SACRAMENTO COUNTY

Patients CY 2021						
Patient Type		**1st Qtr**	**2nd Qtr**	**3rd Qtr**	**4th Qtr**	**Goal**
Unduplicated Patients Established (Seen)		5,613				11,000
River City Medical Group	Enrolled	7,003				
	Established (Seen)	5,050				
UCD Health Net	Enrolled	3,829				
	Established (Seen)	2,044				
Nivano	Enrolled	1,095				
	Established (Seen)	390				
Healthy Partners	Enrolled	3,773				
	Established (Seen)	3,162				
Patient Access		**1st Qtr**	**2nd Qtr**	**3rd Qtr**	**4th Qtr**	**Goal**
No Show Rate – Adult Primary Care		17.0 %				
No Show Rate – Pediatrics & Adolescent Care		17.2 %				
No Show Rate – Family Medicine		14.8 %				

Clinical Performance Measures CY 2021					
HEDIS	**1st Qtr**	**2nd Qtr**	**3rd Qtr**	**4th Qtr**	**Goal**
Chlamydia Screening	51.0%				56.1 %
Diabetes Eye Exam	NA				57.8 %
Diabetes HbA1c Testing	40.0%				87.8 %
Diabetes Nephropathy	NA				90.5 %
Immunization for Adolescents	34.4%				31.9 %
Monitoring of Therapeutic Agents ACE/ARB	NA				88.2 %
Monitoring of Diuretics	NA				88.3 %
Postpartum Care	72.1%				65.2 %
Weight Assessment and Counseling – BMI	33.6%				79.0 %
Weight Assessment and Counseling – Nutritional Counseling	36.8%				70.9%
Weight Assessment and Counseling – Physical Activity Counseling	33.9%				65.0%
Well-Child Visits for 0 – 15 months	7.6%				66.2 %
Well-Child Visits for 3-6 year olds	20.2%				73.9 %
Well-Care visits for 12-21 year olds (Adolescent Well-Care Visits)	3.2%				54.5 %

Clinical Performance Measures CY 2021					
HRSA	**1st Qtr**	**2nd Qtr**	**3rd Qtr**	**4th Qtr**	**Goal**
Colorectal Cancer Screening	16.7 %				30.1 %
Controlling High Blood Pressure	41.0 %				88.6 %
HIV Linkage to Care					100.0 %
HIV Screening	75.9 %				
Ischemic Vascular Disease (IVD): Use of Aspirin or Another Antiplatelet	80.0 %				80.0 %
Low Birth Weight*					10.0 %*
Screening for Clinical Depression and Follow-Up Plan	19.6 %				60.0 %
Depression Remission at Twelve Months	1.7 %				
Statin Therapy for the Prevention and Treatment of Cardiovascular Disease	72.1 %				82.9 %
Tobacco Use: Screening and Cessation Intervention	85.8 %				88.6 %
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents	28.9 %				85.0 %

Clinical Performance Measures CY 2021										
HEDIS & HRSA	**HEDIS**					**HRSA**				
	1st Qtr	**2nd Qtr**	**3rd Qtr**	**4th Qtr**	**Goal**	**1st Qtr**	**2nd Qtr**	**3rd Qtr**	**4th Qtr**	**Goal**
Body Mass Index (BMI) Screening and Follow-Up Plan	NA				88.6 %	26.2 %				75.0 %
Breast Cancer Screening	50.8%				58.0 %	52.7 %				
Cervical Cancer Screening	35.0%				60.1 %	54.9 %				40.0 %
Child Immunization Status	12.0%				71.5 %	29.3 %				55.0 %
Early Entry into Prenatal Care	69.8%				83.2 %	53.2 %				50.0 %
Diabetes HbA1c Testing Poor Control*	70.3%				38.2 %*	37.2 %				20.0 %*

* Target Goals for these Measures are inverted.

Greyed out measures are done by Chart reviews at the close of the Calendar Year.

2020 QI Plan Monitoring

AIM: Population Health Outcomes

Operational Definition: ***Reducing health inequities & assisting patients in achieving better health outcomes through best practice and/or evidence-based guidelines***

Category: CARE COORDINATION

Goal 1: Improve care coordination of members with high service utilization, or who require services across systems.

Objective 1-1 ***Designate care management team***

Status
1) Care team designated. 2) Workflow developed. 3) Workflow implemented.

Category: CLINICAL PERFORMANCE MEASURES

Goal 1: Improve performance on select UDS and HEDIS quality measures (focused on that signal a healthy start in life and those focused on secondary prevention of health issues prevalent among SCHC patients) and tackle racial and ethnic disparities in such measures.

Objective 1-1 ***Improve chronic disease management and outcomes by achieving at least minimal performance level (MPL) for the following***

Condition	HEDIS Metric	Target	Value (Aug-Sep 2020)	Source
Hypertension	Controlling high blood pressure	62%	46.1%	Latest HEDIS values from IPAs (through Dec)
Diabetes melitus	HbA1c Poor Control (>9.0%)	< 38%	48.8%	
	Had HbA1c Test	89%	78.7%	
	Had Retinal Eye Exam	39%	69.6%	

Objective 1-2 ***Ensure that children have a healthy start in life by achieving at least minimal performance level (MPL) for the following HEDIS***

HEDIS Metric	Target	Value (Aug-Sep 2020)	Source
Initiation of prenatal care	84%	84.9%	Latest HEDIS values from IPAs (through Dec)
Postpartum care	66%	63.4%	
Well-Child Visits 0-15 (W15)	66%	24.2%	
Well-Child Visits 3-6 (W34)	73%	43.3%	
CIS (Two year olds up-to-date)	35%	31.0%	

Objective 1-3 ***Reduce racial and ethnic health disparities in UDS and chosen HEDIS measures in 2020 compared to baseline for 2019.***

Quality Metric	2019	2020	Source
% of patients aged 18-84 with hypertension whose hypertension is controlled			UDS Reports
	Latinx 64% vs. Non-Latinx: 62%	Latinx: 52.% vs. Non-Latinx: 48%	
	AfrAm: 59%; Asian: 70%; White: 60%	AfrAm: 44%; Asian: 46%; White: 53%;	
% of patients with uncontrolled diabetes			UDS Reports
	Latinx 38% vs. Non-Latinx: 34%	Latinx: 44% vs. Non-Latinx: 40%	
	AfrAm: 42%; Asian: 28%; White: 36%	AfrAm: 44%; Asian: 33%; White: 43%;	

CAB Financial Report

Period 8
Current Month **February**
Percentage of Year **67%**

Line Item	Budget	Current Month	Year to date	*Target amount (Budget x %)*	YTD Percentage	Notes
Revenue						
Intrafund Reimbursements	$9,669,568	$756,409	$5,527,650	*$6,446,379*	57%	Encumbrance = when we send charges to another Department, a receivable is created in our system. The payment, once received, will go into actuals and wipe out the encumbrance.
Intergovernmental Revenue	$11,928,600	$1,020,115	$8,776,143	*$7,952,400*	74%	
Charges for Services	$76,800	$15,423	$93,217	*$51,200*	121%	CMISP old pre-2014 service charges
Miscellaneous Revenue	$17,368	$290	$1,179,191	*$11,579*	6789%	FY 2018-19 Cost settlement and accrual vs actual claims mismatch causes huge discrepancy vs. budget
Total Revenue	**$21,692,336**	**$1,792,237**	**$15,576,201**	*$14,461,557*	**72%**	
Expenses						
Personnel	$10,394,126	$770,829	$6,100,336	*$6,929,417*	59%	
Services & Supplies	$11,479,039	$1,232,138	$5,739,427	*$7,652,693*	50%	Add notes, check actuals
Other Charges	$894,833	$97,269	$529,921	*$596,555*	59%	
Equipment	$250,000	$0	$94,510	*$166,667*	38%	
Intrafund Charges (Allocation costs)	$2,679,271	$202,637	$1,079,153	*$1,786,181*	40%	
				$0		
Total Expenses	**$25,697,269**	**$2,302,873**	**$13,543,347**	***$17,131,513***	**53%**	

Why is the budgeted expenses more than the budgeted revenue? The remainder is the Clinic's "Net County Cost" or General Fund allocation, which is treated like a special revenue of last resort that the Clinic can use to support its expenses.

GRAND TOTAL **-$4,004,933** **$2,032,854** ***-$2,669,955***

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

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** **Policy and Procedure**	Policy Issuer (Unit/Program)	**Clinic Services**
		Policy Number	**01-03**
		Effective Date	**01-31-13**
		Revision Date	**04-09-21**
Title: **Sacramento County Health Center Co-Applicant Board – Conflict of Interest**		Functional Area: **Organization**	
Approved By: -Sharon Hutchins, HRSA Project Director			

Policy:

Sacramento County Clinic Services adheres to the Health Services and Resource Administration (HRSA) requirement to maintain written standards of conduct covering conflict of interest. Conflicts of interest involving the Sacramento County Health Center Co-Applicant Board (CAB) must be identified and disclosed when the Co-Applicant Board member is considering entering into a transaction, arrangement, policy, financial, or other work that might benefit the private interest of the Board member. Board members with conflicts of interest including financial interests may not participate in Co-Applicant Board discussions about or decisions regarding that issue. This policy is intended to supplement but not replace any applicable state and federal laws governing conflict of interest that are applicable to governmental, nonprofit, and charitable organizations.

Definitions:

A. Conflict of Interest – An actual or perceived interest by a Board member in an action which results, or has the appearance of resulting, in personal, organizational, or professional gain. A financial interest is a type of conflict of interest.

B. Financial Interest – A Co-Applicant Board member has a financial interest if s/he, directly or indirectly through business, investment, or family has:

1. An ownership or investment interest in any entity with which the Co-Applicant Board has a transaction or arrangement.
2. A compensation arrangement with any entity or individual with which the Co-Applicant Board has a transaction or arrangement. Compensation includes direct and indirect remuneration as well as gifts or favors that are not insubstantial, such as consultancy, fee-paid work, and shareholdings.

Procedures:

A. Form 700 - Statement of Economic Interests

1. Co-Applicant Board members are required to fully disclose their personal assets and income.
2. Co-Applicant Board members complete and file Form 700 with the Clerk of the Board of Supervisors:
   a. within 30 days of position appointment;
   b. annually during appointment by the date specified in the California Fair Political Practices Commission; and
   c. no later than 30 days after leaving the appointed position.

B. Ethics Training

1. Co-Applicant Board members are required to take the provided Ethics Training course to educate them on the ethical standard
    a. within 30 days of position appointment; and
    b. once every two years during appointment.
2. The Ethics Training course is provided either in person or on-line.

C. Disclosure and Attestation Statement

1. Co-Applicant Board Bylaws require Board members to declare any potential conflicts of interest by completing a Sacramento County Health Center Co-Applicant Board Conflict of Interest: Disclosure and Attestation Statement, indicating that they meet membership requirements from HRSA that reduce the likelihood of a conflict of interest arising from
    a. being a Health Center employee or
    b. having an immediate familial relationship (defined as being a spouse, child, parent, or sibling [by blood, adoption, or marriage] of a Sacramento County Health Center employee or a CAB Officer.
2. Upon ratification by the Board of Supervisors and before becoming voting members, new CAB members complete the Sacramento County Health Center Co-Applicant Board Conflict of Interest: Disclosure and Attestation Statement, indicating that they meet membership requirements from HRSA that reduce the likelihood of a conflict of interest and submit it (hard copy or scanned electronic form) to the HRSA Project director or designee.
3. Continuing members annually complete the Sacramento County Health Center Co-Applicant Board Conflict of Interest: Disclosure and Attestation Statement and submit it (hard copy or scanned electronic form) in October to the HRSA Project director or designee.

D. Health Program Manager Responsibilities

1. Reviews and discusses this policy on an annual basis during a Co-Applicant Board meeting.
2. Provides a Disclosure and Attestation Statement to new Co-Applicant Board members for completion.
3. Ensures timely submission and completion of Form 700 - Statement of Economic Interests and Ethics Training.

E. Board Member Responsibilities

1. Disclose any conflict of interest and all material facts to the Co-Applicant Board when there is a proposed transaction or arrangement.
2. Abstain from Co-Applicant Board discussion about an issue with which that member has a conflict of interest (including financial interest).
3. Abstain from voting in a situation where a conflict of interest (including financial interest) exists for that member.

4. Is not an employee or immediate family member of an employee (as defined above) of the Sacramento County Health Center or the Department of Health Services of the County of Sacramento.

References:

HRSA Health Center Program Compliance Manual. Chapter 13: Conflict of Interest

California Fair Political Practices Commission

Sacramento County eDisclosure

Sacramento County Co-Applicant Board Bylaws

California Form 700, Statement of Economic Interests

Attachments:

Sacramento County Health Center Co-Applicant Board Conflict of Interest: Disclosure and Attestation Statement

Contact: Sharon Hutchins, Ph.D., MPH, Health Program Manager

Co-Applicant Board Approval Date: 4/16/2021

	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	**01-26-21**
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 (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 Hour 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.

c. Follow Steps outlined in C.3.a and C.3.b

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. If patient is assigned to the SCHC and <u>did</u> talk to the provider during call:

a) Locate provider's encounter for the DOS of the call.

b) Addend encounter.

c) Create a new note.

d) Take a screen shot of the FONEMED report and paste it into the encounter NOTE and accept note.

e) Sign encounter.

ii. If patient is assigned to SCHC and did not talk to the provider during call:

a) Create a telephone encounter and contact the patient.

b) Take a screen shot of the FONEMED report and paste it into the encounter NOTE and accept note.

c) Create a new note and document patient's questions and actions taken.

d) Accept note, and if the encounter does not need to be escalated to PCP, sign encounter.

e) If encounter needs to be escalated to PCP, route telephone encounter to the PCP and cc: other departments as appropriate.

iii. If patient is not assigned to the SCHC and the patient did not talk with the provider

a) Call the patient and refer him/her to their own PCP.

iv. If patient is not assigned to the SCHC (does not have an OCHIN) chart and the patient did talk with the provider

a) Do not take action. Member Services is responsible for responding to the After Hours Clinician Form.

3. At start of the shift on the next business day, the after-hours clinician will:

a. If the patient had an OCHIN chart, 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.

b. If the patient did not have an OCHIN chart, the after-hours clinician will fill out the After Hours Clinician Form (Attachment B).

i. If there is a clinical component that needs to have follow up, the after-hours clinician will also email the Supervising Nurses of Adult, Family Medicine, and Pediatrics (include Pediatrics only if patient is less than 18).

ii. Supervising Nurse will email the After Hours Clinician Form to Member Services (see list in Attachment B).

c. Reviewing Telephone Encounters

i. The recipient of a telephone encounter from the after-hours clinician will handle it as the specific circumstances dictate, just like other telephone encounters.

ii. If a telephone encounter is sent to two Supervising Nurses, both recipients will discuss the appropriate next steps (e.g. PCP or clinical area assignment) if they are available. If not, the supervising nurse present will determine how to handle the message.

d. Reviewing After-Hours Clinician Form

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

a) For uninsured patients, Member Services will assist the patient to enroll in health insurance

b) For insured patients, Member Services will fax the form to the appropriate IPA (Attachment E).

c) At the start of the shift on the next business day, the after-hour clinician will

1) If the patient had an OCHIN chart, 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 rea to identify the appropriate supervising nurse.

2) If the patient did not have an OCHIN chart, the after-hours clinician will fill out the After Hours Clinician Form (Attachment B).
    i. If there is a clinical component that needs to have follow up, the after-hours clinician will also email the Supervising Nurses of Adult, Family Medicine, and Pediatrics (include Pediatrics only if patient is less than 18).
    ii. Supervising Nurse will email the After Hours Clinicial Form to Member Services (see list in Attachment B).

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: 04-16-21

Sacramento County Health Center

2018-2020 Health Center Sliding Fee Scale Evaluation Report
April 2021

Background

Purpose

As required by the federal Health Resources and Services Administration (HRSA), the Sacramento County Health Center (SCHC) evaluates its Sliding Fee Discount Schedules (SFS) at least once every three years to determine whether it effectively reduces financial barriers to care for patients at or below 200% of the Federal Poverty Guidelines. This report covers the time period 2018-2020.

SFS Structure

While under *Section 330(k)(3)(G) of the PHS Act; 42 CFR 51c.303(f), 42 CFR 51c.303(g), 42 CFR 51c.303(u), 42 CFR 56.303(f), 42 CFR 56.303(g), and 42 CFR 56.303(u),* Federally Qualified Health Centers (FQHC)s are allowed to have multiple Sliding Fee Discount Schedules for different broad service types, SCHC maintains a single SFS for all services (required and additional) within its HRSA-approved scope of services. SCHC updates its SFS annually after the publication of the new Federal Poverty Level (FPL). As shown in Table 1, the scale contains eight tiers. The SHCH's SFS did not change between 2018 and 2020, although the Federal Poverty Level, on which the tiers are based, did. The SFS was most recently reviewed and approved by the SCHC Co-Applicant Board on March 19, 2021.

Table 1: 2021 Sliding Fee Discount Table

Persons in Family	Nominal Fee ≤100%	A >100% and ≤125%	B >125% and ≤150%	C >150% and ≤175%	D >175% and ≤200%	Full Price >200%
1	≤ $12,880	$12,881 – $16,100	$16,100 – $19,320	$19,321 – $22,540	$22,541 – $25,760	$25,761
2	≤ $17,420	$17,421 – $21,775	$21,776 – $26,130	$26,131 – $30,485	$30,486 – $34,840	$43,841
3	≤ $21,960	$21,961 – $27,450	$27,451 – $32,940	$32,941 – $38,430	$38,431 – $43,920	$43,921
4	≤ $26,500	$26,501 – $33,125	$33,126 – $39,750	$39,751 – $46,375	$46,376 – $53,000	$53,001
5	≤ $31,040	$31,041 – $38,800	$38,881 – $46,560	$46,561 – $54,320	$54,321 – $62,080	$62,081
6	≤ $35,580	$35,581 – $44,475	$44,476 – $53,370	$53,371 – $62,265	$62,266 – $71,160	$71,161
7	≤ $40,120	$40,121 – $50,150	$50,151 – $60,180	$60,181 – $70,210	$70,211 – $80,240	$80,241
8	≤ $44,460	$44,461 – $55,825	$55-826 – $66,990	$66,991 – $78,155	$78,156 – $89,320	$89,321
Fee	**$15**	**$20**	**$30**	**$40**	**$50**	**NO DISCOUNT**

Under the same authority mentioned above, FQHCs must implement an SFS consisting of progressive discounts on fees, with no discount over 200% of FPL and a full discount for 100% or less of FPL. The FQHC can implement this gradient of discounts either as specific fees or as a percentages of the full fee. SCHC uses the second option: a set of fees moving down from full price at over 200% of FPL to a full discount at or below 100% of FPL. In addition, FQHCs may set a nominal charge for services consistent with the FQHCs goals (for example, to enhance the perceived value of the service) that would not impose barriers on patients and does not the actual cost of the service provided. As shown in Table 1, SCHC has set a nominal charge of $15 for its patients at or below 100% of FPL.

Report and Discussion

SFS Structure

Single SFS

SCHC has chosen to establish a single SFS for all HRSA-covered service to enhance patient understanding of the system and to reduce potential barriers to care from a multiple SFS system. Although having multiple SFSs does not on its own present a barrier to care in the abstract, having services with higher fees may cause a patient to avoid those and thereby forgo care.

SCHC's HRSA-approved scope of service expanded during the time period studied, with the addition of two specialty services—cardiology and neurology in September 2019. Patient feedback survey results were examined with the expectation that the addition of the new services would not decrease patient understanding of what they were asked to pay. As shown in Table 2, the percentage of SCHC patients who reported not understanding what they were asked to pay did not change appreciably in the surveys conducted just before and after the addition of these specialty services. This finding provides support for maintaining a simple single SFS at SCHC.

Table 2: SCHC Patient Feedback Regarding Fees

Patient Satisfaction Survey Period	Do Not Understand What Asked to Pay
May 2019	9.5%
October 2019*	10.4%

Discounted Fees vs. Percentages

SCHC has implemented a SFS with set discounted fees rather than percentage discounts in order to avoid having different fees for different types of services, which may cause patients to avoid higher cost services. For example, the full fee for the shortest type of Office Visit at SCHC is $80.05, while the cost for the longest type of Office Visit is $264.79. If the SCHC SFS used percentage discounts, the discounted fee for the latter service would be three times higher than the former service. This variation in final cost after the application of the sliding fee discount could easily lead cost sensitive patients to artificially lower the duration of their office visits by refraining from asking questions of their medical provider or providing short and incomplete answers to questions asked by their provider. In such a situation, even if there was a not a complete barrier to care, this could be a barrier to high quality care.

To examine whether the intended goal of avoiding causing patients to forgo needed care due to expense, we examined the most recent patient survey findings for SCHC and peer health centers using the same survey instrument and vendor. As Table 3 shows, a smaller percentage of SCHC patients indicated that they had to forgo care due to expense than those at other health centers. While there may be many reasons for this finding, including the magnitude of the discounts offered, the finding does indicate that SCHC's goal of reducing barriers to care is effective.

Table 3: Patients Forgoing Care Due to Expense at SCHC vs. Peer Health Centers

Patient Satisfaction Survey Period	Had to Forgo Care Due to Expense	
	SCHC	Peers
July-December 2020	11.1%	21.7%

Reasonableness of SCHC SFS

While the SCHC SFS was set after an analysis of market conditions, including comparing SFS' of other local health centers, it is important to examine whether the SFS remains reasonable.

Perceived Reasonableness

To determine whether patients continue to feel that SCHC costs, including the SFS, are reasonable, we examined patient feedback survey results. As shown in Table 4 below, the percentage of SCHC who feel that what they pay is reasonable was over 90% at each time surveyed. Unfortunately, the vendor removed this question from the survey in 2020.

Table 4: Patient Feedback Regarding Fees at SCHC vs. Peers

Patient Satisfaction Survey Period	Feel Cost is Unreasonable	
	SCHC	Peers
Early 2018	5.5%	4.1%
Early 2019	3.8%	4.1%
Late 2019	8.4%	3.8%
Late 2020*	NA	NA

We also examined requests for fee waivers over the time period studied. No SFS patient requested relief of their fees due to hardship/inability to afford services after their Sliding Fee was applied. This finding suggests that SCHC SFS patients do not find the fees unreasonable.

Economic Conditions

To determine whether the SCHC SFS remains reasonable, we also examined trends in costs that likely affect SCHC patients. A good overall metric is the Core Consumer Price Index (CPI-U), which covers a basket of goods and services considered to be representative of general costs incurred by urban dwellers. Another important metric in Sacramento is housing costs, particularly rent. While there are homeowners with incomes at or below 200% of Federal Poverty Level (FPL), the large majority of those living at this economic level do not own the home they reside in, and thus rent increases are likely to be relevant to a majority of SFS patients.

As shown in Table 4, the CPI for the Sacramento region has risen each year. Because CPI is a year-over-year percentage measurement, the increase in general costs over the period of this analysis is not the sum of the percentages above, 9.7%. Rather, it is a cumulative increase in costs over the period, which totals 10.05%. Likewise, the average rent has increased during this time (although the data source does not include the entire period). In sum, Table 4 shows that expenses for SFS participants likely rose considerably during the time period studied.

Table 4: Percentage Change in Key Cost of Living Metrics by Year

Metric	2018	2019	2020	2021	Cumulative
CPI-U[1]	3.2	2.4	2.5*	1.6*	10.05
Rent[2]	3.5	2.5	--	--	6.08

[1]Source: Federal Bureau of Labor Statistics BLS 21-409-SAN, using CPI-U for the West Region.
**2021 period is 11 months. March data to be released on 04/13/2021.*
[2]Source; United States Census/American Community Survey (ACS)
--2020 data to be released in September of 2021.

Relative Impact of SFS

After reviewing historic changes in average costs likely to affect patients, we examined average Physician Office Utilization to help determine the relative burden on patients' budgets SCHC SFS fees may place. The National Center for Health Statistics of the Centers for Disease Control and Prevention reports the annual average number of Office Visits to be 277.9 per 100 people. Of the total number of visits, 54.5% are Primary Care physician visits. This would mean that the per-person average annual visit number is 2.78, from which an average of 1.51 are Primary Care visits. For our purposes of exploring whether the SCHC SFS presents a barrier to care, we rounded up to the nearest whole visit and used an estimate of 2 visits per person per year, which will over-estimate the relative burden of the SCHC SFS on its patients.

Table 5 shows the cost that would be incurred by a family in 2021 if each member had 2 visits per year under SCHC's current SFS charges. The cost is expressed as both a dollar amount and as a percentage of family income. For tiers where eligible income is a range, we used the highest value, again to tend to over-estimate the burden of the SFS. As shown, the highest estimated total cost and highest estimated cost as a percentage of income are for a family of 8 with an income of $89,320. A family falling into this category this would spend less than 1 percent of their income for the number of visits we estimate. The percentage of family budget the projected SFS for two visits for each family member would constitute is progressively smaller down the tiers (to ≤100% FPL).

To show change over time, the total cost and cost as a percentage of family income was calculated on the same estimated number of visits against SCHCs 2018 Sliding Fee Scale. Those results are shown in Table 6. Again, the highest estimated total cost and highest estimated cost as a percentage of income would be for a family of 8 with an income of $84,760. As in 2021, a family falling into this category this would spend less than 1 percent of their income for the number of visits we estimate. As in 2021, the percentage of family budget the projected SFS for two visits for each family member would constitute was progressively smaller down the tiers (to ≤100% FPL).

This analysis shows that the projected impact of the SFS on SCHC patients, based on national average primary care utilization, did not substantially change over the time period of the study. By maintaining the SCHC SFS charges unchanged over this time period, the affordability of health care offered by SCHC has not decreased.

Table 5: 2021 Sliding Fee Discount Table with Cost Projections

Family Size (persons)	Nominal Fee			A			B			C			D			Full Price
	Less than or equal to 100% Maximum Income	Cost of Two visits per person per year	Cost of Visits as a percentage of income	101% – 125% Maximum Income	Cost of Two visits per person per year	Cost of Visits as a percentage of income	126% – 150% Maximum Income	Cost of Two visits per person per year	Cost of Visits as a percentage of income	151% – 175% Maximum Income	Cost of Two visits per person per year	Cost of Visits as a percentage of income	176% – 200% Maximum Income	Cost of Two visits per person per year	Cost of Visits as a percentage of income	Over 200%
1	$12,880	$30	0.23%	$16,100	$40	0.25%	$19,320	$60	0.31%	$22,540	$80	0.35%	$25,760	$100	0.39%	$25,761
2	$17,420	$60	0.34%	$21,775	$80	0.37%	$26,130	$120	0.46%	$30,485	$160	0.52%	$34,840	$200	0.57%	$43,841
3	$21,960	$90	0.41%	$27,450	$120	0.44%	$32,940	$180	0.55%	$38,430	$240	0.62%	$43,920	$300	0.68%	$43,921
4	$26,500	$120	0.45%	$33,125	$160	0.48%	$39,750	$240	0.60%	$46,375	$320	0.69%	$53,000	$400	0.75%	$53,001
5	$31,040	$150	0.48%	$38,800	$200	0.52%	$46,560	$300	0.64%	$54,320	$400	0.74%	$62,080	$500	0.81%	$62,081
6	$35,580	$180	0.51%	$44,475	$240	0.54%	$53,370	$360	0.67%	$62,265	$480	0.77%	$71,160	$600	0.84%	$71,161
7	$40,120	$210	0.52%	$50,150	$280	0.56%	$60,180	$420	0.70%	$70,210	$560	0.80%	$80,240	$700	0.87%	$80,241
8	$44,460	$240	0.54%	$55,825	$320	0.57%	$66,990	$480	0.72%	$78,155	$640	0.82%	$89,320	$800	0.90%	$89,321
Per Visit Fee	$15			$20			$30			$40			$50			NO DISCOUNT

Note: Table is based on the 2021 Federal Poverty Guidelines (http:/aspe.hhs.gov/poverty) for annual income.

Table 6: 2018 Sliding Fee Discount Table with Cost Projections

Family Size (persons)	Nominal Fee			A			B			C			D			Full Price
	Less than or equal to 100% Maximum Income	Cost of Two visits per person per year	Cost of Visits as a percentage of income	101% – 125% Maximum Income	Cost of Two visits per person per year	Cost of Visits as a percentage of income	126% – 150% Maximum Income	Cost of Two visits per person per year	Cost of Visits as a percentage of income	151% – 175% Maximum Income	Cost of Two visits per person per year	Cost of Visits as a percentage of income	176% – 200% Maximum Income	Cost of Two visits per person per year	Cost of Visits as a percentage of income	Over 200%
1	$12,140	$30	0.25%	$15,175	$40	0.26%	$18,210	$60	0.33%	$21,245	$80	0.38%	$24,280	$100	0.41%	$24,281
2	$16,460	$60	0.36%	$20,575	$80	0.39%	$24,690	$120	0.49%	$28,805	$160	0.56%	$32,920	$200	0.61%	$32,921
3	$20,780	$90	0.43%	$25,975	$120	0.46%	$31,170	$180	0.58%	$36,365	$240	0.66%	$41,560	$300	0.72%	$41,561
4	$25,100	$120	0.48%	$31,375	$160	0.51%	$37,650	$240	0.64%	$43,925	$320	0.73%	$50,200	$400	0.80%	$50,201
5	$29,420	$150	0.51%	$36,775	$200	0.54%	$44,130	$300	0.68%	$51,485	$400	0.78%	$58,840	$500	0.85%	$58,841
6	$33,740	$180	0.53%	$42,175	$240	0.57%	$50,610	$360	0.71%	$59,045	$480	0.81%	$67,480	$600	0.89%	$67,481
7	$38,060	$210	0.55%	$47,575	$280	0.59%	$57,090	$420	0.74%	$66,605	$560	0.84%	$76,120	$700	0.92%	$76,121
8	$42,380	$240	0.57%	$52,975	$320	0.60%	$63,570	$480	0.76%	$74,165	$640	0.86%	$84,760	$800	0.94%	$84,761
Per Visit Fee	$15			$20			$30			$40			$50			NO DISCOUNT

Table is based on the 2018 Federal Poverty Guidelines (http:/aspe.hhs.gov/poverty) for annual income.

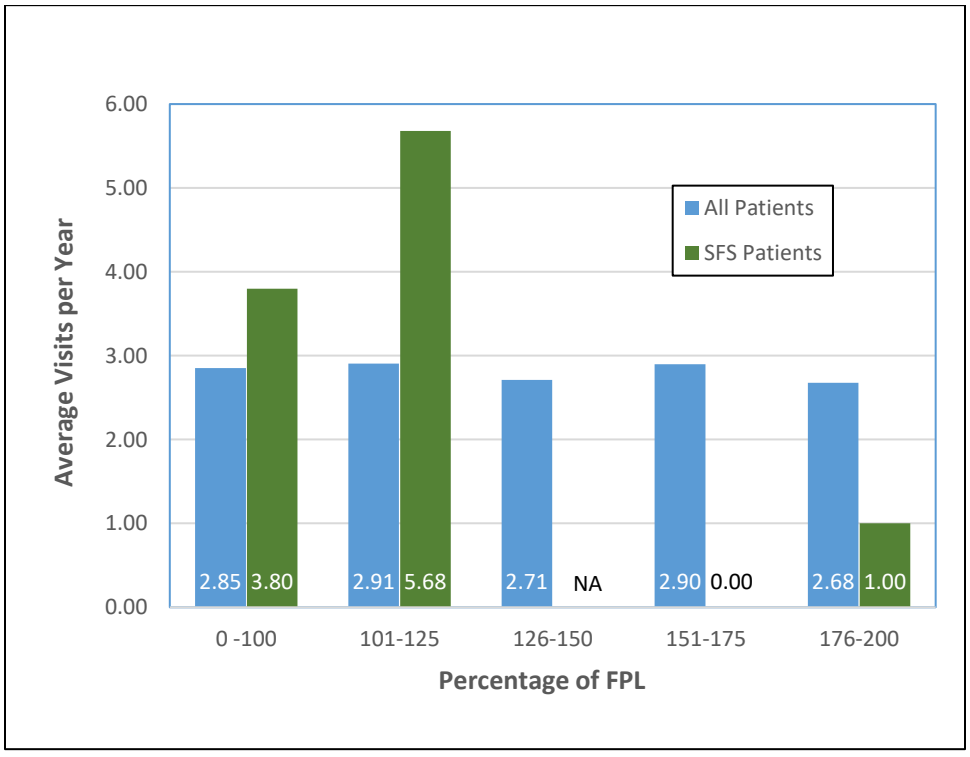
Impact of SCHC SFS

To examine the actual, rather than projected, impact of the SCHC SFS on its patients, we examined utilization patterns as well as patient self-report information. First, as discussed earlier in the report, we examined whether patients reported forgoing care (see Table 3). In late 2020, the patient satisfaction survey found 11.1% of SCHC's patients compared to 21.7% of peer health center's patients reported having forgone care due to expense.

Second, we examined utilization patterns for SFS patients between 2018 and 2020. As discussed earlier, utilization of SFS is not frequent at SCHC; with fewer than two dozen participants during this period. Due to this fact, there were insufficient patients in some SFS tiers to statistically compare utilization by tier. For example, no patients living between 126% and 150% of FPL were enrolled in the SFS program during this time period. Given that complication, we compared average visits per year for a specific SFS tier to the average for all patients in that FPL band (see Figure 1). For SFS patients who ended participation in SFS earlier, usually due to becoming eligible for health coverage with no co-pays, their utilization was annualized based on the number of days enrolled and number of visits during that period.

Again, while statistical comparisons are not possible due to low (or zero) SFS patients in particular bands, the graph below does not suggest that the SFS discount schedule is a barrier to care. On average, SFS patients during this time had 3.7 average annual visits compared to 2.9 visits for all patients. This suggests that the SFS improves access to care.

Figure 1: Average Annual Visits by Patients per FPL Tier: All Patients vs. SFS Patients



The overall low utilization of the SFS program is due to at least two causes. First, as discussed earlier, SCHC has the Healthy Partners Program for undocumented individuals who receive their care for free through earmarked county funding. Many of these individuals would otherwise be eligible for SFS. Healthy Partners patients make up more than 25% of SCHC patients. Second, the rapid implementation of

telehealth during the pandemic disrupted normal procedures. These changes likely meant that some patients eligible for SFS may not have been identified in 2020.

Conclusions

- This analysis suggests that SCHC's SFS structure, particularly a single SFS with discount fees and a nominal charge is appropriate.
- This analysis also suggests that SCHC SFS fees are appropriate and do not act as a barrier to care.
- Overall SFS utilization at SCHC is low, partly due to SCHC's unique mixture of patients and available coverage and possibly partly due to deviations from eligibility checking procedures detailed in *Policy and Procedure 03-05 Sliding Fee Scale*, especially during the pandemic.

Recommendations

- Keep a single SFS.
- Keep flat fees, not percentages.
- Do more to educate patients on SFS availability and fees, especially for patients using telehealth.
- Re-train staff on the correct procedures to identify patients eligible for sliding fee scale and ensure that new telehealth protocols incorporate these procedures so no possibly eligible SFS patients are missed.

Co-Applicant Board Action

- The Co-Applicant Board (CAB) voted unanimously to accept the Sliding Fee Evaluation Report for the 2018-2020 period and directed SCHC leadership to submit it to HRSA.
- CAB also directed SCHC leadership to implement the report recommendations.

Sacramento County Health Center
Co-Applicant Board

BOARD BYLAWS

Revision Date: April 16, 2021

Table of Contents

Introduction

This body shall be known as the Sacramento County Health Center Co-Applicant Board, and shall be hereafter referred to as "CAB". The CAB is also known as "Board" under Health Resources and Services Administration (HRSA). The CAB shall serve as the independent local co-applicant governing board pursuant to the Public Health Services Act and its implementing regulations. The County of Sacramento, a public entity and political subdivision of the State of California, shall act as co-applicant with the CAB.

Article I: Purpose

The CAB is the community-based governing board mandated by the Health Resources Services Administration's ("HRSA") Bureau of Primary Health Care ("BPHC") to set health center policy and provide oversight of the County's Federally Qualified Health Center ("FQHC"), which shall be hereafter referred to as "Health Center".

The CAB shall work cooperatively with the County of Sacramento acting in its role as co-applicant, to support and guide the Health Center in its mission:

Vision: Unparalleled experience as a trusted partner in health care for our Sacramento County community.

Mission: Provide high-quality, caring, and comprehensive healthcare services for our diverse Sacramento County community through partnering with patients, academic institutions, and community-based organizations.

Values: Respect, Compassion, Learning, Excellence, Efficiency, Accountability

Article II: Responsibilities

The CAB has specific responsibilities to meet the governance expectations of HRSA, while day-to-day operational and management authority reside with Sacramento County, Department of Health Services (DHS), Primary Health Services Division staff.

The CAB's responsibilities include providing advice, leadership, and governance in support of the Health Center's mission. .

The CAB shall have the following responsibilities:

A. Hold final authority on all areas assigned to the Health Center's HRSA scope of project, including services and supports provided through HRSA grant funds, program income, and all appropriated funds;

B. Hold monthly meetings and maintain a record of all official actions;

C. Approve the annual Health Center budget;

D. Identification, consultation and selection of services beyond those required in law to be provided, as well as the location, mode of delivery of those services and the hours of operation;

E. Adopt policies necessary and proper for the efficient and effective operation of the Health Center;

F. Periodic evaluation of the effectiveness of the Health Center in making services accessible to County residents, particularly those experiencing homelessness;

G. Develop and implement a procedure for hearing and resolving patient grievances; Approve quality of care protocols and audits;

H. Delegate credentialing and privileging of providers to the Medical Director of the Health Center, as referenced in the PP CS 07-05 Credentialing and Privileging;

I. Ensure compliance with federal, state, and local laws and regulations;

J. Adopt Bylaws;

K. Approve the selection, performance evaluation, retention, and dismissal of the Health Center's Project Director;

L. Approve Health Center Sliding Fee Discount policy;

M. Long-term strategic planning, which would include regular updating of the Health Center's mission, goals, and plans, as appropriate;

N. Approve HRSA applications related to the Health Center, including grants/designation application and other HRSA requests regarding scope of project;

O. Ensure new board members are oriented and trained regarding the duties and responsibilities of being a board member of an organization subject to FQHC requirements and satisfying the educational and training needs of existing members; and

P. Officially, accept the annual audit report and management letter performed by an independent auditor in accordance with federal audit requirements.

NOTE: No individual member shall act or speak for the CAB except as may be specifically authorized by the CAB. Members (other than the Health Center Chief Executive Officer/Project Director) shall refrain from giving personal advice or directives to any staff of the Health Center.

Article III: Limitations of Authority

The Board of Supervisors shall maintain the authority to set general policy on fiscal and personnel matters pertaining to the Health Center, including financial management practices, charges and rate setting, and labor relations and conditions of employment. The CAB may not adopt any policy or practice, or take any action, which is inconsistent with the County Code, or which alters the scope of any policy of the Board of Supervisors regarding fiscal or personnel issues. All policies and practices must adhere to California law, Brown Act requirements, and are subject to the Public Records Act.

The COUNTY through its DHS in consultation with the CAB, shall be solely responsible for the management of the financial affairs of the Health Center, including capital and operating borrowing; for the development and implementation of financial policies and controls related to the Health Center; and receive, manage, allocate, and disburse, as applicable, revenues necessary for the operation of the Health Center.

Article IV: Members

Section 1: Membership

There shall be between nine (9) and thirteen (13) at large voting members of the CAB and one (1) ex-officio non-voting member.

A. Membership categories:

1. Board Members - Consumers:

    a. A majority of members of the board shall be individuals who are served by the Health Center. This means an individual who is a currently registered patient who has accessed Health Center services in the past 24 months and received at least one service.

    b. As a group, patient members of the board reasonably represent individuals who are served by the Health Center in terms of demographic factors such as race, ethnicity gender, socioeconomic status, and age.

    c. At least one representative on the board will be from each targeted population serviced by the Health Center including homelessness, as specifically defined under the section 330 grant.

    d. A legal guardian of a patient who is a dependent child or adult, or a legal sponsor of an immigrant, may also be considered a patient for purposes of board representation.

2. Board Members - Community Members:

    a. Members of the board have a broad range of skills, expertise and perspectives representing the community served by the Health Center.

    b. Members shall be individuals from differing segments of the County with expertise in community affairs, finance, legal affairs, business or other commercial concerns.

    c. Members may be an advocate who has personally experienced being a member of or represent, or have expertise in or work closely with the special population such as individuals experiencing homelessness.

3. The HRSA Project Director, or designee, shall serve as an ex-officio non-voting member of the CAB.

Section 2: Membership Qualifications

A. No more than half of the Community members may receive more than ten percent (10%) of his or her annual income from the health care industry (health care industry is understood to mean any community clinic or hospital providing health services to low income residents of Sacramento).

B. All members must work, reside in, or be associated with, Sacramento County. No member of the CAB shall be an employee or an immediate family member (i.e., spouse, child, parent, or sibling, [related by blood, adoption, or marriage]) to such an employee of the Department of Health Services of the County of Sacramento, or CAB officer. No member shall have a financial interest, which would constitute a conflict of interest.

Section 3: Member Recruitment, Selection, and Ratification

A. Establishment of CAB

The initial voting members of the CAB were nominated and appointed by the Board of Supervisors.

B. Continuation of CAB

1. Member Recruitment

The CAB (or a sub-committee appointed for this purpose) develops a recruitment plan each year, to identify and recruit potential members that help fill existing and forecasted gaps in CAB membership including regarding

a. Member classifications,

b. Populations represented on the CAB,

c. Member skills, experience and perspectives; and

d. Segments of the community about which members have expertise.

The recruitment plan includes strategies designed to effectively reach targeted groups or classes of individuals.

Expiring Terms

a. Terms end in January. Recruitment for soon to be expiring terms will begin in September so that candidate members can be considered and a new CAB member approved prior to the end of the term.

Vacancies during Terms

a. The recruitment plan may designate a period during which membership applications will be accepted and reviewed

2. Application Review

The application for CAB membership and instructions for completing and submitting it—as well as information about the Health Center, the CAB, and its role, as well as open seats and deadlines for application—are made widely available to possible members, including on the Health Center website.

a. Nominations for voting membership on the CAB may be submitted by anyone so long as the nominee meets the membership requirements of these Bylaws.

b. Nominated individuals must submit an application to provide required information and to verify their interest and ability to serve as CAB members.

c. Applications are submitted to Health Center staff designated by the HRSA Project Director. Staff verify that applicants meet CAB membership requirements. The names of all applicants who meet the membership requirements are presented to the Governance Committee.

d. The Governance Committee of the CAB reviews the membership

applications and talk with possible candidates.

3. Approval of CAB members

   The CAB (or a designated Committee or staff member) interviews prospective members that meet membership requirements and review their skills, experience, perspectives, and other possible contributions to the CAB. The CAB votes on prospective members.

4. Ratification of CAB members

   a. As outlined in the Co-Applicant Agreement between the CAB and the Sacramento County Board of Supervisors, Once approved by the CAB, Health Center staff provides the names of approved CAB members to the Clerk of the Board or designee.

   b. The Clerk of the Board, or designee, reviews materials and submits for ratification by the Board of Supervisors.

   c. The Clerk of the Board notifies the designated Health Center staff of BOS actions related to CAB members and sends a ratification letter to each new ratified CAB member.

B. Verification of Eligibility of Existing CAB members

   1. By December 31st of each calendar year, Health Center staff will verify existing CAB member eligibility. Each CAB member will complete the Co-Applicant Board Member Secondary Attestation Form attesting to their eligibility (in October).

Section 4: Responsibilities and Rights of Members

A. All members must:

   1. Attend all CAB meetings, unless excused by the Chair.

   2. Be subject to the conflict of interest rules applicable to the Board of Supervisors of the County of Sacramento and the laws of the State of California.

B. Members shall be entitled to receive agendas, minutes, and all other materials related to the CAB, may vote at meetings of the CAB, and may hold office and may chair CAB committees.

Article V: Term of Office

The term of office for CAB members shall be for four (4) years. A member shall be limited to no more than four (4) consecutive terms of membership. The effective date of membership corresponds to the date of appointment.

Any elected member who has served four (4) consecutive, four (4) year terms shall not be eligible for re-election until one (1) year after the end of his or her fourth term. Election to fill a vacancy for less than three (3) years shall not be counted as service of a four (4) year term for this purpose. Unless terminated earlier in accordance with the Bylaws, members shall serve their designated term until their successors are elected and qualified.

Article VI: Removal

Any member may be removed whenever the best interests of the Health Center or the CAB will be served. The member whose removal is placed in issue shall be given prior notice of his/her proposed removal, and a reasonable opportunity to appear and be heard at a meeting of the CAB. A member may be removed pursuant to this section by a vote of two-thirds (2/3) of the total number of members then serving on the CAB.

Continuous and frequent absences from the CAB meetings, without reasonable excuse, shall be among the causes for removal. In the event that any member is, absent without acceptable excuse from three (3) consecutive CAB meetings or from four (4) meetings within a period of six (6) months, the CAB shall automatically consider the removal of such person from the CAB in accordance with the procedures outlined in this Article.

The CAB will accept a written or emailed resignation of a CAB member, or a verbal resignation if given during a full CAB meeting. The CAB Chair or designee will send an email or letter to the CAB member confirming the resignation. Following seven (7) days of receipt of the letter by the CAB, the resignation is accepted.

Article VII: Conflict of Interest

A conflict of interest is a transaction with the Health Center in which a CAB member has a direct or indirect economic or financial interest. Conflict of interest or the appearance of conflict of interest by CAB members, employees, consultants and those who furnish goods or services to the Health Center must be declared. CAB members are required to declare any potential conflicts of interest by completing a *Conflict of Interest: Disclosure and Attestation Statement* per County of Sacramento policy for members appointed to advisory boards (see Appendix A) as well as annually complete the *Co-Applicant Board Conflict of Interest: Disclosure and Attestation Statement* (see Appendix B), in which they attest that they are not,

- An employee of the Sacramento County Health Center; nor
- An immediate family member (i.e., spouses, children, parents, or siblings [through blood, adoption, or marriage]) of an employee or CAB officer.

In situations when a conflict of interest may exist for a member, the member shall declare and explain the conflict of interest. No member of the CAB shall engage in discussion about or vote on a topic where a personal conflict of interest exists for that member. In addition to the requirements imposed by these Bylaws, CAB members shall also be subject to all applicable state and federal conflict of interest laws.

Article VIII: Compensation

Members of the CAB shall serve without compensation from the Health Center. Travel and meal expenses when traveling out of Sacramento County for CAB business shall be approved in advance by the CAB.

Article IX: Meetings

Section 1: Regular Meetings

The CAB shall meet monthly and maintain records/minutes that verify and document the Board is functioning. Where geography or other circumstances make monthly, in-person participation in board meetings burdensome, monthly meetings may be conducted by telephone or other means of electronic communication where all parties can both listen and speak to all other parties.

Section 2: Conduct of Meeting

The meeting shall be conducted in accordance with the most recent edition of The Sturgis Standard Code of Parliamentary Procedure unless otherwise specified by these Bylaws.

Section 3: Open and Public

All meetings will be conducted in accordance with the provisions of the Ralph M. Brown Act, open public meeting law, as amended.

Section 4: Notice, Agenda and Supportive Materials

A. Written notice of each regular meeting of the CAB, specifying the time, place and agenda items, shall be sent to each member not less than seventy-two (72) hours prior to the meeting except as permitted by the Ralph M. Brown Act. Preparation of the agenda shall be the responsibility of the Chair in conjunction with the Project Director, or his or her designee.

B. The agenda of each regular meeting shall be posted at the Health Center and on the Health Center's website: https://dhs.saccounty.net/PRI/Pages/Health%20Center/Co-Applicant%20Board/County-Health-Center-Co-Applicant-Board.aspx. .

C. Supportive materials for policy decisions to be voted upon shall be distributed to all members along with the agenda. If, on a rare occasion, such prior submission is precluded by time pressures, and if the urgency of a CAB vote is established by the Chair of the CAB, an item may be placed on the agenda although supporting materials are not available in time to be distributed. However, such material shall be available at the meeting.

D. Items, which qualify as an emergency, can be added to the agenda pursuant to the Ralph M. Brown Act.

Section 5: Special Meetings

A. To hold a special meeting, advance notice of such meeting shall be given.

B. The CAB shall hold an annual meeting during November, at such time and place as is established by the Board upon proper notice, for election of new members and officers, and for the transaction of such other businesses as may properly come before the CAB. The annual meeting shall serve as the regular meeting for that month. Notice of the annual meeting shall be given in writing by the Project Director or his or her designee to each member not less than thirty (30) nor more than sixty (60) days prior to the date of such meeting.

Section 6: Quorum and Voting Requirements

A. A quorum is necessary to conduct business, make recommendations, or approve items. A quorum shall be constituted by the presence of a majority of the appointed members of the CAB.

B. A majority vote of those CAB members present and voting is required to take any action.

C. Each member shall be entitled to one (1) vote. Voting must be in person or telephonically; no proxy votes will be accepted.

D. CAB member attendance at all meetings shall be recorded. Members are responsible for signing the attendance sheet or informing the Chair of their participation by telephone or teleconference software. The names of members attending shall be recorded in the official minutes. Where geography or other circumstances make monthly, in-person participation in board meetings burdensome, monthly meetings may be conducted by telephone or other means of electronic communication where all parties can both listen and speak to all other parties. Attendance will be recorded by the Project Director or his or her designee with a roll call and participation recorded in the official minutes.

E. The Project Director shall have direct administrative responsibility for the operation of the Health Center and shall attend, or assign a delegate in his/her absence to all meetings of the CAB, but shall not be entitled to vote.

Article X: Officers

Section 1: Eligibility

The Chair and Vice-Chair shall be chosen from among the voting members of the CAB. Members of the CAB shall not be eligible for an officer position until they have served for at least six (6) months with the CAB as an active member. An active member is defined as a member who has attended all meetings, with the exception of up to two (2) excused absences, in the past six months.

Section 2: Nomination and Election

Initial selection of officers upon creation of the CAB transpired at the same CAB Board meeting following the adoption of these Bylaws.

Henceforth, nominations for officers shall be made at the regular October meeting. A nominee may decline nomination.

Officers shall be elected annually by a majority vote of those members present and voting, as the first order of business at the November meeting of the CAB.

Section 3: Appointment of Chair and Vice-Chair

Only members who have been an active member of the CAB for at least six (6) months are eligible to be appointed and serve as officers.

Officers shall be elected for a term of one (1) year, or any portion of an unexpired term thereof. A person shall be limited to no more than four (4) consecutive terms of office. Any elected officer who has served four (4) consecutive, one (1) year terms of office shall not be eligible for re-election until one (1) year after the end of his or her second term of office.

This limitation of consecutive terms may be waived by a majority vote of the CAB (with the officer in question recusing him or herself from the vote) if no other CAB member is willing to serve in that office. A term of office for an officer shall start January 1, and shall terminate December 31, of the same year; however, an officer may serve after his or her term ends until a successor is elected.

Section 4: Vacancies

Vacancies created during the term of an officer shall be filled for the remaining portion of the term by special election by the CAB, at a regular or special meeting in accordance with this Article.

Section 5: Responsibilities

The officers shall have such powers and shall perform such duties as from time to time shall be specified in these Bylaws or other directives of the CAB.

A. Chair

The Chair shall preside over meetings of the CAB, shall serve as Chair of the Executive Committee, and shall perform the other specific duties prescribed by these Bylaws or that may from time to time be prescribed by the CAB.

B. Vice-Chair

The Vice-Chair shall perform the duties of the Chair in the latter's absence and shall provide additional duties that may from time to time be prescribed by the CAB.

Article XI: Amendments and Dissolution

A. Amendments

The Bylaws may be repealed or amended, or new Bylaws may be adopted at any meeting of the CAB at which a quorum is present, by two-thirds (2/3) of those present and voting. At least fourteen (14) days written notice must be given to each member of the intention as to alter, amend, repeal, or to adopt new Bylaws at such meetings, as well as the written alteration, amendment or substitution proposed. Any revisions and amendments must be approved by the CAB. County Board of Supervisors must approve any change that alters or conflicts with their action establishing CAB.

B. Dissolution

Dissolution of the CAB shall only be by affirmative vote of the CAB and County Board of Supervisors at duly scheduled meetings.

Certification

These Bylaws were approved at a meeting of the board by a two-thirds (2/3) majority vote on December 15, 2017.

These Bylaws were amended at a meeting of the board by a two-third (2/3) majority vote on April 16, 2021.

Signed copies available upon request,

Jan Winbigler, CAB Chair April 16, 2021

Appendix A

Sacramento County Health Center Co-Applicant Board Conflict of Interest: *Disclosure and Attestation Statement*

Conflict of Interest: Defined as an actual or perceived interest by the member in an action, which results or has the appearance of resulting in personal, organizational, or professional gain.

Duty of Loyalty: CAB members shall be faithful to the organization and can never use information obtained in his/her position as a CAB member for personal gain.

Responsibilities of CAB Members:

A. A CAB member must declare and explain any potential conflicts of interest related to:

   1. Using her/his CAB appointment in any way to obtain financial gain for the member's household or family, or for any business with which the CAB member or a CAB member's household or family is associated; and/or

   2. Taking any action on behalf of the CAB, the effect of which would be to the member's household or family's, private financial gain or loss.

B. No member of the CAB shall vote in a situation where a personal conflict of interest exists for that member.

C. No voting member of the CAB shall be an employee or an immediate family member of an employee of the Health Center; however, a member may otherwise be an employee of the County or Department of Health Services.

D. No CAB member shall be an employee or an immediate family member of an employee of a Federally Qualified Health Center.

E. Any member may challenge any other member(s) as having a conflict of interest by the procedures outlined in the CAB's Bylaws, Article IX.

As a CAB member, my signature below acknowledges that I have received, read, had an opportunity to ask clarifying questions regarding these conflict of interest requirements and the CAB Conflict of Interest Policy and that I understand the contents of this policy as it relates to my membership and responsibilities as a CAB member in capacity of officer, expert volunteer, advocate, consumer, or County staff member. I understand that any violation of these requirements may be grounds for removal from CAB membership. I further understand that I may be subject to all other applicable state and federal conflict of interest requirements in addition to the provisions set forth in these Bylaws.

I declare that the above statement is true and accurate to the best of my knowledge and hereby attest to the fact that I am not,

____ *INITIALS* A Sacramento County Health Center employee; nor

____ *INITIALS* An immediate family member (defined as a spouse, child, parent, or sibling [by blood, adoption, or marriage] of

- ____ *INITIALS* A Sacramento County Health Center employee; nor
- _____ *INITIALS* A Sacramento County Health Center Co-Applicant Board Officer.

_____ *PRINTED NAME* _____ *SEAT NUMBER*

_____ *SIGNATURE* _____ *DATE*