

## HRSA Project Director / Medical Director Report to CAB April 15, 2022

### 1. **Strategic Plan**

#### (a) Space

- i. Suite 2600 will become available to Primary Health in June/July
- ii. Capitol American Rescue Plan ARP grant from HRSA to create new exam rooms and office space:
  - a. SCHC personnel are still submitting required documents needed before SCHC can receive HRSA approval to proceed.
  - b. Cost of remodel with Capitol ARP grant was not as high as expected so SCHC leadership is brainstorming other ways to utilize the money (equipment, pre-fab trailer in the parking lot to be utilized for office/exam room space?)

#### (b) Staffing

- i. *Phase 2 County American Rescue Plan Act (ARPA):* We have been asked to submit requests and budget; Priority is to extend funding for the positions that are currently being funded by HRSA and County ARPA Phase 1. Second priority is for additional personnel, equipment (ultrasound machine, laptops, Zoom licenses etc.), and services (interpreter services)
- ii. *Staff vacancies:* 15 permanent and 12+ temp positions still vacant; Instructed Supervisors to prioritize recruitment and hiring
  - a. *Clerical Supervisor:* Position is now vacant and ready for recruitment,
  - b. *Division Manager:* Recruitment is still underway.
  - c. *Senior Office Assistants:* Two offers have been made; both have been accepted

#### (c) Focus on serving homeless individuals

- i. *Mobile Medical Van:*
  - a. Awaiting DMV registration
  - b. County Loaves & Fishes (L&F) clinic team has developed an initial P&P and is working on details regarding van hours, days of week, location of services, van driver, meds and supplies.
- ii. *Van Driver:* Meeting with County Risk Management on 4/12 to discuss who is allowed to drive the van.
- iii. *Training:*
  - a. Working with Department of Health Services (DHS) Leadership to provide de-escalation training for the County L&F team to prevent situations from scaling up.
  - b. Also working with DHS Leadership to provide Vicarious Trauma and Self Care training/tips for County L&F team (and all DHS employees).

### 2. **Program highlights/Focus points:**

#### (a) *Meet and Greet with the Director:*

- i. UCD Program Leads for Adult Medicine, Psychiatry, Family Medicine, Pediatrics, Chronic Disease Management and Homeless services had the chance to meet with Chevon Kothari in person and share their experience, challenges and vision working at SCHC;
  - ii. Jan Winbigler had a virtual meeting with Chevon
- (b) *Complex Care Management Team Program to prevent frequent ER and Hospital use:*
  - i. Enrollment into the program has been slow but of the 38 who enrolled, there was a reduction of 50% of ER visits and 40% reduction in hospital visits at 3 months after enrollment; after 6 months, there was an average of 80% reduction in ER/Hospital visits!
  - ii. Due to the success, the pilot project abstract was accepted for presentation at the national Society of General Internal Medicine conference in a few weeks.
- (c) *Call Center and Referral Program Assessments:* Dr. Mishra has received the consultant's Project Analysis and solutions to improving efficiencies and work product in these programs and is reviewing recommendations.
- (d) *Pediatrics:*
  - i. Medical Records Request for children: Foster Care Clinic is growing and a new situation has arisen requiring us to understand regulations regarding what medical records may be provided to parents, specifically biological parents of children in foster care. We will be meeting with County Attorneys to discuss.
  - ii. Co-location of child development and autism assessment and therapy: Meetings are continuing between MIND, County Health Center, County Behavior Health and Regional Centers to see what is preventing children from receiving early assessment and intervention for developmental problems including autism.
- (e) *Family Medicine:* Consultant has developed a Project Plan for the Comprehensive Perinatal Services Program (CPSP).
- (f) *Health Information Exchange (HIE):* Ahead of the County DHS Strategic Health Information Exchange (SHIE) initiative, Dr. Mishra is working with the Department of Technology (D-Tech) to increase the visibility between the electronic medical records (EMRs) used by other County Divisions.

## 2021 SCHC Quality Improvement Plan Racial and Ethnic Disparities Analysis

### Introduction: QI Plan Goal and Objective

The Co-Applicant Board and the Quality Improvement Committee of the Sacramento County Health Center (SCHC) are committed to improving and reaching equity in health access and outcomes. This commitment was reflected in the SCHC 2021 Quality Improvement Plan, as shown in the Clinical Performance Measures section below.

### Clinical Performance Measures

- Goal 1: Improve performance on select UDS and HEDIS quality measures (focused on those 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 3: Reduce racial and ethnic health disparities in control of diabetes and hypertension in 2021 compared to baseline for 2019.

Hypertension and diabetes were the conditions chosen because they are among the most common suffered by our patients and have a serious effect on length of and quality of life. It is very difficult to detect systematic differences in small groups. For this reason, the most common conditions were chosen to see if disparities could be detected.

Racial and ethnic disparities were selected as the focus both because research has shown many large and important racial and ethnic disparities in access to health services and health outcomes and because SCHC has relatively good data available as to the race and ethnicity of its patients. As a federally qualified health center (FQHC), SCHC must report race and ethnicity information about its patients to its funder, the federal Health Resources and Services Agency (HRSA). In addition, SCHC must use the definitions and categories of race and ethnicity produced by the federal Office of Management and Budget (OMB). OMB defines race as a socially constructed category based primarily on skin color and ethnicity as a socially constructed category based primarily on culture and language. With these definitions, race and ethnicity are separate and independent. In the US, the dominant ethnic categories are Hispanic/LatinX and Non-Hispanic/LatinX. A Hispanic/LatinX person (descended from settlers from the Iberian Peninsula) may be of any race. For example, many Hispanics/LatinX from the Caribbean are African or a member of a Native tribe while Hispanics/LatinX from the Philippines are typically Pacific Islanders. Since these are socially created categories, ideas about them change. The newer concept of “people of color” redefines LatinX individuals as a separate “brown” race. SCHC has many patients who self-report as Hispanic/LatinX and no racial category. However, SCHC is mandated to use the federal categories and ask patients to self-report their racial and ethnic identities using them.

## Findings

### Hypertension

#### *Ethnic Disparities*

As shown in the table below, the percentage of hypertensive patients with uncontrolled blood pressure differed in 2021 by patient ethnicity, with the smallest proportion of Hispanic/LatinX patients being uncontrolled.

**Table 1: Ethnic Disparities in Hypertension Control, 2021**

<b>Ethnic Group</b>	<b>Patients 18-84 w/ Hypertension</b>	<b>% Uncontrolled<sup>1</sup></b>
Hispanic/LatinX	1,116	45.6%
Non-Hispanic/LatinX	1,089	52.1%
Unreported/Refused	79	70.0%

*From CY 2021 UDS Report for SCHC*

<sup>1</sup>Percentage of patients aged 18-84 years with hypertension whose blood pressure was  $\geq 140/90$  mmHg at the last reading of the year.

To determine whether the ethnic disparities detected were reflective of long-term trends, data were examined for a three-year period. Table 2 shows the percentage of uncontrolled hypertensive patients by ethnicity between 2019 and 2021. The table shows a large increase in the proportion of hypertensive patients whose blood pressure was not under control between 2019 and 2020 and little change between 2020 and 2021. The most likely explanation is related to the public health pandemic, which increased stress in many people at the same it reduced the likelihood of patients seeking care, particularly in person. The higher likelihood of Non-Hispanic/LatinX hypertensive patients being uncontrolled was seen for all three years. The relative risk for the group whose ethnicity is not known was more variable. This is likely due to the much smaller numbers in this group.

**Table 2: Trends in Ethnic Disparities in Hypertension Control**

<b>Ethnic Group</b>	<b>% Hypertensive Patients Uncontrolled</b>		
	<b>2019</b>	<b>2020</b>	<b>2021</b>
Hispanic/LatinX	35.3%	48.0%	45.6%
Non-Hispanic/LatinX	37.8%	52.4%	52.1%
Unreported/Refused	36.4%	67.7%	70.0%

To help illustrate the relative proportions of uncontrolled patients, Table 3 shows the rank, with '1' indicating the group with the lowest proportion of uncontrolled patients and '3' the group with the highest proportion. The Non-Hispanic/LatinX group has a higher rank (thus more uncontrolled hypertensives) each year than the Hispanic/LatinX group.

**Table 3: Rank by Proportion of Uncontrolled Hypertension**

Ethnic Group	Rank <i>(Lowest proportion uncontrolled = 1)</i>		
	2019	2020	2021
Hispanic/LatinX	1	1	1
Non-Hispanic/LatinX	3	2	2
Unreported/Refused	2	3	3

The reasons for this ethnic disparity need to be explored so that strategies for helping Non-Hispanic/LatinX (and other) patients control their diabetes can be identified.

*Racial Disparities*

The percentage of hypertensive patients with uncontrolled blood pressure differed in 2021 by patient self-reported race. As shown in Table 4, in 2021, Native Hawaiian and Other Pacific Islanders had the smallest proportion of patients being uncontrolled, and patients with unidentified race the largest.

**Table 4: Racial Disparities in Hypertension Control, 2021**

Race	Patients 18-84 w/ Hypertension	% Uncontrolled <sup>1</sup>
American Indian/Alaska Native	13	<i>N &lt; 30</i>
Asian/Asian American	284	45.1%
Black/African American	365	56.7%
Multi-racial	8	<i>N &lt; 30</i>
Native Hawaiian or Other Pacific Islander	43	37.2%
White	1,389	47.7%
Unreported/Refused to state	182	58.4%

*From CY 2021 UDS Report for SCHC*

<sup>1</sup>*Percentage of patients 18-84 with hypertension with BP ≥140/90 mmHg at last reading*

*Note: Percentage is not reported for racial groups with fewer than 30 members with hypertension.*

To determine whether the disparities detected were reflective of trends through time, data were examined for a three-year period. Table 5 (on the next page) shows the percentages of uncontrolled hypertensive patients by self-reported race, with the groups with fewer than 30 hypertensive patients removed. The table shows great variability in the percentage of uncontrolled patients per group across the three-year time span.

**Table 5: Trends in Racial Disparities in Hypertension Control**

Race	Percent of Uncontrolled <sup>1</sup> Patients		
	2019	2020	2021
Asian/Asian American	29.5%	54.3%	45.1%
Black/African American	41.4%	55.7%	56.7%
Native Hawaiian or Other Pacific Islander	45.2%	45.0%	37.2%
White	39.2%	47.1%	47.7%
Unreported/Refused to state	34.0%	55.5%	58.4%

To highlight the relative proportions of uncontrolled patients per group per year, Table 6 below ranks the groups by percentage of uncontrolled hypertensive patients, from ‘1’ (smallest proportion of uncontrolled patients) to ‘5.’ Again, the large variability in relative rank per year is shown. For example, in 2019, the Native Hawaiian or Other Pacific Islander group had the highest percentage of uncontrolled hypertensive patients, but this group had the lowest percentage in 2020 and 2021. However, it is clear that Black/African American patients are more likely to have uncontrolled hypertension than White or Asian/Asian American patients.

**Table 6: Rank by Proportion of Uncontrolled Hypertension**

Race	Rank (Lowest proportion uncontrolled = 1)		
	2019	2020	2021
Asian/Asian American	1	3	2
Black/African American	4	5	4
Native Hawaiian or Other Pacific Islander	5	1	1
White	3	2	3
Unreported/Refused to state	2	4	5

Diabetes

*Ethnic Disparities*

As shown in Table 7 below, the percentage of diabetic patients with uncontrolled blood sugar differed in 2021 by patient ethnicity, with patients whose race was unreported having the smallest proportion of uncontrolled blood sugar. There was essentially no difference in the percentage of Hispanic/LatinX and Non-Hispanic/LatinX patients with uncontrolled diabetes in 2021.

**Table 7: Ethnic Disparities in Diabetes Control, 2021**

<b>Ethnic Group</b>	<b>Patients 18-75 w/ Diabetes</b>	<b>% Uncontrolled<sup>1</sup></b>
Hispanic/LatinX	954	60.9%
Non-Hispanic/LatinX	607	60.8%
Unreported/Refused	34	41.2%

*From CY 2021 UDS Report for SCHC*

<sup>1</sup>Percentage of patients aged 18-75 years with diabetes whose last HbA1c value was >9%.

To determine whether this ethnic disparity detected in 2021 was reflective of longer-term trends, data were examined for a three-year period. Table 8 shows the percentage of uncontrolled diabetic patients by self-reported race between 2019 and 2021. The table shows a large increase in the proportion of patients with uncontrolled diabetes between 2019 and 2020 for Hispanic/LatinX patients and Non-Hispanic/LatinX patients, and then between 2020 and 2021 for both of these groups. During this period, the proportion of uncontrolled Hispanic/LatinX patients started out higher than that of Non-Hispanic/LatinX patients, but the Non-Hispanic/LatinX group’s proportion of uncontrolled diabetes rose more sharply to nearly equal the Hispanic/LatinX group in 2021. No clear trend is seen for the patients with unreported race, which may be due to smaller numbers in this group. As discussed in the *Hypertension* section of the report, the most likely explanation for the increase in uncontrolled diabetes is increased stress with unhealthy coping mechanisms and deferred care during COVID pandemic.

**Table 8: Trends in Racial Disparities in Hypertension Control**

<b>Ethnic Group</b>	<b>% Diabetic Patients Uncontrolled</b>		
	<b>2019</b>	<b>2020</b>	<b>2021</b>
Hispanic/LatinX	38.0%	43.6%	60.9%
Non-Hispanic/LatinX	34.3%	40.1%	60.8%
Unreported/Refused	34.7%	49.2%	41.2%

To help illustrate the relative proportions of uncontrolled patients, Table 9 shows the rank, with ‘1’ indicating the group with the lowest proportion of uncontrolled patients and ‘3’ the group with the highest proportion. The Non-Hispanic/LatinX group has a higher rank (thus a higher percentage of hypertensive patients with uncontrolled blood pressure) in 2019 and 2020 than the Hispanic/LatinX group, but they are essentially equal in 2021.

**Table 9: Rank by Proportion of Uncontrolled Diabetes**

Ethnic Group	Rank <i>(Lowest proportion uncontrolled = 1)</i>		
	2019	2020	2021
Hispanic/LatinX	3	2	2.5
Non-Hispanic/LatinX	1	1	2.5
Unreported/Refused	2	3	1

While SCHC is committed to improving and reaching health equity, the intention is not for groups with better health outcomes to deteriorate to reduce a disparity. Improvement for all groups is the goal, along with the reduction in disparities.

*Racial Disparities*

Unsurprisingly, the percentage of diabetic patients with uncontrolled blood sugar differed in 2021 by patient self-reported race. As shown in Table 10, in 2021, patients with unidentified race had the smallest proportion of patients being uncontrolled, and patients who self-identified as Asian/Asian American the largest.

**Table 10: Racial Disparities in Hypertension Control, 2021**

Race	Patients 18-84 w/ Hypertension	% Uncontrolled <sup>1</sup>
American Indian/Alaska Native	11	<i>N &lt; 30</i>
Asian/Asian American	210	65.7%
Black/African American	167	59.3%
Multi-racial	6	<i>N &lt; 30</i>
Native Hawaiian or Other Pacific Islander	36	58.3%
White	1,047	60.4%
Unreported/Refused to state	118	53.4%

*From CY 2021 UDS Report for SCHC*

<sup>1</sup>Percentage of patients aged 18-75 years with diabetes whose last HbA1c value was >9%.

*Note: Percentage is not reported for racial groups with fewer than 30 members with diabetes.*

To determine whether the disparities detected were reflective of trends through time, data were again examined for a three-year period. Table 11 shows the percentages of uncontrolled diabetic patients by self-reported race, with the groups with fewer than 30 diabetic patients removed. The table shows increases year-over-year in uncontrolled diabetes for each group.

**Table 11: Trends in Racial Disparities in Diabetes Control**

Race	Percent of Uncontrolled Patients		
	2019	2020	2021
Asian/Asian American	27.8%	33.0%	65.7%
Black/African American	42.0%	43.7%	59.3%
Native Hawaiian or Other Pacific Islander	36.4%	42.9%	58.3%
White	36.3%	43.0%	60.4%
Unreported/Refused to state	37.5%	46.8%	53.4%

Figure 1 below also illustrates the increasing trend in uncontrolled diabetes over time. The figure also shows that African Americans had relatively higher likelihood of uncontrolled diabetes than other groups in 2019. However, this disparity was essentially erased, as all groups' uncontrolled proportion increased in 2020 and 2021.

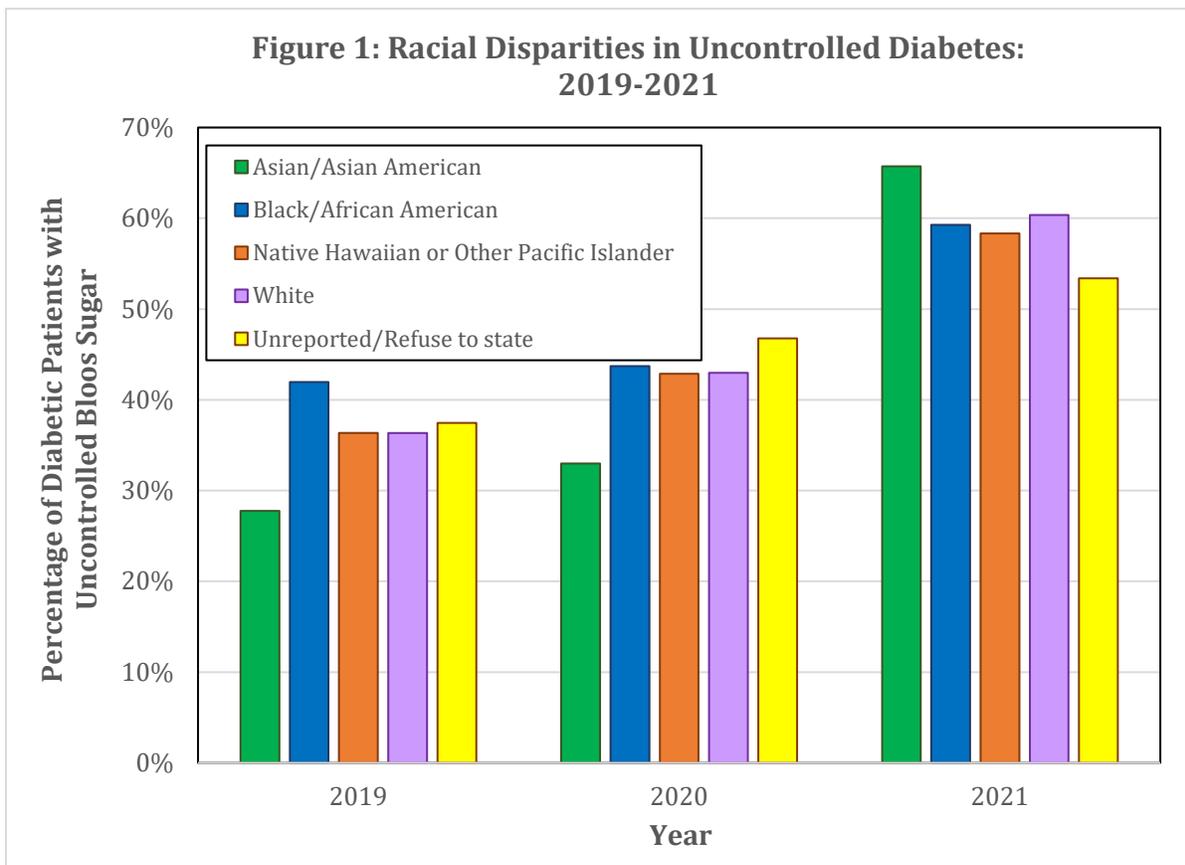


Table 12 ranks the groups by percentage of uncontrolled diabetic patients, from ‘1’ (smallest proportion of uncontrolled patients) to ‘5.’ This table shows a small change in relative rank in proportion of uncontrolled diabetic patients by race from 2019 to 2020, and much larger changes from 2020 to 2021.

**Table 12: Rank by Proportion of Diabetic Patients with Uncontrolled Diabetes**

Race	Rank <i>(Lowest proportion uncontrolled = 1)</i>		
	2019	2020	2021
Asian/Asian American	1	1	5
Black/African American	5	4	3
Native Hawaiian or Other Pacific Islander	2.5	2.5	2
White	2.5	2.5	4
Unreported/Refused to state	4	5	1

**Discussion and Next Steps**

The findings presented about racial and ethnic disparities in the two conditions of greatest burden on the SCHC patient population are not easy to interpret or act on. It is important to understand the limitations in the data when thinking about the implications and possible actions.

First, while SCHC has data on self-reported race and ethnicity, not all patients disclose this information. For each analysis, more than 100 patients did not report their race, with a smaller number not reporting their ethnicity. Lack of reporting makes identifying existing disparities more difficult.

Second, it is not clear that everyone is interpreting the categories in the same manner. For example, some new arrivals from Afghanistan report that they are “Asian” (assumedly because Afghanistan is in Asia) while others report that they are “White” (likely based on skin color or tradition). Likewise, an increasing number of Hispanic/LatinX individuals indicate that this is their race and refuse to select a HRSA race category or select “other.” SCHC also needs to determine whether staff interpret these categories in the same way, or what type of assistance, if any, they provide to patients with questions about these official categories of race and ethnicity.

Third, the sole ethnic distinction available for HRSA reporting (i.e. Hispanic/LatinX or Non-Hispanic/LatinX) is not relevant to many new arrivals to the US, which make up a substantial minority of SCHC patients. For example, groups such as Hazara, Pashtun,

Uzbek, and Tajik are familiar ethnic categories for individuals from Afghanistan; none are reportable to HRSA, and all these are grouped as “Non-Hispanic/LatinX.”

Fourth, direct experience of prejudice is a contributor to poor health. This common finding indicates that other people’s perceptions of one’s race or ethnicity may be more powerful than one’s self-identification in certain ways. SCHC collects only self-reported race and ethnicity.

Fifth, many racial and ethnic disparities are rooted in a long history of unequal treatment of racial and ethnic minorities. Institutionalized racism in the US has produced practices such as “red-lining” in which minority groups are confined to less desired places to live, where environmental and other health hazards (including violence) are more common. Factors that negatively affect health (such as minority status, poverty, exposure to health hazards, increased reliance on public transit, and decreased access to financial and education opportunities) tend to geographically cluster. However, not all members of minority groups experience all of these factors.

Sixth, research into ethnic disparities has shown that acculturation (often measured by a proxy variable of time living in the US) is often a confounding factor. This is frequently found for protective factors seen in recent immigrants (e.g. traditional diet) that tend to disappear over generations. SCHC has no way to measure acculturation or time in the US.

Seventh, as briefly mentioned earlier in the report, SCHC patients come from many racial groups, some very small and some much larger. The smaller a group, the harder it is to detect statistical differences. This “small N” problem is why SCHC only looks at very common conditions in these analyses. Only for these conditions are there enough patients from different groups to detect any existing differences. In addition, there may not be sufficient patients in any year’s worth of data to actually do so.

These are all reasons, among many others, why disparities in health outcomes and their underlying causes of disparities can be hard to identify. However doing so can help identify that strategies for helping patients control their hypertension and/or diabetes. For example, do Hispanics/LatinX patients experience protective factors that help them control their blood pressure, such as increased social capital, a healthier diet, and/or increased physical activity? Are providers more likely to prescribe medications to this group to control their blood pressure? Are Hispanics/LatinX more likely take to prescribed medications to control blood pressure? Do other groups face particular challenges that place them at higher risk of uncontrolled blood pressure (i.e. risk factors? When protective and risk factors are identified, the next step is to determine whether they can be altered to help patients become healthier.

This report suggests that SCHC leadership can take two sets of actions to further the pursuit of health equity at the Health Center. First, improved data collection and analysis



methods may help identify and clarify existing disparities. SCHC is represented on the UC Davis Health's Workgroup to Reduce Health Inequities, where such data-focused discussions can take place with experts. Second, SCHC can seek input from stakeholders, including members of the Co-Applicant Board, the Quality Improvement Committee, staff and providers, and patients themselves. Such interactions may help identify Health Center practices that (unintentionally) contribute to health disparities as well as factors for which interventions can be identified, including social determinants of health.

The first practical step will be discussion with the Co-Applicant Board on 3/18 and with the Quality Improvement Committee on 3/24.

## 2021 QI Plan Monitoring Report

**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 Improve coordination among SCHC providers for truly team-based care (pharmacy, behavioral health, chronic disease).**

No metrics agreed on.

**Category CLINICAL PERFORMANCE MEASURES**

**Goal 2 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*	2021 Value	Source
Hypertension	Controlling high blood pressure	55.35%	41.67%	Final HEDIS values from IPAs
Diabetes mellitus	HbA1c Poor Control (>9.0%)	< 43.19%	55.30%	
	Had HbA1c Test	82.97%	78.90%	

**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*	2021 Value	Source
Initiation of prenatal care	89.05%	82.5%	Final HEDIS values from IPAs
Postpartum care	76.4%	66.3%	
Well-Child Visits 0-15 (W15)	54.97%	40.4%	
Well-Child Visits 3-6 (W34)	45.31%	32.5%	
CIS (Two year olds up-to-date)	37.47%	20.8%	
IMA (adolescents prior to 13 yrs)	36.86%	39.9%	

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

*See separate report.*

*Target\*: Note, HEDIS targets changed during the 2021 year due to the difficulty in providing certain types of services during the pandemic. The targets in this document are different from those in the adopted SCHC 2021 Annual Quality Improvement Plan for this reason. However, the plan calls for meeting and exceeding the current HEDIS/UDS target.*

<b>Period</b>	<b>8</b>
<b>Current Month</b>	<b>February</b>
<b>Percentage of Year</b>	<b>67%</b>

CAB Financial Report

Line Item	Budget	Current Month	Year to date	Encumbrance	YTD		Notes
					Total (YTD+Encumbrance)	Percentage (Total/Budget)	
<b>Revenue</b>							
Inter/Intrafund Reimbursements	\$9,525,910	1,318,185	4,281,130	\$0	\$4,281,130	45%	
Intergovernmental Revenue	\$10,989,662	1,392,497	7,567,270	\$0	\$7,567,270	69%	Medi-Cal revenue, HRSA & Refugee grants
Charges for Services	\$52,000	9,635	54,137	\$0	\$54,137	104%	CMISP old pre-2014 service charges
Miscellaneous Revenue	\$17,368		16,268	\$0	\$16,268	94%	
<b>Total Revenue</b>	<b>\$20,584,940</b>	<b>\$2,720,318</b>	<b>\$11,918,805</b>	<b>\$0</b>	<b>\$11,918,805</b>	<b>58%</b>	
<b>Expenses</b>							
Personnel	\$11,351,014	811,616	6,465,470	\$0	\$6,465,470	57%	Permanent vacancies in recruitment
Services & Supplies	\$10,314,243	1,292,617	5,869,680	3,343,848	\$9,213,529	57%	
Other Charges	\$449,477	33,436	274,240	193,206	\$467,446	61%	
Equipment	\$247,077	14,181	155,946	112,053	\$268,000	63%	Encumbrance is for radiology upgrades
Intrafund Charges (Allocation costs)	\$2,373,021	207,512	1,156,606	\$0	\$1,156,606	49%	
<b>Total Expenses</b>	<b>\$24,734,832</b>	<b>\$2,359,362</b>	<b>\$13,921,942</b>	<b>\$3,649,107</b>	<b>\$17,571,049</b>	<b>56%</b>	

<b>GRAND TOTAL</b>							
<b>(Net County Cost)</b>	<b>-\$4,149,892</b>	<b>\$360,955</b>	<b>-\$2,003,137</b>				

**GRANT SUMMARY**

HRSA	Start	End	Total Grant	FY 21/22	FY 21/22 YTD Actual	Notes
HRSA (HCH)	3/1/2021	2/28/2022	\$ 1,386,602	\$ 924,401	\$ 775,298	Spending on track
HRSA (HCH)	3/1/2022	2/28/2023	\$ 1,386,602	\$ 462,201	\$ -	No claims yet for this grant period
HRSA ECT H8E	5/1/2021	4/30/2022	\$ 261,424	\$ 164,015	\$ 143,801	Grant will be fully expended after PPE purchase
HRSA H8F ARPA	4/1/2021	3/31/2022	\$ 1,285,475	\$ 1,285,475	\$ 339,638	Jul-Dec claims low due to slow hiring, can carryover funds to next year
HRSA H8F ARPA	4/1/2022	6/30/2023	\$ 1,248,400	\$ 312,100	\$ -	Grant period has not begun
HRSA C8E ARP CIP	9/15/2021	9/14/2022	\$ 619,603	TBD	\$ -	Construction timeline not yet determined
<b>Refugee</b>						
RHAP	10/1/2021	9/30/2022	\$ 1,958,204	\$ 1,468,653	\$ 403,934	Spending on track
RHPP	10/1/2021	9/30/2022	\$ 82,014	\$ 61,511	\$ 22,154	Spending on track
RHPP Multi-Year	10/1/2021	9/30/2022	\$ 153,000	\$ 94,492	\$ -	New award, no claims yet for this grant period
RHPP AHP	10/1/2021	9/30/2022	\$ 200,000	\$ 150,000	\$ -	New award, no claims yet for this grant period
<b>Miscellaneous</b>						
CalVax			\$ 11,000	\$ 11,000	\$ 11,000	Fully expended
Anthem QI			\$ 16,000	\$ 16,000	\$ -	Spending on track

## April 2022: Governance Committee Report to CAB

- |   |             |
|---|-------------|
| 1. Tobacco Cessation Resource Update    | Information |
| 2. BOS Ratification of Members          | Information |
| 3. Update on Technology for CAB Members | Information |
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### 1. Tobacco Cessation Resource Update

Tobacco quit kits will be made available for immediate distribution at SCHC. Staff worked with the Tobacco Education Program who will provide the standard kits and the Oral Health Program who will donate oral health supplies to include in the kits.

### 2. BOS Ratification of Members

On March 22, 2022, the Board of Supervisors ratified the two existing members whose term has expired and the proposed new members. After ratification, Ms. Miller and Bohamera will be able to vote.

### 3. Update on Technology for CAB Members

The Department of Technology informed SCHC that they will have to purchase devices outside of DTech's process otherwise the devices would require updates such as two-factor authentication, which we want to avoid for CAB members. SCHC is free to choose the hardware but needs to decide on the funding source and get approval from Dr. Mishra and Ms. Kothari.

No Show Rates – Q1 2022 (01/01/2022 – 03/31/2022)

Sacramento County Health Center

	Medi-Cal Patients			Healthy Partners Patients			Overall No Show Rate
	No Show Visits	Completed Visits	Medi-Cal No Show Rate	No Show Visits	Completed Visits	Healthy Partners No Show Rate	
<b>Adult Medicine</b>	<b>849</b>	<b>3,249</b>	<b>20.7%</b>	<b>264</b>	<b>1,275</b>	<b>17.2%</b>	<b>19.7%</b>
On Site	707	1,834	27.8%	229	763	23.1%	26.5%
Telehealth	133	1,390	8.7%	32	512	5.9%	8.0%
Psych	9	25	26.5%	3		100.0%	32.4%
<b>Adult Medicine (TEACH)</b>	<b>247</b>	<b>760</b>	<b>24.5%</b>	<b>88</b>	<b>434</b>	<b>16.9%</b>	<b>21.9%</b>
On Site	221	475	31.8%	80	302	20.9%	27.9%
Telehealth	26	285	8.4%	8	132	5.7%	7.5%
<b>Family Medicine</b>	<b>163</b>	<b>695</b>	<b>19.0%</b>	<b>7</b>	<b>29</b>	<b>19.4%</b>	<b>19.0%</b>
On Site	136	523	20.6%	4	25	13.8%	20.3%
Telehealth	20	143	12.3%	3	4	42.9%	13.5%
Psych	7	29	19.4%			N/A	19.4%
<b>Pediatrics</b>	<b>401</b>	<b>1,358</b>	<b>22.8%</b>	<b>0</b>	<b>0</b>	<b>N/A</b>	<b>22.8%</b>
On Site	349	1,117	23.8%	0	0	N/A	23.8%
Telehealth	52	241	17.7%			N/A	17.7%
<b>BHC</b>	<b>61</b>	<b>209</b>	<b>22.6%</b>	<b>23</b>	<b>63</b>	<b>26.7%</b>	<b>23.6%</b>
On Site	57	171	25.0%	22	61	26.5%	25.4%
Telehealth	4	38	9.5%	1	2	33.3%	11.1%
<b>GA</b>	<b>12</b>	<b>24</b>	<b>33.3%</b>	<b>0</b>	<b>0</b>	<b>N/A</b>	<b>33.3%</b>
On Site /Telehealth	12	24	33.3%	0	0	N/A	33.3%
<b>Loaves &amp; Fishes</b>	<b>27</b>	<b>243</b>	<b>10.0%</b>	<b>0</b>	<b>2</b>	<b>0.0%</b>	<b>9.9%</b>
On Site	27	105	20.5%	0	1	0.0%	20.3%
Support Staff		138	0.0%		1	0.0%	0.0%
<b>Pharmacy</b>	<b>97</b>	<b>438</b>	<b>18.1%</b>	<b>56</b>	<b>230</b>	<b>19.6%</b>	<b>18.6%</b>
On Site	97	429	18.4%	56	227	19.8%	18.9%
Telehealth		9	0.0%		3	0.0%	0.0%
<b>Same Day</b>	<b>30</b>	<b>296</b>	<b>9.2%</b>	<b>6</b>	<b>144</b>	<b>4.0%</b>	<b>7.6%</b>
On Site	30	296	9.2%	6	144	4.0%	7.6%
<b>Specialty</b>	<b>63</b>	<b>179</b>	<b>26.0%</b>	<b>22</b>	<b>110</b>	<b>16.7%</b>	<b>22.7%</b>
On Site	63	170	27.0%	22	108	16.9%	23.4%
Telehealth		9	0.0%		2	0.0%	0.0%
<b>Support Staff</b>	<b>328</b>	<b>1,037</b>	<b>24.0%</b>	<b>101</b>	<b>322</b>	<b>23.9%</b>	<b>24.0%</b>
On Site	112	446	20.1%	46	125	26.9%	21.7%
COVID (MMS or Vaccine)	216	591	26.8%	55	197	21.8%	25.6%