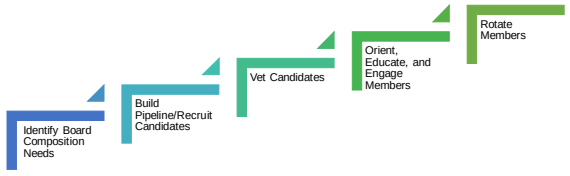
Strategic Planning & Thinking (cont'd)

- Requirements in the *Health Center Program Compliance Manual* that apply:
  - Chapter 3: Needs Assessment
  - Chapter 19: Board Authority



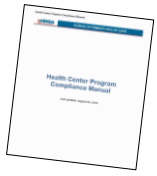
See Chapter 19 and Chapter 3 of the Health Center Program Compliance Manual for more details
https://bphc.hrsa.gov/programrequirements/compliancemanual/introduction.html

Board Composition



Board Composition (cont'd)

- Requirements in the *Health Center Program Compliance Manual* that apply:
  - Chapter 20: Board Composition



See Chapter 20 of the Health Center Program Compliance Manual for more details
https://bphc.hrsa.gov/programrequirements/compliancemanual/chapter-20.html#tittletop

Policies

- Approve, ensure compliance with, and periodically review/update the bylaws and key policies
- Requirements in the *Health Center Program Compliance Manual*
  - Chapter 19: Board Authority
  - Chapter 20: Board Composition
  - Chapter 9: Sliding Fee Discount Program
  - Chapter 10: Quality Improvement/Assurance
  - Chapter 13: Conflicts of Interest
  - Chapter 16: Billing and Collections

Oversight

- Finance
- Quality
- Corporate Compliance
- Risk Management
- Health Center Program Compliance

Ensure Resources

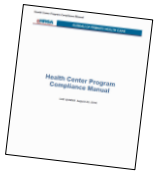
- Ensure the health center has the financial resources it needs
  - Engage in fundraising (if conducted by health center)
- Leverage the community voice, appropriate advocacy in coordination with staff
  - See http://www.hcadvocacy.org/boardresources for more on advocacy
- Approve major partnership activities

Select, Support, Evaluate, and Partner with the CEO

- Hire the Chief Executive Officer (CEO)
- Ensure the CEO has clear goals
- Evaluate the CEO's performance
- Have a succession plan
- Establish CEO compensation based on comparable market data

Select, Support, Evaluate, and Partner with the CEO (cont'd)

- Requirements in the *Health Center Program Compliance Manual* that apply:
  - Chapter 11: Key Management Staff
  - Chapter 19: Board Authority



See Chapter 19 and Chapter 11 of the Health Center Program Compliance Manual for more details
https://bphc.hrsa.gov/programrequirements/compliancemanual/introduction.html

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Board Functioning

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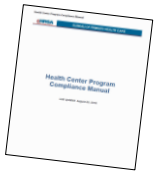
Board Functioning (cont'd)

- Requirements in the *Health Center Program Compliance Manual* that apply:
  - Chapter 19: Board Authority



See Chapter 19 of the Health Center Program Compliance Manual for more details
https://bphc.hrsa.gov/programrequirements/compliancemanual/introduction.html

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Individual Board Member – Legal Duties

- Duty of Care
  - Acting in good faith with the degree of diligence, care, and skill that prudent people would use in similar circumstances
- Duty of Loyalty
  - Acting in the best interests of the corporation and avoiding even the appearance of a conflict of interest
- Duty of Obedience
  - Ensuring that the corporation uses its resources to advance its purpose and goals, and that it complies will all appropriate laws

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The People:
Board/CEO (Staff)

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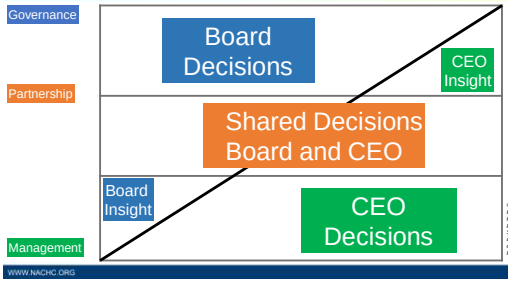
The Constructive Partnership



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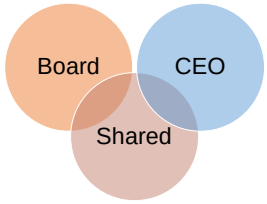
Shared Responsibility



Shared Responsibility for:
- Strategic planning
- Stewardship
- Fundraising
- Meeting preparation
- And more!

Governance vs Management - Examples

	Board /Governance	CEO/Management
Strategic Direction	• Participates in establishing strategic plan • Approves strategic plan • Monitors progress of strategic plan • Engages in ongoing strategic thinking	• Engages board, staff, and other stakeholders in developing strategic plan • Implements strategic plan with staff • Works with Board Chair to include strategic issues on board agendas
Oversight - Financial	• Approves budget • Monitors financials • Oversees audit • Approves certain policies	• Prepares and proposes budget to board along with key financial staff • Manages programs in alignment with financial policies and budget guidelines
Oversight - Quality	• Establishes and revises quality assurance (QA) and quality improvement (QI) policies • Ensures follow-up taken regarding quality, patient grievances, etc.	• Ensures staff manage the quality program
Policy	• Approves certain policies	• Makes recommendations to board • Implements policies

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Whose Role Is It?

Governance vs. Management

Why do boards and board members cross the line into management?

- Boards are given management information
- Crisis
- CEO turnover
- Specialized knowledge & interests
- Board does not have an orientation program

Adapted from McNally & Associates. Developed for NACHC, P&I 2018.

Consideration of a Constructive Partnership

- What does the Board need and what should they expect from the CEO?
- What does the CEO need and what should they expect from the Board?

Tool: Guiding Questions

Questions to help a board stay focused on governance

1. Is it big?
2. Is it about the future?
3. Is it core to the mission?
4. Is it a critical board oversight function?
5. Is a high-level policy decision needed to resolve a situation?
6. Is a red flag flying?
7. Is a watchdog watching?
8. Does the CEO want & need the board's support?

Source: Adapted from Barry Bader, "Distinguishing Governance and Management," (Great Boards)
http://trustees.aha.org/boardculture/archive/Great-Boards-fall-2008-reprint-distinguishing-governance-and-management.pdf

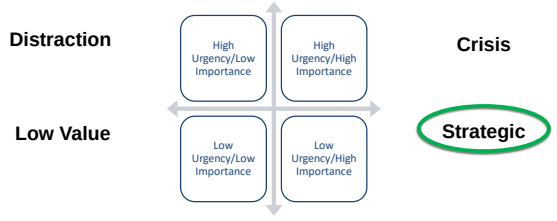
The Culture & Impact

Board Functioning

Poll Question

What does your governing board find most challenging?

Focus on Strategic Issues



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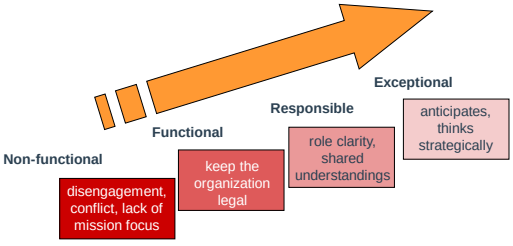
Governance Continuum



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Acknowledgements

Based on input and guidance from the NACHC/PCA-TTA Advisory Group, a NACHC/PCA TTA Sub-group on Governance was formed to develop and deploy two governance curriculum modules to be shared through a train-the-trainer model. We wish to acknowledge members of the Sub-group on Governance that participated in the development of the shared governance curriculum modules:

- Katie Henley Bandtlow, formerly Senior Program Manager of Workforce Development, Community Health Center Association of Connecticut
- Emily Heard, Director of Health Center Governance, NACHC
- Cassidy Heit, Director of Communications, Oklahoma Primary Care Association
- Suzanne Rossel, Senior Vice President of Health Center Support & Development, Community Health Care Association of New York State

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Resources

Visit the Health Center Resource Clearinghouse https://www.healthcenterinfo.org/ for Governance Resources!

- Governance Guide for Health Center Boards (formerly Governance Workbook)
- Recorded Webinars and Online Modules
- And more!

County of Sacramento **Department of Health and Human Services** **Division of Primary Health Services** **Policy and Procedure**		Policy Issuer (Unit/Program)	**Clinic Services**
		Policy Number	**03-04**
		Effective Date	**03-07-12**
		Revision Date	**02-16-18**
Title: **Emergency Medical Response Team**		Functional Area: **Clinic Operations**	
Approved By: John Onate, MD, Medical Director			

Policy

Sacramento County Health Center has a team response to medical emergencies within the Primary Care Center building. The Emergency Response Team (ERT) consists of employees trained to respond to medical emergencies. Assigned ERT responds to all clinic area emergencies and stays with the patient until paramedics arrive.

Procedures

A. Requesting Medical Emergency Response

1. An individual requiring immediate medical attention may be identified by any staff member.
2. Staff will use the overhead paging system to call the response team. (To access paging system, dial 76, enter #10, state announcement, press end call).
3. State “Emergency Response Team Code Green to [location] if adult patient emergency.” If pediatric emergency, state “Emergency response Code Pink to [location].”
4. If Security is asked to complete the overhead page, they must be advised to include the location and notice of adult or pediatric emergency as noted above.

B. Emergency Response Team Restrictions

The ERT shall not:

1. Provide medical treatment other than basic lifesaving procedures.
2. Move patient unless directed by a provider.
3. Put the safety of themselves or others at risk.

C. Required Training for ERT

1. Cardiopulmonary resuscitation (CPR) – all Clinical staff
2. Overhead paging system – all staff
3. Competency in use of oxygen, ambu bag and Automated External Defibrillator (AED) – Clinical staff only

D. ERT Schedule

1. Team assignments are rotated and are the responsibility of the designated manager and reviewed by the Medical Director.
2. ERT schedule and corresponding activities are posted on the white board located across from the MA work area on both floors.

E. ERT Composition and Roles

TEAM MEMBER	RESPONSIBILITY
Staff person who is witness to or informed of event	1. Use overhead paging system to call ERT to location of emergency. 2. Press 76 to access paging system. 3. At steady tone, enter # 10, announce “Emergency Response Team Code Green to [location]” if adult patient; if it is a child, announce “Emergency response Code Pink to [location].” 4. If an interpreter is needed, request required language (if possible) in the announcement “Spanish interpreter or Spanish speaking staff needed.”
Senior Office Assistant/Clerical Supervisor	1. Notify Security (874-2575) of location of emergency and ask officer to respond to clear scene of bystanders. 2. Print insurance information, last progress note, recent labs, medication list, known allergies, health conditions, current or history of acute or reoccurring symptoms, label(s) and emergency contact information. 3. Provide individual’s information to First Responders if indicated.
Provider (MD, NP)	1. Responsible for coordination of emergency response – assume lead role at the scene. 2. Determine 911 intervention, if necessary. 3. Remain with the patient until secure handoff to first responders or patient status is no longer emergent.
Primary Registered Nurse (RN)	1. Provide emergency assessment. 2. Obtain emergency response bag (PINK bag for pediatrics). See Section F, Number 4 for emergency response bag supplies. 3. Complete Clinic Services Incident Report and submit to the Senior Health Program Coordinator for review and follow-up. 4. Replace emergency supplies after the emergency.
Secondary RN	Record details of event and pertinent medical information during Primary RN assessment.
Medical Assistant (MA)	1. Bring AED and Oxygen to the scene. 2. Dial 911, at Provider direction. 3. Assist RN and Provider as directed.
Security Officer on Scene	1. Inform Security desk of impending ambulance arrival. 2. Control crowd, allow the ERT access and room to work. Direct other personnel back to their workstations.

F. Emergency Response Bag Contents and Maintenance

1. First Floor emergency response bags are located in the Medication Room.
2. Second Floor emergency response bags are located in 2210 (Pediatrics – pediatric bag) and 2140 (Refugee Clinic – adult bag).
3. The emergency response bag contains the following emergency medications:

Emergency Response Bag Medication Contents	
ADULTS	**PEDIATRICS**
Epi Pen 0.3mg (1:1000)	Epinephrine 0.3mg
Glucagon 1mg/1ui IM	Epi Jr. 0.15mg
Nitrostat 0.4mg SL (25 tablets/bottle)	Diphenhydramine HCl 50mg/ml
Tube Fast Acting Glucose Gel (24g carbohydrate)	Diphenhydramine HCl 25mg/cap
Ammonia Inhalants Amp(0.33mL= alcohol 35% - Ammonia 15%/1)	Benadryl (chew) 12.5mg/tab 20tabs
Diphenhydramine 50mg/mL IM (1 ml vial)	Children's Acetaminophen 160mg/5ml
Diphenhydramine 25mg Tablets	Proventil, spacer
Aspirin 81mg Tablets	Ammonia Inhalant
	Glucagon ER response bag

4. The emergency response bag contains items sized appropriately for either adults or children:
   a. Ambu Bag w/mask
   b. High Concentration Oxygen Mask
   c. Thermometer
   d. Bite Block
   e. EKG Tab Electrode
   f. Multifunction Defibrillator Electrode Pedi.Padz®
   g. Instant Cold General Purpose 4 X 6 Inch
   h. Blood pressure cuff and stethoscope
   i. Glucometer with lancets and strips
   j. Pulse oximeter
   k. Airways
   l. Nasal cannula or oxygen face mask (i.e., ambu bag)
   m. Personal Protective Equipment (PPE)
5. Emergency equipment is monitored and maintained weekly by an assigned RN.

6. Assigned RN or MA provides monthly routine maintenance using the Automated External Defibrillator (AED)/ Oxygen (O2) Monthly Log and Maintenance Checklist.
7. Oxygen is supplied in tanks with a capacity of 2,200 pounds per square inch (PSI). When oxygen levels fall below one-half as indicated on the dial, designated staff will notify “Life Save” for servicing. An additional portable oxygen tank is available in Health Center observation area for immediate use, if necessary.

G. Mutual Aid Agreement with Chest Clinic (Division of Public Health)

1. Chest Clinic Office Assistant (OA) or other staff will call for ERT. May use Security for overhead page.
2. Chest Clinic clinical personnel will initiate AED if appropriate while awaiting the ERT arrival.
3. Chest Clinic clinical personnel or OA may take a role with the ERT as noted above in ERT Composition and Roles.
4. Chest Clinic personnel will identify themselves and their role to responding provider.
5. All personnel without assigned roles will return to their workstations.

References:
N/A

Attachments:
Clinic Services Incident Report

Contact:
Laurie Haugen, BSN, RN, Supervising Registered Nurse

Ainur Sapargaliyeva, RN, Supervising Registered Nurse

	County of Sacramento **Department of Health Services** **Division of Primary Health** **Policy and Procedure**	Policy Issuer (Unit/Program)	**Clinic Services**
		Policy Number	**04-12**
		Effective Date	**05-07-15**
		Revision Date	**05-10-21**
Title: **Patient Satisfaction Survey**		Functional Area: **Clinic Services**	
Approved By: Sharon Hutchins, Health Program Manager			

Policy:

Clinic Services has a standardized approach to obtain and review information about a patient's overall satisfaction and perceived quality of care. Surveys are used for self-assessment and as part of the periodic assessment of the quality of service provided by the Health Center in compliance with Health Resources & Services Administration (HRSA) quality improvement/assurance requirements.

Procedures:

A. Survey Tool

1. A validated survey tool is used to assess the following key areas:
    a. Access to care
    b. Customer service
    c. Facility
    d. Clinical care received
    e. Overall visit experience
2. The survey is offered in English and Spanish to ensure ease of completion. Additional languages will be considered.
3. The survey is on a two-sided scantron form that is ordered through the vendor. Scantron forms are machine-readable, multiple-choice answer sheets.

B. Survey Period

    a. A survey period is completed every six months (usually May and October, barring unusual events like a Public Health Emergency).
    b. A survey period is to be two full weeks. Do not select a two week period that includes a site closure (i.e. holidays).

C. Preparation

1. Prior to the survey period, the Clerical Supervisor or designee shall:
    a. Notify all Health Center staff of the upcoming survey period.
    b. Send the vendor an updated list of payer types and providers.
    c. Order a sufficient number of surveys (English and Spanish) from the vendor.
    d. Distribute surveys to all registration staff in the Health Center.

e. Set up locked collection boxes in each clinic with an opening marked “Completed Patient Surveys”.

f. Prepare two boxes of #2 pencils for patient use.

g. Ensure hard surfaces (table or clipboards) are available for patients to fill out the survey.

h. Review the scantron completion instructions and approved script with all registration staff.

2. Prior to the survey period, the registration staff for each clinical area being surveyed will write and bubble in the site location and provider number at the top right side of the survey with a #2 pencil or black or blue pen. Do not use pens with ink that soaks through the paper (i.e. Sharpie).

D. Administering the Survey

1. Registration staff will

a. theyProvide each patient with a survey and a #2 pencil during patient registration and encourage them to complete and submit the survey immediately following their service.

b. Ask the patient if they would like help in completing the survey. Provide assistance as needed or ask the MA to do so before discharge.

c. Provide the following instructions/information to each patient/parent of a patient:

a) Use the provided #2 pencil. Black or blue ink pens are also acceptable. Colored pencils, pens, or markers of any kind will not work.

b) Fill in the circles completely. Do not make a check mark or line through your choice. Do not make stray marks on the form.

c) Do not fold or bend the form. Place the completed form into the locked survey box.

d) Completion of the survey is voluntary and will not affect the care you receive in our clinic.

e) The survey is anonymous and all responses will be kept confidential. Please complete the survey to help us improve the quality of our services.

3. Patients who choose not to complete the surveys are not to be treated differently than patients who choose to do so.

4. A collection box is available in each clinic lobby (Suite 1100, 2100, 2200, Loaves & Fishes) in a high visibility location on the exit route for patients.

5. If staff receive a survey from a patient, they should place the survey in a collection box immediately, without reading the contents.

E. Data Collection and Analysis

1. The Clerical Supervisor (or designee) collects completed Patient Satisfaction Surveys periodically throughout the sampling period and reviews for completion errors.
    a. If surveys are incorrectly filled out by staff or by patients, the Clerical Supervisor reviews the scantron completion instructions and approved script with all registration staff.
2. The Clerical Supervisor (or designee) submits completed surveys to the designated Senior Office Assistant.
3. The designated Senior Office Assistant
    a. Reviews all completed surveys to ensure the site location and provider number is written and bubbled in.
    b. Contacts the vendor prior to sending in completed surveys to provide additional data separation instructions as needed (i.e. separate “Uninsured” comments from “Medical” comments).
    c. Scans a copy of the surveys in case the package goes astray.
    d. Mails all completed surveys to the vendor for scoring. Surveys are to be packed in a box and shipped with a tracking number.
    e. Send the results files to the designated Health Program Manager for review once results are received from vendor.

F. Data Interpretation and Summarization

1. The designated Health Program Manager
    a. Reviews the results files sent.
    b. Conducts additional data summaries.
    c. Writes one or more reports.
    d. Sends the completed reports to the HRSA Project Director for review.

G. Review and Recommendations:

1. Several bodies review the reports once completed, including the Health Center Management Team, the Quality Improvement Committee (QIC), and the treatment teams. Each group may recommend actions based on the findings or trends.
2. If actions are indicated, the Health Center Management Team will document actions, resolution and provide feedback to the QIC.
3. The reports will be shared at the Co-Applicant Board (CAB) Meeting during staff report. Modifications in service delivery and operations may be implemented based on data trends and CAB recommendations and requests.

References:
HRSA Compliance Manual, Chapter 10: Quality Improvement/Assurance

Attachments:
Patient Satisfaction Survey - Staff Script

Contact:
Sandra Johnson, Senior Public Health Program Coordinator

Co-Applicant Board Approval Date: 05/21/2021