The County of Santa Cruz
Integrated Community Health Center Commission
AGENDA

May 10th 2018 @ 12:30 pm

Meeting Location: 1080 Emeline Avenue, DOC Conference Room (Second Floor), Santa Cruz, CA 95060
155-5th St , San Francisco, Ca 94103

ORAL COMMUNICATIONS - Any person may address the Commission during its Oral Communications period. Presentations must not exceed three (3) minutes in length, and individuals may speak only once during Oral Communications. All Oral Communications must be directed to an item not listed on today's Agenda, and must be within the jurisdiction of the Commission. Commission members will not take actions or respond immediately to any Oral Communications presented, but may choose to follow up at a later time, either individually, or on a subsequent Commission Agenda.

1. Welcome/Introductions
2. Oral Communications
3. April 12th 2018 Meeting Minutes – Recommend for Approval
4. Quality Management Committee Update
5. Budget Presentation – Recommend for Approval
6. CEO Update

Action Items from Previous Meetings:

Action Item	Person(s) Responsible	Date Completed	Comments
#1 Dinah Phillips requested data on the Over Dose rate for the County.			
#2 Len Finocchio requested follow-up from Dr. Leff regarding the process of identifying Physicians in question of charging fee for service from Medi-Cal patients.			
#3 Len Finocchio requested additional time with Jenn Phan regarding her presentation of Service Area Review data.			
#4 Kristen requested policy verification be added to Credentialing and Privileging tracking sheet.			

Next meeting: June 14, 2018 12:30 pm-2:30 pm
1080 Emeline Ave, Building D, DOC Conference Room, Second Floor, Santa Cruz, CA

The County of Santa Cruz Integrated Community Health Center Commission

Minute Taker: Linda Manley

Minutes of the meeting held May10, 2018

1. Attendance	
Rahn Garcia	Chair
Christina Berberich	Member
Nicole Pfeil	Member
Pam Hammond	Member
Gustavo Mendoza	Member
Dinah Phillips	Member
Len Finocchio	Member
Marco Martinez-Galarce	Member
Amy Peeler	County of Santa Cruz, Health Services, CEO of Clinic Services Division
Raquel Ramirez Ruiz	County of Santa Cruz, Senior Health Services Manager
Mimi Hall	County of Santa Cruz, Assistant Director of Health Services
Jeanette Garcia	County of Santa Cruz, Health Services, Admin Services Manager
Linda Manley	County of Santa Cruz, Health Services, Admin Aide
Meeting Commenced at 12:36 pm and Concluded at 2:07 pm	

Excused/Absent:

2. Excused: Kristin Meyer, Holly Shelton, Rama Khalsa

Oral Communications:

3. Review of April 12, 2018 minutes - Recommended for Approval. Dinah motioned for the acceptance of the minutes, the motion was seconded by Gustavo. The rest of the members present were in favour.
4. Mimi Hall, Assistant Director of Health Services, was introduced.

Quality Management Committee Update:

5. Quality Management Committee Update: Raquel presented 'Credentialing and Privileging Approval List for May 2018'. In the future the report will only contain new hires and completed re-certifications.
   Current version of the 'Quality Management Plan' was given to members to review and will be set for approval at next meeting.
   Raquel presented the results from the January 2018 Patient Satisfaction Survey. Break down of survey requested as action item for next meeting.

Budget/Financial Update:

6. Budget Presentation – Recommend for Approval. Presented by Jeanette Garcia and Amy Peeler. Marco motioned for acceptance, the motion was seconded by Dinah. The eight member vote in favour was unanimous.
   Jeanette also gave an update on the year to date financial report.

CEO update:

7. Amy announced that Dr Violich has received the _____award.
8. Amy gave out handouts titled "HRSA – Grants Policy Bulletin: Legislative Mandates In Grants Management for FY 2018".
   "AAPCHO – Talking Points for Health Centers and Health Care Providers – Public Charge"
   _____OD Data

Previous action items:

From 4/12/18: Len Finocchio requested follow-up from Dr. Leff regarding the process of identifying Physicians in question of charging fee for service from Medi-Cal patients. – pending response from Dr Leff

From 4/12/18: Len Finocchio requested additional time with Jenn Phan regarding her presentation of Service Area Review data.

Kristen requested policy verification be added to Credentialing and Privileging tracking sheet. **Completed**

Dinah Phillips requested data on the Over Dose rate for the County. **Completed**

Action items:

1. Brown Act information to be sent out with next months agenda

2. Current Patient Satisfaction Survey questions to be provided to members with next months agenda. The questions will be discussed for possible editing prior to distribution next January. Members would like to know where the questions originated. 3. Dinah requested a breakdown of data per site for the Patient Satisfaction Survey. Len requested a breakdown of same survey per the demographic data.
4. Luncheon / Meeting with HRSA team scheduled for Wednesday May 16, 2018. Invite to be posted per Brown Act.

Next Meeting: June 14, 2018 12:30 PM at 1080 Emeline Ave Building D (DOC Conference Room, Second Floor), Santa Cruz, CA

☐ Minutes approved _____ ___/___/___

(Signature of Board Chair or Co-Chair) (Date)

Credentialing and Privileging Approval List for May 2018

Approval Process per Credentialing and Privileging Policy # 200.03: Health Services Agency Co-Applicant Board authorizes the Medical Director, in combination with the appropriate Supervising Practitioner, to approve credentialing and privileging of health care practitioners who meet the standards for verification. The Supervising Practitioner and Medical Director will assess the credentials of each health care practitioner as outlined in the Credentialing/ Re-credentialing Checklist. Upon the final decision by the Medical Director, HSA staff will notify the physician in a timely manner of the approval and the next re-credentialing period. If the Medical Director denies the practitioner's application the Medical Director will work with the Personnel Department on next steps.

Last Name	First Name	Title	Clinical Privileging/Credentialing Renewal Date
Condon	Kathleen	BEHAVIORAL HLTH PROG MGR.	10/4/18
Heavey	Deirdre	CLINIC NURSE I	5/7/20
Cohen	Elvia	CLINIC NURSE II	5/8/20
Smith	LeeAnne	CLINIC NURSE II	5/4/20
Brodkey	Marion	CLINIC NURSE III	5/4/20
Camunez	Maria	CLINIC NURSE III	5/4/20
Keane	Adrienne	CLINIC NURSE III	5/7/20
Mota	Marcela	CLINIC NURSE III	5/8/20
Padilla	Catalina	CLINIC NURSE III	5/8/20
Wass	Andrea	CLINIC NURSE III	5/3/20
Brooks	Robin	CLINIC PHYSICIAN-HSA	9/8/18
Buntin	Chante	CLINIC PHYSICIAN-HSA	1/29/20
Cisneros	Jeanette	CLINIC PHYSICIAN-HSA	3/21/19
Cristobal	Carmelita	CLINIC PHYSICIAN-HSA	4/4/19
Hansen	Anniken	CLINIC PHYSICIAN-HSA	3/21/19
Haubach	Carol	CLINIC PHYSICIAN-HSA	12/14/19
Kelley	Judith	CLINIC PHYSICIAN-HSA	9/8/18
Leonard	Wendy	CLINIC PHYSICIAN-HSA	11/18/18
Lipson	John	CLINIC PHYSICIAN-HSA	12/14/19
Lou	Linda	CLINIC PHYSICIAN-HSA	9/22/18
Sanford	Eric	CLINIC PHYSICIAN-HSA	3/21/19
Santillano	Eugene	CLINIC PHYSICIAN-HSA	9/9/18
Beihaghi	Farah	CLINICAL LAB SCIENTIST	5/3/20
Singer	Susan	CLINICAL LAB SCIENTIST	5/4/20
Model	Daniel	CLINICAL PSYCHOLOGIST	10/4/18
Stiles	Joel	CLINICAL PSYCHOLOGIST	10/4/18
Willkie	Catherine	CLINICAL PSYCHOLOGIST	10/4/18
Rees	Rachel	DIR OF LABRATORY SVCS	5/4/20
Crosby	Kevin	LAB ASST/PHLEBOTOMIST	5/7/20
Cruz	Clementina	LAB ASST/PHLEBOTOMIST	5/4/20
Dymesich	Diane	LAB ASST/PHLEBOTOMIST	5/4/20
Larson	Renee	LAB ASST/PHLEBOTOMIST	5/7/20

Credentialing and Privileging Approval List for May 2018

Last Name	First Name	Title	Clinical Privileging/Credentialing Renewal Date
Zajac	Jeffrey	LAB ASST/PHLEBOTOMIST	5/2/20
Violich	Michele	MED DIR - PRIMARY CARE	3/23/19
Alcaraz-Franco	David	MEDICAL ASSISTANT	5/8/20
Alejo	Maria	MEDICAL ASSISTANT	5/8/20
Bermudez	Alejandra	MEDICAL ASSISTANT	5/3/20
Bermudez	Maria	MEDICAL ASSISTANT	5/8/20
Carranza	Adrian	MEDICAL ASSISTANT	5/31/18
Cermeno	Evelyn	MEDICAL ASSISTANT	5/8/20
De Santos	Cynthia	MEDICAL ASSISTANT	5/7/20
Dorantes	Estela	MEDICAL ASSISTANT	5/8/20
Fernandez	Yesika	MEDICAL ASSISTANT	5/8/20
Garcia	Almendra	MEDICAL ASSISTANT	5/2/20
Groyon	Risa	MEDICAL ASSISTANT	5/7/20
Guerrero	Ana	MEDICAL ASSISTANT	5/7/20
Hernandez	Laura	MEDICAL ASSISTANT	5/7/20
Lomeli	Maribel	MEDICAL ASSISTANT	5/7/20
Magana	Gabriela	MEDICAL ASSISTANT	5/8/20
Martinez	Anabertha	MEDICAL ASSISTANT	5/7/20
McNaught	Riley	MEDICAL ASSISTANT	5/7/20
Melgoza	Mariela	MEDICAL ASSISTANT	5/7/20
Mendez	Eloy	MEDICAL ASSISTANT	5/8/20
Mendez	Leticia	MEDICAL ASSISTANT	5/8/20
Montes	Lucy	MEDICAL ASSISTANT	5/7/20
Mora Martinez	Jeanette	MEDICAL ASSISTANT	5/8/20
Orozco	Kitzia	MEDICAL ASSISTANT	5/8/20
Ortiz	Teresa	MEDICAL ASSISTANT	5/7/20
Ponce	Nelly	MEDICAL ASSISTANT	5/8/20
Rodriquez	Victoria M.	MEDICAL ASSISTANT	5/7/20
Rubalcaba	Maria	MEDICAL ASSISTANT	5/8/20
Ruiz	Esther	MEDICAL ASSISTANT	5/8/20
Saldivar	Rosa	MEDICAL ASSISTANT	5/7/20
Sanchez	Sulema	MEDICAL ASSISTANT	5/7/20
Shakespeare-Leon	Shannon	MEDICAL ASSISTANT	5/9/20
Souza	Sarah	MEDICAL ASSISTANT	5/7/20
Trujillo	Delia	MEDICAL ASSISTANT	5/7/20
Zamora	Marilu	MEDICAL ASSISTANT	5/8/20
Zamora	Mayra	MEDICAL ASSISTANT	5/8/20
Zavala	Norma	MEDICAL ASSISTANT	5/8/20
Contreras	Danny	MH CLIENT SPECIALIST	5/4/20

Credentialing and Privileging Approval List for May 2018

Last Name	First Name	Title	Clinical Privileging/Credentialing Renewal Date
Yanez	Victor	MH CLIENT SPECIALIST	5/7/20
Hogeland	Christie	MH SUPVG CLIENT SPEC	5/3/20
Alvarado	Fabian	PHYS ASST/NURSE PRACT	10/6/18
Galvan	Veronica	PHYS ASST/NURSE PRACT	12/14/19
Gehringer	Sharon	PHYS ASST/NURSE PRACT	5/27/19
Henderson	Catherine	PHYS ASST/NURSE PRACT	9/14/18
Johnston	Jason	PHYS ASST/NURSE PRACT	10/6/18
Jordan	Marion	PHYS ASST/NURSE PRACT	9/8/18
Kollmann	Alice	PHYS ASST/NURSE PRACT	3/21/19
Reyes	Wilibaldo	PHYS ASST/NURSE PRACT	3/21/19
Wall	David	PHYS ASST/NURSE PRACT	9/14/18
Whitehead	Allison	PHYS ASST/NURSE PRACT	3/15/19
Bacos	Dimitri	PSYCHIATRIC MEDICAL DIRECTOR	10/4/18
Desai	Toral	PSYCHIATRIST	12/7/19
Jovel	Jose	PSYCHIATRIST	4/17/20
Krishnan	Brinda	PSYCHIATRIST	10/4/18
Wu	Ina	PUB HLTH MICROBIOLOGIS	5/7/20
Nathanson	Matthew	PUB HLTH NURSE II	5/2/20
Samson	Suzanne	PUB HLTH NURSE II	5/3/20
Gendreau	Paul	PUB HLTH NURSE III	5/2/20
Brown	Lori	SR MH CLIENT SPECIALST	12/12/19
De La Rosa	Laura	SR MH CLIENT SPECIALST	4/17/20
Duque	Jorge	SR MH CLIENT SPECIALST	5/3/20
Laurent	Julie	SR MH CLIENT SPECIALST	4/17/20
McDonald	Kristin	SR MH CLIENT SPECIALST	12/12/19
Nguyen	Nhi	SR MH CLIENT SPECIALST	5/3/20
Talbot	Jennifer	SR MH CLIENT SPECIALST	12/12/19
Murai	Gerrod	SR PUB HLTH MICROBIOLG	5/7/20

Santa Cruz County Health Services Agency
Clinic Services Division
Quality Management Plan

May ~~2017~~2018

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Introduction and Statement of Purpose

Santa Cruz County Health Services Agency's Clinic Services Division (CSD) is committed to ensuring access to high quality patient-centered health care for all members of our community. Our Mission, embodied in the work of all staff who support patient care at HSA Clinics, ***is to provide high quality, comprehensive primary care services, outreach, and advocacy to community members who have traditionally been marginalized by socioeconomic, cultural, language or other barriers to health care.*** Our collaborative approach fosters teamwork between clinicians, support staff, patients and outside community resources. As part of this commitment, our organization embarked upon a vigorous review of our existing Quality Management system. This has been a collaborative effort that includes administrators, clinicians, and support staff from Homeless Persons Health Project (HPHP), Watsonville Health Center and Santa Cruz Health Center.

CSD has clearly defined our division-wide goal for Quality Management, identified current barriers to reaching this goal, and developed a comprehensive approach to overcoming these barriers and providing consistent, high quality health care to all who are served at each of Santa Cruz County Health Service Agency's primary care health facilities. Throughout our planning process, CSD has included activities to ensure maintenance of the quality standards for primary health care that have been established by the Health Resources and Services Administration's Bureau of Primary Health Care. Specifically, our Quality Management Plan will provide leadership and guidance in support of the division's mission and for ensuring that the health centers are operating in accordance with applicable Federal, State, and local laws and regulations. This Quality Management document reflects the outcomes of our extensive planning work, and provides a framework for continual reassessment of our Quality Management program over time.

Purpose:

The Purpose of our Quality Management Plan is to ensure high quality care and services for our patients that is reflected in a holistic set of indicators that are objectively measured and trusted, and driven by stakeholder engagement and institutional value of providing high quality care.

Background:

Our Clinic Services Division established a Steering Committee in 2012 to improve communication between health centers and across the wide variety of Quality Improvement (QI) activities being conducted within the Health Services Agency. Despite improved communication, our organization continued to lack a systematic means of determining the quality of care our patients receive or a consistent approach to enacting change. Although QI projects were being successfully performed, there was no framework for expanding the new process at an institutional level. In addition, our organization was reporting on clinical indicators to various upstream stakeholders without clearly defined and agreed upon processes to regularly review clinical measures, design improvements or track changes over time. Because of the disconnect between health care providers and data reporting, the Steering Committee found that the accuracy of data generated from the Electronic Health Record (EHR) was inconsistent due to variability in data entry and access to discrete fields for data extraction. This had contributed to the devaluing of the Quality Management process amongst health care providers because the data did not consistently reflect the work being performed. Furthermore, we found that there has not been a clear process in place for reporting problems that arise from a staff or patient perspective.

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Our Theory of Change

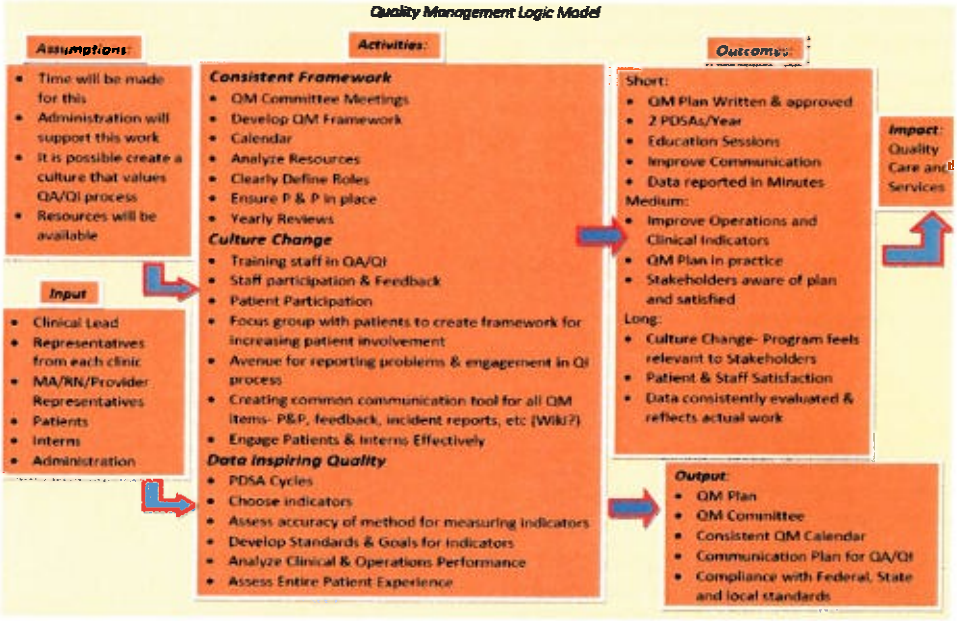
Our Quality Management team has defined a clear set of objectives that will allow us to overcome barriers and reach our goal of consistently high quality patient care that is confirmed through objective measures.

We will reach our goal by focusing on the following three Objectives:

1. ***Develop and Maintain a Cohesive and Comprehensive Framework that includes a plan for engagement of and communication to all stakeholders, as well as a playbook for change that provides a structured process for implementing improvements.***
2. ***Create an institutional consensus around shared definitions of Quality Assurance and Quality Improvement that provides the foundation for improving the perceived value of this process by all stakeholders.***
3. ***Utilize trustworthy data from our robust EHR to drive improvements in quality and efficiency of care and services to our patients.***

Our Logical Framework:

The Quality Management team has developed a logic model that will serve as a framework for continual reassessment of our Quality Management plan. The model is considered a fluid process that is open for stakeholder feedback and will be reevaluated yearly to ensure we are meeting our goals.



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Scope of Work

The scope of work within our Quality Management plan is comprehensive, and includes all stakeholders involved in the direct or indirect provision of clinical care to patients seen at our four health facilities. Our goal is to provide a quality experience for all patients, including sub-populations such as those experiencing homelessness or living with HIV, throughout the entire process of accessing, receiving and continuing care. To this end, the scope includes all administrative and clinical departments who participate in providing primary care, in-house specialty services such as HIV, Orthopedics, Tuberculosis, Behavioral Health, Dental, Immunizations, and any support services. To ensure quality care is provided to HSA patients who are seen by outside service providers, we will undergo a due diligence process when signing contracts and perform intermittent quality reviews that include patient satisfaction surveys.

Program Structure and Accountability

Organizational Structure and Accountability

The Co-Applicant Board is ultimately accountable for the quality of care and services provided to the patients cared for at the health centers overseen by the Clinics Services Division. The Co-Applicant Board has delegated oversight responsibility for the effectiveness and efficiency of care and services to the Chief of Clinic Services, who has assigned responsibility for implementation of policies to the Medical Services Director. The Medical Services Director has designated the Senior Health Services Manager to facilitate the Quality Management Committee and to work directly with medical directors at each health center to ensure quality and implement all aspects of the Quality Management Program.

The operation of the CSD Quality Management program is the collaborative responsibility of the CSD Quality Management Committee, which involves all appropriate personnel including management, clinical staff, and support staff representing each of our four health centers. The Quality Management Committee may consist of the following members and other staff as necessary:

1. CSD Medical Services Director
2. CSD Chief of Clinics
3. Data Analyst
4. Santa Cruz Health Center QI Lead
5. Homeless Persons Health Project (HPHP) Health Center QI Lead
6. Watsonville Health Center QI Lead
7. Public Health/Clinics Physician Liaison QI Lead
8. Nursing (RN or MA) Representative for Watsonville Health Center
9. Nursing Representative (RN or MA) for Santa Cruz Health Center
10. Nursing Representative (RN or MA) for HPHP Health Center
11. Representative At-Large (Intern, patient, registration staff, or community partner)
12. Representative from Integrated Behavioral Health team

The Senior Health Services Manager acts as the facilitator of the Quality Management Committee, and prepares the Committee Agendas and Meeting Minutes. These documents are contained within a shared drive on the CSD computer system. A quorum is defined as presence of 4 core members.

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Representatives to the committee are re-assessed on an annual basis.

The Quality Management Committee is responsible for:

- Developing priorities and setting thresholds for Quality Indicators
- Ensuring that all sub-populations are represented in Quality indicators and activities
- Requesting further investigation of specific topics
- Analyzing data and audits
- Recommending membership on Quality Improvement Teams
- Participating in and assessing patient satisfaction surveys
- Reporting committee findings and recommendations to all stakeholders
- Facilitating an annual evaluation of the Quality Management Program.

Meeting Structure

Meetings are conducted on the same day and time on a monthly basis. A Yearly Calendar has been created to ensure that the Quality Management Committee meets all of its objectives for the year. The template includes key operational and clinical indicators, reporting expectations, and quality improvement activities. As this is an iterative process, we utilize our experience in prior years to improve upon our processes for the following year.

A template for the meeting Agenda and Minutes can be found in Attachment 2. An annual 'open house' provides all stakeholders with the opportunity to learn more about the committee, contribute additional ideas and consider membership. This provides the committee with an opportunity to further engage ~~stakeholders, and~~stakeholders and promotes the ability to ~~meet the second objective outlined in our Strategic Plan that focuses on~~ strengthen~~ing~~ the institutional value of quality assurance and quality improvement. To this end, the Quality Management Committee has identified the following key stakeholders:

- Patients
- Clinic Providers
- Nurses, Medical Assistants
- Front Office Staff
- Administrators
- Community Partners
- Co Applicant Commission

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Defining Quality and Quality Management

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Developing a comprehensive Quality Management Plan requires a commonly agreed upon definition of Quality. This is particularly important as we engage stakeholders in the integration of quality management into our institutional work. For the purpose of this plan, CSD has chosen to adopt the World Health Organization (WHO)[1] and Institute of Medicine (IOM) definition of quality as it pertains to health systems. The definition emphasizes a whole-system perspective that reflects a concern for the outcomes achieved for both individual service users and whole communities. This is particularly applicable given our dual role of providing individual clinical care and protecting public health. The WHO and IOM definition suggests that a health system should seek to make improvements in six areas of quality.

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[1] Quality of Care: A process for making strategic choices in health systems. World Health Organization, 2006

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Our shared definition of Quality requires that health care be:

- ***Effective***- delivering health care that is adherent to an evidence base and results in improved health outcomes for individuals and communities, based on need;
- ***Efficient***- delivering health care in a manner which maximizes resource use and avoids waste;
- ***Accessible***- delivering health care that is timely, geographically reasonable, and provided in a setting where skills and resources are appropriate to medical need;
- ***Acceptable/Patient-Centered***- delivering health care which takes into account the preferences and aspirations of individual service users and the cultures of their communities;
- ***Equitable***- delivering health care which does not vary in quality because of personal characteristics such as gender, race, ethnicity, geographical location, or socioeconomic status;
- ***Safe***- delivering health care which minimizes risks and harm to service users.

Santa Cruz Health Services identifies three major components to Quality Management that includes Quality Assessment, Quality Improvement and Quality Assurance. By addressing these three separate and essential components to Quality Management, the Quality Management Committee strives to meet all of these dimensions of quality health care. Because the committee recognizes that the entire health system from both an Operational and Clinical perspective must work collaboratively to achieve our goals, we consider Quality indicators across all departments. The diagram below provides a simple illustration of the intersection of Quality Assessment and Quality Improvement across both Operations and Clinical Care.

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Quality Assessment

Quality Assessment involves the identification of indicators that best reflect quality clinical and operational performance and review of these indicators to ensure that all of our health facilities are meeting Standards and Goals that we have set for ourselves. Quality Assessment includes a thorough review of the process by which to measure these indicators to ensure accuracy.

Indicator Selection

Indicators are identified through a variety of internal and external processes that reflect a patient's ability to efficiently access high quality health care. For this reason, indicators often reflect both operational and clinical service provision. The following categories, along with specific examples, are major drivers in indicator selection:

- Indicators reflecting timely Access to Care
  - Time to next appointment
  - Timely phone responses
- Indicators reflecting efficient Provision of Care
  - Patient Cycle times
  - Use of My Chart EHR functionality

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    - Departmental Communication Systems
- Indicators reflecting Evidence-based Clinical Care
    - Clinical Indicators identified by external sources such as the Uniform Data System (UDS) Clinical Outcomes and Quality Care measures and other Clinical Guidelines
    - Clinical Indicators reflecting health of sub-populations served by CSD such as those living with HIV, homelessness, mental illness or substance abuse
    - Clinical Indicators identified by CSD clinicians to be key to quality care provision
- Indicators driven by Patient and Staff Satisfaction via surveys and informal feedback
- Indicators reflecting Safe provision of care as identified through Safety and Incident Reports

In many cases, similar indicators may fall under several categories. For example, UDS measures Pap smear utilization and our HIV Quality Management Committee follows a similar indicator. It is the responsibility of the CSD QM Committee to create a streamlined means of selecting indicators that can efficiently serve all of our patients and simultaneously address the needs of sub-populations and various reporting entities. To improve integration and efficiency, the CSD QM Committee facilitates collaboration to ensure that system improvements follow a similarly streamlined approach.

Indicator Measurement

It is the responsibility of the CSD QM Committee to review methods of measuring indicators. The Data Analyst effectively extracts data from our robust EHR system, and depends upon all stakeholders to consistently enter data into discrete data fields. The QM Committee reviews the data fields used and the process for determining if an indicator has been met. These processes must then be communicated to stakeholders and reviewed for user functionality. Adjustments are then made and stakeholders are trained in the final process.

Indicator Analysis

The CSD QM Committee is responsible for developing standards and goals for the indicators we have chosen to follow. Results will be compared to HSA Clinics' internal goals and to external benchmarking standards. Indicators are reviewed by the CSD QM Committee at intervals determined by our yearly calendar and as indicated by stakeholder request. Results are available to all stakeholders upon request.

Indicator Reporting

Indicators are reported at QM Committee meetings based upon our set yearly calendar. All data reports reviewed at each meeting are included in the Meeting Minutes, and these Minutes are distributed to all HSA Clinics staff members. Meeting Minutes are also made available upon request to patients and community partners.

Indicator Tracking

Indicators that have not met our internal goals or external benchmarking standards are identified and quality improvement activities are developed. It is the responsibility of the QM Committee to facilitate quality improvement teams, track progress, and determine successful outcomes.

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Quality Improvement

Once gaps in quality care have been identified through the process of Quality Assessment, the QM Committee chooses priority indicators to focus improvement efforts. A Process Improvement Team[2] is appointed by the committee and tasked with first addressing the following three questions:

1. What are we trying to accomplish? (Setting our AIM)
2. How will we know that a change has led to improvement? (Establishing Measures)
3. What changes can we make that will result in improvement? (Selecting Change)

Once these questions are addressed, a pilot 'change' project is designed and implemented by the Process Improvement Team through a Plan, Do, Study, Act (PDSA) cycle. Baseline measures should be established prior to the PDSA cycle, and appropriate comparison measures should be obtained to assess for success of the intervention. The Process Improvement Team presents their findings to the QM Committee, and successful interventions are implemented throughout all health facilities. The QM Committee is responsible for ensuring consistent implementation, which includes communication to and training of appropriate staff members. This may also include the establishment or revision of Policies and Procedures. In this case, the QM Committee is responsible for appointing appropriate personnel to develop and implement the policy or procedure in a systematic way.

Clinic Level Quality Improvement

Although most system improvements will be expanded throughout all CSD health facilities, each health facility has unique sub-populations and system challenges. In these cases, the QM Committee representative from each health facility is responsible for choosing Process Improvement Teams for their sites and then reporting results to the QM Committee. When appropriate, system improvements may be replicated across all sites.

Provider Level

Since our EMR system allows health care providers to run reports on their individual patient panels, some providers have conducted their own internal improvement activities in collaboration with their team members (medical assistant and RN). Providers are encouraged to present their experiences to the QM Committee via their health center QI representative so that all providers can learn from their experience.

Quality Assurance Activities

For the purposes of CSD Quality Management, Quality Assurance is considered a process of ensuring basic standard practices within the health system from both an operational and clinical standpoint. In addition to indicators that are chosen by the QM Committee, routine audits will be conducted. Audits may also be triggered by challenges brought to the committee through a variety of channels. When areas of deficit are noted, we follow the workflows described below, and determine the most appropriate action. In some cases, a new Policy or Procedure may be developed. In other cases, the QM Committee may consider quality improvement activities that will improve the system of care.

[2] Adapted from Institute for Healthcare Improvement
http://www.ihi.org/resources/Pages/HowtoImprove/ScienceofImprovementFormingtheTeam.aspx

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SOURCES OF AUDIT TOPICS

Audit and data collection may be directed at problem areas identified by:

1. Needs assessment data
2. Clinical Guidelines Audits
3. Licensing and funding standards
4. Data reports from internal and external sources
5. Peer Review
6. Prescribing patterns
7. Billing data
8. Scheduling and staffing plans
9. Incident/occurrence reports, and
10. Patient satisfaction surveys/grievance forms.

Quality Assurance activities may also be triggered by:

1. Patient Complaint
2. Staff Complaint
3. Community Complaint
4. Provider variability in terms of meeting clinical indicators or utilization of services
5. Malpractice Data

Quality Assurance Work Flow for Issues Brought to the Committee:

1. Comes to attention of the committee
2. Committee will:
   a. Determine who will investigate (internal or external auditor)
   b. Gather data (either committee members or investigator)
   c. Formulate plan of action
   d. Designated investigator reports back to committee with results and recommendations

Quarterly Audit Activities will be conducted, and may include 1-2 of these topics:

1. Registration
2. Clinical Care
3. Epic Documentation
4. Prescriptions
5. Referrals

Resource Assessment

Although quality care should not be driven by financial incentives alone, financial resources are essential to providing quality care and promoting health center program sustainability. The Quality Management Committee is tasked with ensuring that the quality of care we provide is reflected in the data that is presented to reporting and funding entities. When funding opportunities are missed, this must be reviewed to assess for avoidable causes and addressed by the QM Committee. In addition, the Quality Management Committee is tasked with advocating the need for the Health Services Agency to commit resources towards Quality Management for the promotion of consistency in the quality of care we provide across all health facilities and patient populations.

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Strengthening Institutional Consensus

To maintain a successful Quality Management Program, it is essential that all stakeholders trust in the process we have created. The QM Committee is committed to building and maintaining an institutional consensus around Quality Improvement that promotes a shared definition of quality and unified approach to reaching our goals. To this end, we are developing a plan that will foster and maintain a culture shift within our organization that inspires stakeholder value in Quality Assessment and Improvement. This plan includes the following processes:

- Training staff in Quality Assessment, Quality Improvement, and Quality Assurance
- Staff participation & Feedback
- Patient Participation
- Focus group with patients to create framework for increasing patient involvement
- Avenue for reporting problems and involvement in QI process
- Create common communication tool such as a ~~Wiki~~ an Intranet page for all QM items
- Engage Patients, Interns and Community Partners Effectively
- Data Quality- ensuring accuracy and communicating measurement process

Additional Components of Quality Management

Utilization Management

The CSD Utilization Management program provides a comprehensive process through which review of services is performed in accordance with both quality clinical practices and the guidelines and standards of local, state and federal regulatory entities. The Utilization Management program is designed to monitor, evaluate and manage the quality and timeliness of health care services delivered to all health center patients. The program provides fair and consistent evaluation of the medical necessity and appropriateness of care through use of nationally recognized standards of practice and internally developed clinical practice guidelines. This work is integrated into the QM Committee's ongoing assessment of Operational Indicators.

Credentialing, Recredentialing, and Privileges

Our credentialing and privileging processes accomplish initial credentialing, required recredentialing, and specific privileging for all contracted, voluntary and employed providers. This ensures appropriate qualifications to provide care and services and verifies the absence of any State and Centers for Medicare and Medicaid Services (CMS)-imposed sanctions. Specific quality indicators addressing the credentialing and privileging processes are part of CSD QM Program.

Risk Management and Patient Safety

The Clinic Services Division Risk Management program monitors the presence and effectiveness of patient risk minimization activity, including incident reports, sentinel events, infection control, lab quality control and patient safety. These risk minimization activities will be proactive whenever possible. Improvements to related processes and policies will also result from QM activities based upon triggers listed in the Quality Assurance section. The Santa Cruz County Health Services Agency's Safety Committee is ultimately responsible for monitoring the breadth of patient and staff safety within our Agency. The Safety Committee reports their findings to the Quality Management Committee, and the QM Committee will respond when appropriate and when the issue is within our Scope of Work. The total Risk Management program is closely integrated with the CSD Quality Management Program.

~~Confidentiality~~

~~The activities of the Quality Management Program are legally protected under the California Health & Safety Code Section 1370. The law protects those who participate in quality of care or utilization review. It provides further that "neither the proceedings nor the records of such reviews shall be subject to discovery, nor shall any person in attendance at such reviews be required to testify as to what transpired thereat."~~

~~All copies of minutes, reports, worksheets and other data are stored in a manner ensuring strict confidentiality. A written confidentiality policy detailing procedures for maintenance and release of data and other QI related information governs the release of such information. This policy specifies the use of record number or other identifiers in place of patient names, and code numbers in place of physician or other provider and staff names. This policy also provides methods for restricting all quality improvement documents solely to authorized individuals. In addition, all data will be treated as Medical Staff peer review information as defined in the California Statute and shall be considered protected information under the provisions of the California Evidence Code 1157.~~

Health Records

Santa Cruz Health Services Agency Clinics will achieve continued excellence with respect to its health records. These records will be maintained in a manner that is current, detailed, secure, and enabling of effective, confidential patient care and quality review. Health records will reflect all aspects of care and will be complete, accurate, systematically organized, legible, authenticated, and readily available to all appropriate health care practitioners and other necessary parties, in strict accordance with the Health Information Portability and Accountability Act (HIPAA) guidelines.

Process for Revision of Quality Management Plan

Each year, the Quality Management Committee will facilitate the review and update of our Quality Management Plan and logical framework. We will invite all stakeholders identified previously in this document to participate in this review. This annual review will be scheduled into our Yearly Calendar to ensure its prioritization.

☐ Board approved _____ ____/____/____

(Signature of Board Chair or Co-Chair) (Date)

Attachment 1: Quality Management Work Plan Template

County of Santa Cruz, Health Services Agency, Clinic Services Division

Our goal ~~for 2018~~ is to refine and further standardize our process for evaluating current practice and improving upon the quality of our services. The Quality Management Committee has identified three key categories to focus on. These include Patient & Staff Satisfaction, Clinical Care, and Clinical Operations. Throughout the year, we will focus on clarifying key indicators within each of these categories and on improving the quality of the data we record, collect, and analyze. We will strive to build upon prior work and conduct 1 PDSA within each category per year. In addition, Quality Assurance activities will be conducted throughout the year.

PATIENT SATISFACTION					
STAFF SATISFACTION					
CLINICAL CARE					
CLINICAL OPERATIONS					

	PATIENT & STAFF SATISFACTION	CLINICAL CARE	CLINICAL OPERATIONS
DEFINE/CLARIFY KEY INDICATORS			
IMPROVE DATA COLLECTION METHODS			
BUILD UPON PRIOR PROJECTS			
IMPROVE- PDSAs			

Attachment 2: Quality Management Committee Meeting Agenda and Minutes

QM Committee:	
Date/Time:	-------, 8:30 to 9:30 am
Meeting Location:	
Leader:	
Facilitator/Transcriber:	
Attending:	
Guest(s):	

Persistent Focus on Excellence in Patient Care in a Compassionate Environment

Agenda Items	Discussion	Data/Trends Reviewed	Action/Decision	Who	Date Due
Agenda review and announcements				Committee	n/a
Approve minutes				Committee	Today
Review incident reports				Committee	Today
Calendar Activities for Month					
Other Action Items Due					

☐ Minutes approved _____
__/__/__
(Signature of committee facilitator) (Date)

Next Meeting

Date/Time:	
Meeting Location:	1080 Emeline, Room 200

AAPCHO
Association of Asian Pacific Community Health Organizations

Talking Points for Health Centers and Health Care Providers – "Public Charge"

Last Updated: May 7, 2018

Background

- The Trump administration has a new proposal—this is still only an idea and is not yet official—to deny permanent resident status ("green cards") to, and even deport, families residing legally in the U.S. on visas if they—or their family members, including U.S. citizen children—use health care and food programs.

- The Trump administration's idea is to take a little-known immigration law term called "public charge," (a category that is currently used to deny green card status to those likely to use cash assistance or long-term care), and apply it more broadly to larger categories of immigrant families, including U.S. born citizen children.

- This dangerous proposal that was leaked to the media. If passed, would constitute a radical change in a longstanding tenet of U.S. immigration policy—to keep families together.

- Patients and families who are covered by Medicaid, health insurance subsidies, or enrolled in other health and food programs could have their use of services potentially used against loved ones who are seeking permanent residency in the U.S.

- Note: refugees and asylees are not currently included in the Trump Administration's proposed changes to the immigration "public charge" category.

An Anti-Family Policy

- This is an attack on Asian Americans, Pacific Islanders and all immigrant families.

- Under this new proposal, the government is threatening to deny permanent residency and potentially separate entire families if even one person in his or her family signs up for Medicaid, or gets a health insurance tax credit, *even if the family member is a U.S. citizen.* We cannot let this proposal pass.

- If the Trump administration's proposal is carried out, individuals who are legally in the U.S. on a visa could be denied a green card for permanent residency or potentially deported if they or

any of their family members legally in the U.S., including their U.S. citizen children, enroll in programs including:

- ❖ Medicaid
- ❖ Children's Health Insurance Program (CHIP)
- ❖ Food Stamps (SNAP)
- ❖ Women, Infants, Children (WIC) nutrition services and supplies
- ❖ Earned Income Tax Credit, or tax credits to purchase private health insurance on the Affordable Care Act (ACA) health insurance marketplace.

- This proposal would place families in the heart-breaking position of deciding whether to get health care and food for their children—or forgo these vital services in order to stay together.

Chilling Effect on Patients and Families

- Moms should have timely prenatal care services, and parents should seek the care of a doctor if they or their children have uncontrolled diabetes. Children should have immunizations before they start school.

- Now that people are hearing about this disastrous latest proposal, patients are worried that going to the doctor or dentist could jeopardize their residency in the U.S. and lead to separation from their kids.

- Patients are canceling visits or dropping insurance altogether.

- In one urgent care center, so many patients left that the health center sat empty for days during this year's flu season.

- When we call families to renew their health insurance, they are telling us that they don't want to re-enroll, even if they are U.S. citizens.

- Health coverage and food have nothing to do with applying for a green card.

A Distraction from the Real Problems: Child Poverty and Lack of Affordable Health Care

- Like many other working families, Asian American, Native Hawaiian and Pacific Islander families get stuck in low-paying service jobs with no health coverage.

AAPCHO
Association of Asian Pacific Community Health Organizations

- Instead of trying to solve America's problems like the lack of health coverage and child poverty, this proposal makes them worse.

- 1 in 4 children in the U.S. currently have at least 1 parent born outside of the U.S. Denying the U.S.'s next generation of U.S. citizen children and children of legal immigrants in the U.S. access to basic health and nutritional programs puts families at risk, and will only increase emergency hospitalizations and ER use.

Take Action

Keep getting health care for you and your family

- Spread the word – this Trump administration's proposal is only a draft and is not law.

- Keep your health insurance—there is no advantage to dis-enrolling because the proposal is a draft. Come into your health center if you or your family needs medical, dental or mental health services.

Keep applying for permanent residency and naturalized citizenship

- Your green card application is not affected by using health care, food programs, and many other programs. Currently, only cash assistance and long-term care falls under the immigration term "public charge."

- Until the proposal is finalized, nothing has changed.

For specific questions, consult with legal organizations

- Many communities have free or low-cost legal services. Consult with a reputable immigration lawyer.

- Do not pay anyone for legal services unless they are affiliated with a reputable law firm or non-profit organization.

HRSA
Health Resources & Services Administration

Grants Policy Bulletin

Legislative Mandates in Grants Management for FY 2018

Bulletin Number: 2018 - 04
Release Date: April 4, 2018
Related Bulletins: Replaces 2017 - 07
Issued by: Office of Federal Assistance Management (OFAM), Division of Grants Policy (DGP)

Purpose

The purpose of this Policy Bulletin is to clarify the requirements mandated by the FY 2018 Consolidated Appropriations Act 2018 (Public Law 115-141), signed into law on March 23, 2018, which provides funding to HRSA for the fiscal year ending September 30, 2018. The intent of this Policy Bulletin is to provide information on the following statutory provisions that limit the use of funds on HRSA grants and cooperative agreements for FY 2018. Legislative mandates remain in effect until a new appropriation bill is passed setting a new list of requirements.

Implementation

FY 2018 Legislative Mandates are as follows:

Division H, Title II
(1) Salary Limitation (Section 202)
(2) Gun Control (Section 210)

Division H, Title V
(3) Anti-Lobbying (Section 503)
(4) Acknowledgment of Federal Funding (Section 505)
(5) Restriction on Abortions (Section 506)
(6) Exceptions to Restriction on Abortions (Section 507)
(7) Ban on Funding Human Embryo Research (Section 508)
(8) Limitation on Use of Funds for Promotion of Legalization of Controlled Substances (Section 509)
(9) Restriction on Distribution of Sterile Needles (Section 520)
(10) Restriction of Pornography on Computer Networks (Section 521)
(11) Restriction on Funding ACORN (Section 522)

Division E, Title VII
(12) Confidentiality Agreements (Section 743)

Details:

Division H, Title II:

(1) Salary Limitation (Section 202)

"None of the funds appropriated in this title shall be used to pay the salary of an individual, through a grant or other extramural mechanism, at a rate in excess of Executive Level II."

The Executive Level II salary is currently set at $189,600.

(2) Gun Control (Section 210)

"None of the funds made available in this title may be used, in whole or in part, to advocate or promote gun control."

Division H, Title V

(3) Anti-Lobbying (Section 503)

" (a) No part of any appropriation contained in this Act or transferred pursuant to section 4002 of Public Law 111–148 shall be used, other than for normal and recognized executive legislative relationships, for publicity or propaganda purposes, for the preparation, distribution, or use of any kit, pamphlet, booklet, publication, electronic communication, radio, television, or video presentation designed to support or defeat the enactment of legislation before the Congress or any State or local legislature or legislative body, except in presentation to the Congress or any State or local legislature itself, or designed to support or defeat any proposed or pending regulation, administrative action, or order issued by the executive branch of any State or local government, except in presentation to the executive branch of any State or local government itself.

(b) No part of any appropriation contained in this Act or transferred pursuant to section 4002 of Public Law 111–148 shall be used to pay the salary or expenses of any grant or contract recipient, or agent acting for such recipient, related to any activity designed to influence the enactment of legislation, appropriations, regulation, administrative action, or Executive order proposed or pending before the Congress or any State government, State legislature or local legislature or legislative body, other than for normal and recognized executive-legislative relationships or participation by an agency or officer of a State, local or tribal government in policymaking and administrative processes within the executive branch of that government.

(c) The prohibitions in subsections (a) and (b) shall include any activity to advocate or promote any proposed, pending or future Federal, State or local tax increase, or any proposed, pending, or future requirement or restriction on any legal consumer product, including its sale or marketing, including but not limited to the advocacy or promotion of gun control."

(4) Acknowledgment of Federal Funding (Section 505)

"When issuing statements, press releases, requests for proposals, bid solicitations and other documents describing projects or programs funded in whole or in part with Federal money, all grantees receiving Federal funds included in this Act, including but not limited to State and local governments and recipients of Federal research grants, shall clearly state – (1) the

percentage of the total costs of the program or project which will be financed with Federal money; (2) the dollar amount of Federal funds for the project or program; and (3) percentage and dollar amount of the total costs of the project or program that will be financed by non-governmental sources."

(5) Restriction on Abortions (Section 506)

"(a) None of the funds appropriated in this Act, and none of the funds in any trust fund to which funds are appropriated in this Act, shall be expended for any abortion.

(b) None of the funds appropriated in this Act, and none of the funds in any trust fund to which funds are appropriated in this Act, shall be expended for health benefits coverage that includes coverage of abortion.

(c) The term ''health benefits coverage'' means the package of services covered by a managed care provider or organization pursuant to a contract or other arrangement."

(6) Exceptions to Restriction on Abortions (Section 507)

"(a) The limitations established in the preceding section shall not apply to an abortion – (1) if the pregnancy is the result of an act of rape or incest; or (2) in the case where a woman suffers from a physical disorder, physical injury, or physical illness, including a life-endangering physical condition caused by or arising from the pregnancy itself, that would, as certified by a physician, place the woman in danger of death unless an abortion is performed.

(b) Nothing in the preceding section shall be construed as prohibiting the expenditure by a State, locality, entity, or private person of State, local, or private funds (other than a State's or locality's contribution of Medicaid matching funds).

(c) Nothing in the preceding section shall be construed as restricting the ability of any managed care provider from offering abortion coverage or the ability of a State or locality to contract separately with such a provider for such coverage with State funds (other than a State's or locality's contribution of Medicaid matching funds).

(d)(1) None of the funds made available in this Act may be made available to a Federal agency or program, or to a State or local government, if such agency, program, or government subjects any institutional or individual health care entity to discrimination on the basis that the health care entity does not provide, pay for, provide coverage of, or refer for abortions.

(d)(2) In this subsection, the term ''health care entity'' includes an individual physician or other health care professional, a hospital, a provider-sponsored organization, a health maintenance organization, a health insurance plan, or any other kind of health care facility, organization, or plan."

(7) Ban on Funding of Human Embryo Research (Section 508)

"(a) None of the funds made available in this Act may be used for – (1) the creation of a

human embryo or embryos for research purposes; or (2) research in which a human embryo or embryos are destroyed, discarded, or knowingly subjected to risk of injury or death greater than that allowed for research on fetuses in utero under 45 CFR 46.204(b) and section 498(b) of the Public Health Service Act (42 U.S.C. 289g(b)).

(b) For purposes of this section, the term ''human embryo or embryos'' includes any organism, not protected as a human subject under 45 CFR 46 as of the date of the enactment of this Act, that is derived by fertilization, parthenogenesis, cloning, or any other means from one or more human gametes or human diploid cells.

(8) Limitation on Use of Funds for Promotion of Legalization of Controlled Substances (Section 509)

"(a) None of the funds made available in this Act may be used for any activity that promotes the legalization of any drug or other substance included in schedule I of the schedules of controlled substances established under section 202 of the Controlled Substances Act except for normal and recognized executive-congressional communications.

(b)The limitation in subsection (a) shall not apply when there is significant medical evidence of a therapeutic advantage to the use of such drug or other substance or that federally sponsored clinical trials are being conducted to determine therapeutic advantage."

(9) Restriction on Distribution of Sterile Needles (Section 520)

" Notwithstanding any other provision of this Act, no funds appropriated in this Act shall be used to carry out any program of distributing sterile needles or syringes for the hypodermic injection of any illegal drug."

(10) Restriction of Pornography on Computer Networks (Section 521)

"(a) None of the funds made available in this Act may be used to maintain or establish a computer network unless such network blocks the viewing, downloading, and exchanging of pornography.

(b) Nothing in subsection (a) shall limit the use of funds necessary for any federal, state, tribal, or local law enforcement agency or any other entity carrying out criminal investigations, prosecution, or adjudication activities."

(11) Restrictions on Funding ACORN

"None of the funds made available under this or any other Act, or any prior Appropriations Act, may be provided to the Association of Community Organizations for Reform Now (ACORN), or any of its affiliates, subsidiaries, allied organizations, or successors."

Division E Title VII

(12) Confidentiality Agreements (Section 743)

(a) None of the funds appropriated or otherwise made available by this or any other Act may be available for a contract, grant, or cooperative agreement with an entity that requires employees or contractors of such entity seeking to report fraud, waste, or abuse to sign internal confidentiality agreements or statements prohibiting or otherwise restricting such

employees or contractors from lawfully reporting such waste, fraud, or abuse to a designated investigative or law enforcement representative of a Federal department or agency authorized to receive such information.

(b) The limitation in subsection (a) shall not contravene requirements applicable to Standard Form 312, Form 4414, or any other form issued by a Federal department or agency governing the nondisclosure of classified information.

Resources

- Consolidated Appropriations Act, 2018 https://www.congress.gov/bill/115th-congress/house-bill/1625

Inquiries

Inquiries regarding this notice can be directed to:
Office of Federal Assistance Management
Division of Grants Policy
Policy & Special Initiatives Branch
Email: DGP@HRSA.gov
Telephone: 301-443-2837

	A	B	C	D	E	F
1		County of Santa Cruz Health Services Agency				
2		FY 17/18 Clinic Services Division				
3			4/30/2018			
4		Sum of Budget	Sum of Actual	Sum of Estimated Actuals (EA)	Sum of EA Variance to Budget	83% Fiscal Year To Date
5	EXPENDITURE	40,231,167	22,421,936	32,556,989	7,674,178	56%
6	CLINIC ADMINISTRATION	5,272,758	2,502,278	4,534,537	738,221	47%
7	CORAL STREET CLINIC (HPHP)	3,883,311	2,527,533	3,277,751	605,560	65%
8	EMELINE CLINIC	8,706,340	5,661,273	7,423,465	1,282,875	65%
9	FORENSIC SERVICES	-	25,107	-	-	NA
10	MENTAL HEALTH FQHC	13,436,639	5,880,299	9,224,895	4,211,744	44%
11	WATSONVILLE CLINIC	7,332,119	5,096,920	6,496,341	835,778	70%
12	WATSONVILLE DENTAL	1,600,000	728,527	1,600,000	-	46%
13						
14	REVENUE	(37,883,508)	(22,747,839)	(30,216,651)	(7,666,857)	60%
15	CLINIC ADMINISTRATION	(1,733,532)	(1,733,532)	(1,733,532)	-	100%
16	CORAL STREET CLINIC (HPHP)	(2,794,849)	(1,436,573)	(2,132,000)	(662,849)	51%
17	EMELINE CLINIC	(8,753,331)	(3,754,629)	(5,937,254)	(2,816,077)	43%
18	MENTAL HEALTH FQHC	(14,536,639)	(7,888,240)	(10,314,456)	(4,222,183)	54%
19	WATSONVILLE CLINIC	(7,865,157)	(6,392,048)	(8,099,409)	234,252	81%
20	WATSONVILLE DENTAL	(2,200,000)	(1,542,817)	(2,000,000)	(200,000)	70%
21	GRAND TOTAL (AKA NET COUNTY COST)	2,347,659	(325,902)	2,340,338	7,321	NA