Sacramento County Primary Health Services

Healthcare for the Homeless Co-Applicant Board (HCHCAB)

Meeting Agenda

March 2, 2015 / 1:00 PM – 2:30 PM ***Special Meeting Date***

Sacramento County Primary Care Medical Home ***Special Meeting Location***
(2nd Floor, Conference Room 2020)
4600 Broadway
Sacramento, CA 95820

Topic	Time	Action or Discussion
Welcome, Introductions– *Paula Lomazzi*, Chair	1:00 – 1:05	Discussion
Standing Items		
Documents Review and Approval – *Marcia Jo* ▪ Policies and Procedures (P&P) ➢ 03-06 Referral Management – Medical Home ➢ 04-10 Care Coordination ➢ 08-14 Documentation ▪ HCH Scope of Project and Budget	1:05 – 1:35	Discussion Action
New Items		
Revise Mission Statement to Reflect ACA Implementation – *Paula Lomazzi*	1:35 – 1:45	Discussion Action
Medi-Cal Managed Care Essential Benefits – *Paula Lomazzi*	1:45 – 1:50	Discussion
Consider Meeting Location Change to Primary Care Center Building – *Marcia Jo*	1:50 – 1:55	Discussion Action
Public Comment - *Paula Lomazzi*	1:55 – 2:00	
Medical Home Tour – *Marcia Jo*	2:00 – 2:30	

Next Meeting: March 20, 2015 / 9:30 AM – 10:30 AM

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	**03-06**
	Effective Date	**09-18-13**
	Revision Date	**12-23-14**
Title: **Referral Management – Medical Home**	Functional Area: **Clinic Operations**	
Approved By: Susmita Mishra, M.D., Medical Director		

Policy:

Sacramento County Primary Health Services is committed to providing a comprehensive medical home for assigned patients. This includes ensuring that patients receive the external specialty services that they need.

Procedures:

A. Documentation

1. Order Entry section of the EMR is used to place requests by providers and document related activities by Care Coordination Team (CCT).
2. Pertinent clinical documentation will be placed in the Reasons and Comments section of the specific order.
3. Interqual criteria are used and progress note must meet this standard.

B. Process Steps

1. During all steps of referral processing, provider may view the referral progress in the Extended Order Entry section of EMR. CCT communicates with provider via patient messages if there is a need for provider to act on any part of the referral.
2. Referrals are ordered as either STAT (these go to the Registered Nurse (RN) for immediate processing) or ROUTINE (see timeframes below).
3. Every day an assigned Medical Assistant or Claims Specialist will print new orders, check for completion and confirm eligibility.
4. Documentation of ordered referrals must be complete. A complete referral includes a completed progress note, diagnosis code, and clinical detail sufficient for managed care (meets interqual criteria). Patient must be an enrolled member.
5. If an ordered referral is not complete, the CCT will notify the ordering provider that the status is either:
    a. Referral DENIED for lack of completeness.
    b. Referral SUSPENDED pending medical information or eligibility confirmation. Referral will be held for 30 days then either proceeds further or denied.
6. A completed referral will be processed by the CCT in coordination with the assigned health plan. For each referral, one of these communications is sent to the health plan:
    a. Service Request Form (SRF) sent for those services that do not require prior authorization. This notifies the health plan and allows staff to arrange for services with network specialist
    b. Prior Authorization Request (PAR) sent for identified services. RN will ensure the request includes all required clinical documentation and meets InterQual criteria. When authorization is received, CCT will proceed to arrange for services with network specialist.

7. The CCT sends appropriate paperwork to specialist and confirms receipt.
    a. Some referrals (Sleep Study, Durable Medical Equipment and Pulmonary Function Test (PFT) may require additional forms from referring provider. Staff must follow the guidelines noted in the managed care manual.
    b. If available, CCT documents date of appointment and name of specialist in Order Entry. This may not be available if the specialist is attempting to contact the patient to schedule
    c. All referrals are filed in designated electronic file cabinet for 120 days, and then destroyed/deleted.
    d. The only documents to be scanned into the EMR are denial letters from Health Plan for requested service.
8. The specialist contacts the enrollee to schedule an appointment, and provide instruction.
    a. If an appointment is not made within 10 days of referral request, staff should call the health plan, document the call, and send an EMR message to the provider regarding any problems encountered with the referral.
    b. If an appointment is not made within 20 days, staff should call the health plan, document the call, and send an EMR message to the provider regarding the problem and notify the Program Coordinator.
9. CCT follows up with the specialist to confirm the appointment is made and kept, and requests the records. CCT staff requests the initial consultation report. Additional records request will be made by the ordering provider's Medical Assistant.
10. A referral may be cancelled for the following reasons:
    a. 30 days elapse and enrollee has not participated with specialist to set up an appointment.
    b. Enrollee no-shows to two (2) appointments with assigned specialist.
    c. Patient disenrolled or declines.

C. Referral Tracking

1. Within 10 days after scheduled appointment, call patient and specialist to confirm that appointment was kept.
2. If appointment is made and kept within 60 days of the referral:
    a. Request records
    b. Document this in Order Entry and move status to Complete.
    c. EMR message the ordering provider
3. If an appointment is not made and kept within 60 days of the referral:
    a. If rescheduled, document new date in Order Entry.
    b. If not kept, and not rescheduled, send Referral Follow-up "Letter to Patient with Expired Referral.
    c. Document this in Order Entry and Cancel referral, moving to Completed.
    d. EMR message the ordering provider.

D. Summary Table of Process

1. The Table below describes the three tabs available for CCT processing in Order Entry:
    a. Pending
    b. In-Process
    c. Completed

Staff Action	Status in EMR	Description
Provider submits a referral. When this happens, status is ⇨	**"PENDING"** Details available in Order Entry	Referrals stay in PENDING: – Until CCT sends the health plan a PAR/SRF. – If they are <u>suspended</u> awaiting information.
CCT sends referral for authorization or sends documents to selected specialist. When this happens, status becomes ⇨	**"IN PROCESS"** Noted in Order Entry *Referrals may stay in this status for quite some time as some specialties are booked 60-90 days out.*	Referrals stay IN PROCESS: – While PAR granted if needed, documents sent to specialist – Appointment kept records requested – Appointment NOT kept within 60 days,
CCT or Provider finishes, cancels, or denies referral. With this action status becomes ⇨	**COMPLETED** Details noted in Order Entry	**Includes:** – Cancelled – Closed – Denied

E. CCT timeframes for referral processing and completion:

Referral component	Timeframe for completion	Staff action if outside of timeframe
Service authorization granted by health plan	10 days from request	Notify supervisor
Specialty appointment made by CCT	20 days from day ordered or authorization received	Notify RN and referring provider
Suspended for lack of managed care assignment or pending labs	30 days from referral	Deny referral Notify referring provider
Medical records from specialty provider	20 days post appointment	Notify health plan if multiple requests have been made

F. Internal Referrals to Specialists in the TEACH Program

1. Provider sends referral via order entry.
2. Pertinent clinical documentation placed in REASON and COMMENTS.
3. Select Internal Referral from order tree and ordering provider's MA as processer.
4. MA schedules appointment and tracks order until completion.
5. Provider's MA will make the appointment with the internal specialist.
6. Specialist will document the visit and notify the ordering provider.
7. If no show to specialist, specialist's MA will document and message the ordering provider.
8. If specialist orders patient to see external specialist, then the order entry goes to the care coordination team as noted above.

References:
N/A

Attachments:
N/A

Contact:
Sandra Johnson, Health Program Coordinator

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	**04-10**
	Effective Date	**07-15-14**
	Revision Date	
Title: **Care Coordination**	Functional Area: **Clinic Operations**	
Approved By: Susmita Mishra, M.D., Medical Director		

Policy

Primary Health Clinical Services ensures quality patient care through timely communication and effective coordination between providers of care for enrolled patients.

Procedures:

A. Hospital Services for Managed Care patients

1. For managed care patients contracted health plans are required to notify the Primary Care Provider (PCP) if an enrolled patient receives emergency or inpatient hospital services.
2. Managed care plan provides inpatient concurrent review, authorizes services, and participates in discharge planning.
3. Hospital discharge planner calls assigned PCP to schedule discharge services.
4. PCP staff document post hospital services at time of appointment or follow-up to reschedule if appointment is cancelled or missed.
5. PCP medical assistant ensures that records are received and reviewed.

B. Specialty Services for Managed Care Patients

1. PP 03-06 Referral Management for Medical Home details processing of specialty referral management for managed care patients.

C. Hospital Services for County Medically Indigent (CMISP) Patients

1. Hospital notifies CMISP Care Coordination staff if an eligible or potentially eligible patient is served.
2. Staff provides inpatient concurrent review, authorizes services, and participates in discharge planning for CMISP patients.
3. Staff requests that records are sent to assigned PCP to be available at the time of the follow up appointment.
4. Staff document post hospital services at time of appointment and follow-up if appointment is cancelled or missed.
5. PCP medical assistant ensures that records are received and reviewed.

D. Specialty Services for County Medically Indigent (CMISP) Patients

1. Provider orders consultation, diagnostics, or specialty care using the electronic medical record (EMR) “order entry” feature.
2. CMISP Care Coordination staff review the service request, provide authorization, and make appointment for patient.
3. All referrals are tracked in database and timelines are monitored by the Care Coordination Registered Nurses.
4. All steps, including patient information and follow-up, are documented in EMR.
5. Records are requested immediately after the specialty service is provided.
6. Records are dropped into EMR using x-medias and copied to the ordering physician for review.

References:
PP 03-06 Referral Management for Medical Home

Attachments:
N/A

Contact:
Susmita Mishra, M.D., Medical Director

NGA #7 Site Visit #8

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	**08-14**
	Effective Date	**04-30-14**
	Revision Date	**11-04-14**
Title: **Documentation**	Functional Area: **Health Information Management**	
Approved By: Susmita Mishra, M.D., Medical Director		

Policy

Clinic Services Providers ensure documentation of care meets required clinical and billing standards.

Procedures for Licensed Staff:

A. Timeliness
   1. All documentation of clinical encounters must be entered into the EMR within 24 hours.
   2. Late entry, errors, or corrections are documented, “Late Entry office visit note for date of entry.”
   3. Teaching programs: residents must document according to these standards with faculty co-signature within 72 hours.
   4. All orders requiring Medical Assistant (MA) actions must be documented in order entry before the MA can take action.

B. Documentation procedures: Licensed providers
   1. Providers will document under their Provider ID number.
   2. All Providers must be familiar with Evaluation and Management (EM) coding system.
   3. Office visit notes must contain sufficient clinical elements to support selected EM code.
   4. Each focused visit (e.g., primary care, urgent care, behavioral health, etc.) includes documentation of the following:
      a. Chief complaint.
      b. History of present illness.
      c. Primary language and linguistic service needs of non-or limited-English proficient (LEP) or hearing-impaired persons.
      d. Allergies (prominently noted).
      e. List of chronic problems and/or significant conditions.
      f. List of current continuous medications.
      g. Note regarding unresolved and/or continuing problems.
      h. Working diagnosis consistent with findings.
      i. Treatment plan consistent with diagnosis.
      j. Instruction for follow-up care: includes a definite time for return visit or other follow-up care. If appointment made, this may be included as a subsequent note.
      k. Appropriate Office Visit and Diagnostic codes.

5. Follow-up of lab results, specialty consultation, or diagnostic reports require Provider documentation. Most follow up notes can be made directly on the scanned result or in progress note. If a patient is contacted, document actions in a progress note titled, “Test Result Note.”
6. Signed Informed Consents are required when any invasive procedure is performed.

C. Documentation procedures LCSW/MFT, Registered Nurse or Clinical Pharmacist
    1. Notes will be service specific and include CPT codes for services provided.

D. Documentation procedures for Medical Assistants and Office Assistants
    1. Medical Assistants: clinical orders
        a. Document completion of orders in order entry.
        b. Injections are also documented in the Health Maintenance tab injection template (lot#, dose, location placed).
    2. Medical Assistants and Office Assistants: messages
        a. Documentation regarding cancelled, rescheduled or No Show. Appointments are made in the Messages tab with .cc to provider.
        b. Documentation of statements the patient makes about their health or symptoms are made in the Messages tab with .cc to provider.
        c. Non-licensed staff is not permitted respond to medical complaints, medication questions, or document medical need.
        d. See also PP 03-01 Telephone Protocol.
    3. Edits/deletions are made according to PP 08-10 EMR Changes or Deletions.
    4. See details in EMR MANUAL here: http://inside.dhhs.saccounty.net/PRI/Pages/GI-PRI-EMR-Training-Manual.aspx

References:
PP 03-01 Telephone Protocol
PP 08-10 EMR Changes and Deletions
http://inside.dhhs.saccounty.net/PRI/Pages/GI-PRI-EMR-Training-Manual.aspx

Attachments:
Visit Code Guidance

Contact
Marcia Jo JD/MPA Health Program Manager

NGA #1 and 2; Site Visit #16 and 2

H80CS0045: COUNTY OF SACRAMENTO DOH & HUMAN SERVICES

Grant Number: H80CS00045
Budget Period: 11/01/2014 - 10/31/2015
BHCMIS ID: 090700
Project Period: 11/01/2001 - 10/31/2015

Required Services

	Service Delivery Methods		
Service Type	Column 1: Direct (Health Center Pays)	Column 2: Formal Written Contract/Agreement (Health Center Pays)	Column 3: Formal Written Referral Arrangement (Health Center DOES NOT Pay)
General Primary Medical Care	X		X (Mgd Care)
Diagnostic Laboratory	X (PH Lab)	X (Quest)	X (Mgd Care)
Diagnostic Radiology	X		X (Mgd Care)
Screenings	X	X (Quest)	X (Mgd Care)
Coverage for Emergencies During & After Hours	X	X (Phone Med)	X (Mgd Care)
Voluntary Family Planning	X		X (Mgd Care)
Immunizations	X		X (Mgd Care)
Well Child Services			X (Mgd Care)
Gynecological Care	X	X(CMISP)	X (Mgd Care)
Obstetrical Care			
Prenatal Care			X (Mgd Care)
Intrapartum Care (Labor & Delivery)			X (Mgd Care)
Postpartum Care			X (Mgd Care)
Preventive Dental			X (Mgd Care)
Pharmaceutical Services	X		X (Mgd Care)
HCH Required Substance Abuse Services	X		X (Mgd Care)
Case Management	X		X (Mgd Care)
Eligibility Assistance	X		
Health Education	X		X (Mgd Care)
Outreach	X		X (Mgd Care)
Transportation	X		X (Mgd Care)
Translation		X (Interpreter contracts)	X (Mgd Care)

Additional Services

	Service Delivery Methods		
Service Type	Column 1: Direct (Health Center Pays)	Column 2: Formal Written Contract/Agreement (Health Center Pays)	Column 3: Formal Written Referral Arrangement (Health Center DOES NOT Pay)
Additional Dental Services			
Behavioral Health Services			
Mental Health Services	X		X
Substance Abuse Services	X		X
Optometry			
Recuperative Care Program Services			
Environmental Health Services			
Occupational Therapy			
Physical Therapy			
Speech-Language Pathology/Therapy			
Nutrition			
Complementary and Alternative Medicine			
Additional Enabling/Supportive Services			
Other Clinical Pharmacy and Psychiatry	X		X

Specialty Services

	Service Delivery Methods		
Service Type	Column 1: Direct (Health Center Pays)	Column 2: Formal Written Contract/Agreement (Health Center Pays)	Column 3: Formal Written Referral Arrangement (Health Center DOES NOT Pay)

NGA #1 and 2; Site Visit #16 and 2

H80CS0045: COUNTY OF SACRAMENTO DOH & HUMAN SERVICES
Grant Number: H80CS00045
Budget Period: 11/01/2014 - 10/31/2015
BHCMIS ID: 090700
Project Period: 11/01/2001 - 10/31/2015

Site Information			
Site Name	**Sacramento County Primary Care Center**	Site Physical Address	4600 Broadway, Sacramento, CA 95820
Site Type	Service Delivery Site	Site Phone Number	(916) 874-9777
Web URL	http://www.dhhs.saccounty.net/PRI/Pages/PRI-Home.aspx		
The following fields are required for "Service Delivery" and Administrative/Service Delivery site types:			
Location Type	Permanent	Site Setting	All Other Clinic Types
Date Site was added to Scope	1/1/1988	Site Operational Date	7/1/2009
FQHC Site Medicare Billing Number Status	This site has a Medicare billing number.	FQHC Site Medicare Billing Number (Required if "This site has a Medicare billing number" is selected in 'FQHC Site Medicare Billing Number Status' field)	005190
FQHC Site National Provider Identification (NPI) Number (optional field)	1366513061	Total Hours of Operation (when patients will be served per week)	40
Months of Operation	January, February, March, April, May, June, July, August, September, October, November, December		
Service Area ZIP Codes	95829, 95825, 95823, 95818, 95621, 95817, 95608, 95828, 95814, 95628, 95662, 95670, 95820, 95660, 95821, 95758, 95812, 95816, 95655, 95673, 95691, 95810, 95826, 95824, 95838, 95815, 95822, 95831, 95835, 95834, 95842, 95841, 95864, 95843		
Number of Contract Service Delivery Locations (Required only for 'Migrant Voucher Screening' Site Type)		Number of Intermittent Sites (Required only for 'Intermittent Site' Type)	
Site Operated by	[X] Health Center/Applicant	[ ] Subrecipient	[ ] Contractor
Subrecipient or Contractor Information: (Required only if 'subrecipient' or 'contractor' is selected in 'Site Operated By' field)			
Subrecipient/Contractor Organization Name			
Subrecipient /Contractor Organization Physical Site Address			
Subrecipient/Contractor EIN			

Site Information			
Site Name	**Mercy Clinic Loaves & Fishes**	Site Physical Address	1321 N. C. Street, Sacramento, CA 95811
Site Type	Service Delivery Site	Site Phone Number	(916) 874-1455
Web URL	http://www.dhhs.saccounty.net/PRI/Pages/PRI-Home.aspx		
The following fields are required for "Service Delivery" and Administrative/Service Delivery site types:			
Location Type	Permanent	Site Setting	All Other Clinic Types
Date Site was added to Scope	1/1/1988	Site Operational Date	1/1/1987
FQHC Site Medicare Billing Number Status	This site has a Medicare billing number.	FQHC Site Medicare Billing Number (Required if "This site has a Medicare billing number" is selected in 'FQHC Site Medicare Billing Number Status' field)	006680
FQHC Site National Provider Identification (NPI) Number (optional field)	1619271129	Total Hours of Operation (when patients will be served per week)	32
Months of Operation	January, February, March, April, May, June, July, August, September, October, November, December		
Service Area ZIP Codes	95814		
Number of Contract Service Delivery Locations (Required only for 'Migrant Voucher Screening' Site Type)		Number of Intermittent Sites (Required only for 'Intermittent Site' Type)	
Site Operated by	[X] Health Center/Applicant	[ ] Subrecipient	[ ] Contractor

Subrecipient or Contractor Information: (Required only if 'subrecipient' or 'contractor' is selected in 'Site Operated By' field)			
Subrecipient/Contractor Organization Name			
Subrecipient /Contractor Organization Physical Site Address			
Subrecipient/Contractor EIN			

Budget Justification	FY 2015		
	Federal	Non-Federal	TOTAL
REVENUE			
PROGRAM INCOME (fees, premiums, 3rd party reimbursements, and payments generated from the projected delivery of services)		814,338	814,338
LOCAL & STATE FUNDS (including local, foundation, and state grants)		4,079,198	4,079,198
OTHER SUPPORT (including contributions and fundraising)		160,000	160,000
FEDERAL 330 GRANT	1,038,395		1,038,395
OTHER FEDERAL FUNDING (break out by source — e.g., HUD, CDC)			0
TOTAL REVENUE	1,038,395	5,053,536	6,091,931
EXPENSES			
PERSONNEL - *Refer to Staffing Plan (Attachment 1)*			
ADMINISTRATION	156,135	678,039	834,174
MEDICAL STAFF	321,930	752,397	1,074,327
DENTAL STAFF	0	0	0
BEHAVIORAL HEALTH STAFF	0	0	0
ENABLING STAFF	0	201,724	201,724
OTHER STAFF	0	0	0
TOTAL PERSONNEL	478,065	1,632,160	2,110,225
FRINGE BENEFITS			
Fringe Benefits @ 62.25% of Salaries (excluding Registry salary). Below is breakdown:			
Health Insurance @ 15.87%	75,868	258,545	334,413
Retirement @ 20.82%	99,533	339,187	438,720
Medicare @ 6.78%	32,413	110,456	142,869
Retiree Health @ .85%	4,064	13,848	17,912
401A Contribution @ .20%	956	3,258	4,214
Other Allocated Benefits @ 17.73% of salaries (includes Worker's Comp, SUI, Insurance Liability)	84,760	288,847	373,607
TOTAL FRINGE BENEFITS	297,594	1,014,141	1,311,735
TRAVEL			
Local Travel: Client bus passes ($200/mo) and taxi vouchers ($50/mo) to assist clients with reaching medical appointments.	0	3,000	3,000
Local Travel: Employee mileage (1800/2039: $4,101 + 1935/2039: $2,400); 2 vehicles lease/mntc (1935/2928: $7,920) plus gas (1935/2938: $1,106)	0	15,527	15,527
Local Travel: Registration for 3 staff at annual UDS Training ($275 ea)	0	825	825

Budget Justification	FY 2015		
	Federal	Non-Federal	TOTAL
Non-Local Travel: Participation at national conference (1800/2031: $2,150 + 1935/2031: $500).	0	2,650	2,650
TOTAL TRAVEL	0	22,002	22,002
EQUIPMENT			
TOTAL EQUIPMENT	0	0	0
SUPPLIES			
Office Supplies Office supplies (1800/2076: $20,413) + Freight cartage (1800/2045: $16,665 + 1935/2045: $600) + county purchasing costs (1800/2925: $2,076 + 1935/2925: $753)	0	40,507	40,507
Postage (mass mailings, postal and courier service): Postal services (1800/2081: $993 + 1935/2081: $487) + Mail/postage charges (1800/2922: $11,225 + 1935/2922: $1,380) + GS Mssngr (1800/2923: $4,002)	0	18,087	18,087
Communication: Telephone services, Cell, Circuit charges, Landline charges, etc. (1935: $4,867 + 1800/2197: $367 + 1800/2227: $43); OCIT Telephone (1800/2987: $19,118)	0	24,395	24,395
Printing Costs: Printing Svc (1800/2085: $1,694) + GS Prntg Svc (1800/2921: $7,130) + Outreach & educational materials (1935: $1,446)	0	10,271	10,271
Medical Equipment Maintenance: Med Eq Mntc Svs (1800/2251: $4,317) + Med Eq Mntc Sup (1800/2252: $7,771)	0	12,088	12,088
Office Equipment Maintenance: Off Eq Mntc Svc (1800/2261: $235) + Off Eq Mntc Sup (1800/2262: $52,213)+ Rnt/lse Eq (1800/2275: $14,006)	0	66,454	66,454
Laundry: Uniform allowance (1800/1143: $5,333 + 1935/1143: $125) + laundering/dry clean svc (1800/2531: $1,511 + 1935/2351-$1,200)	0	8,169	8,169
Dental: Dental Sup (1800/2412: $6,476)	0	6,476	6,476
Radiology: Rad Svc (1800/2471: $34,538) + Rad Sup (1800/2472: $2,159)	0	36,697	36,697
Intrepreter Services: Interpret Svc (1800/2832-$58,067)	0	58,067	58,067
Pharmacy and Over the Counter Supplies (purchased through County Pharmacy includes vaccines) (1935/6420: $20,607)	20,607	0	20,607
TOTAL SUPPLIES	20,607	281,211	301,818
CONTRACTUAL			
UCD CONTRACT - Attachment 2 provides salary detail	138,010	546,421	684,431
TEACH CONTRACT - Attachment 2 provides salary detail	34,697	80,958	115,655
TOTAL CONTRACTUAL	172,707	627,379	800,086

Budget Justification	FY 2015		
	Federal	Non-Federal	TOTAL
OTHER			
NHCHC dues @ $1,000/yr	1,000	0	1,000
Education & training: CPR, first aid, continuing educations (1935: $900) + Ed/Train (1800/2035: $2,031) + Ed/Train Sup (1800/2036: $432) + Tuition Reimb (1800/2037: $2,590)	0	5,953	5,953
Refreshments at homeless board meetings (1935: $100/mo)	0	1,200	1,200
Data Processing Services: Data Proc Svc (1800/2811: $123,281); Data Proc Sup (1800/2812: $21,586); Sys Dev Svs (1800/2911: 87,306 + 1935/2911: 23,325); WAN (1800/2916: $17,472 + 1935/2916: $6,339); OCIT Labor (1800/2910: $18,453 + 1935/2910: $6,695) ; OCIT Fee (1800/2912: $22,353)	0	326,810	326,810
Facility Use: FEDERAL: Main office facility use (1800/2942: 15% of $456,145); NON-FEDERAL Main office facility use (1800/2942: 85% of 456,145 + 1935/2942: $20,718) + security (1800/2571: $27,041 + 1935/2571: $9,810) + refuse collection/disposal (1800/2193: $518 + 1935/2193: $88) + alarm (1800/2917: $1,307 + 1935/2917: $474)	68,422	447,679	516,101
TOTAL OTHER	69,422	781,642	851,064
TOTAL DIRECT CHARGES	1,038,395	4,358,535	5,396,930
INDIRECT CHARGES – *N/A*			
11.41% indirect rate Dept Overhead (1800/6011: $324,982 + 1935/6011: $59,300) + Division Overhead (1800/6012: $146,617 + 1935/6012: $25,272) + Collection Services + (1800/6504: $75,552) + Personnel Services (1800/6541: $46,433 + 1935/6541: $16,845)	0	695,001	695,001
TOTALS (Total of TOTAL DIRECT CHARGES and INDIRECT CHARGES above)	1,038,395	5,053,536	6,091,931

PLEASE NOTE: Sacramento County utilizes the HRSA funding to provide services within our HCH Integrated Behavioral Health Medical Home. Not all enrollees in this medical home are homeless so we utilize a percentage methodology to budget and finally allocate expenses and revenues.

Health Care for the Homeless Co-Applicant Board
Mission Statement
DRAFT

Mission Statement as of May 2014:

The Health Care for the Homeless Co-Applicant Board supports and advocates for Sacramento County's homeless population to achieve optimum level of health care for the men, women and children we serve.

Mission revision – *potential options for review, modification, and/or selection*

a) We achieve health through integrated comprehensive primary care.
b) We improve health outcomes through integrated comprehensive care and service coordination.
c) We achieve optimal health through integrated comprehensive care.
d) We achieve health through timely access to high quality comprehensive care.
e) We improve health through education and comprehensive care.
f) We improve the health, wellbeing and quality of life of each person we serve.

Values – *HCH may wish to choose key values.*

- Respect
- Compassion
- Collaboration
- Empowerment
- Open Communication
- Integrity
- Service Excellence

What are the Medi-Cal Benefits?

Medi-Cal currently provides a core set of health benefits, including doctor visits, hospital care, immunization, pregnancy-related services and nursing home care. The Affordable Care Act ensures all Medi-Cal health plans offer what is known as Essential Health Benefits (EHB). These comprehensive services include the following categories:

1. Outpatient (Ambulatory) services
2. Emergency services
3. Hospitalization
4. Maternity and Newborn care
5. Mental Health and Substance Use Disorder Services, including Behavioral Health Treatment
6. Prescription Drugs
7. Programs such as physical and occupational therapy (known as Rehabilitative & Habilitative Services) and devices
8. Laboratory services
9. Preventive and wellness services & chronic disease management
10. Children's (Pediatric) services, including oral and vision care
11. Dental Services

Adult Medi-Cal Dental benefits were restored as of May 1, 2014. Dental Benefits for children did not change. Dental services may exceed the annual $1,800 limit if shown to be medically necessary. Adult services include:

1. Exams and x-rays
2. Cleanings (Prophylaxis)
3. Fluoride treatments
4. Fillings
5. Root canals in front teeth
6. Prefabricated Crowns (stainless steel or tooth colored)
7. Full dentures
8. Other medically necessary dental services

Dental Resources:
Denti-Cal at 1-800-322-6384
Denti-Cal Website at www.denti-cal.ca.gov